The Global Mode of Experience in Psychodynamic Movement and Dance Therapy – Bodily Awareness as a Therapeutic Factor: Effects and Clinical Considerations

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Bodily awareness has become a central therapeutic factor in psychodynamic and body-oriented psychotherapies, yet its clinical effects and theoretical status remain insufficiently integrated. This paper offers a clinically grounded account of bodily awareness work in Psychodynamic Movement and Dance Therapy (PMT), conceptualising the body as the primary medium of lived experience rather than as an object of intervention. Drawing on phenomenology, developmental psychoanalysis, and clinical theory, the paper argues that therapeutic change in PMT unfolds through prereflective, embodied processes that precede verbal reflection and symbolic articulation. To integrate these perspectives, it introduces the concept of the *global mode of experience*, defined as an amodal, prereflective organisation of experience in which bodily sensation and affective vitality are lived as an integrated whole. Rooted in Daniel Stern's work, this mode is understood as a stable, activatable capacity rather than a regressive state, with orientation to the reality of the here-and-now fundamentally preserved. The paper positions the global mode of experience as a clinically orienting framework for understanding both the therapeutic effects and the limitations of bodily awareness work, highlighting the importance of timing, containment, and indication in psychodynamic movement and dance therapy.

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INTRODUCTION

Bodily awareness has become an increasingly central component of psychodynamic and body-oriented psychotherapies. Across clinical settings, therapists observe that shifts in bodily presence, rhythm, grounding, and affective vitality often precede verbal insight and support therapeutic change. At the same time, bodily awareness work continues to raise unresolved clinical questions regarding its mechanisms, indications, and potential risks.

Within psychodynamic frameworks, bodily processes are frequently understood either as expressions of unconscious conflict or as regressive phenomena linked to early developmental levels. In contrast, phenomenological and body-oriented approaches emphasise the body as the primary medium of lived experience, capable of supporting integration rather than regression. The lack of a shared conceptual language between these perspectives has contributed to uncertainty regarding when bodily awareness facilitates therapeutic change and when it may risk destabilisation.

Psychodynamic Movement and Dance Therapy (PMT) offers a particularly rich clinical field for examining these questions, as bodily awareness is not an adjunct but a core therapeutic medium. Clinical practice in PMT repeatedly demonstrates that bodily engagement can foster affect regulation, relational presence, and creative reorganisation, while also requiring careful attention to timing, containment, and contraindications. Yet these clinical observations are not always adequately captured by existing theoretical models.

The present paper addresses this gap by offering an integrative conceptual framework for understanding bodily awareness as a therapeutic factor in PMT. Drawing on phenomenology, developmental psychoanalysis, and clinical theory, it introduces the concept of the global mode of experience as a way of articulating a prereflective, amodal level of experiential organisation in which bodily sensation and affective vitality are lived as an integrated whole. This concept is proposed not as a technique or a regressive state, but as a clinically orienting framework that clarifies how bodily awareness may support therapeutic change while preserving differentiation and orientation to the reality of the here-and-now.

By situating bodily awareness work within a contained clinical frame and explicitly addressing questions of indication, timing, and contraindication, the paper aims to contribute to a more nuanced and clinically grounded understanding of embodied therapeutic processes in Psychodynamic Movement and Dance Therapy.

THEORETICAL FOUNDATIONS OF BODILY AWARENESS WORK

The Body as an Experiential Medium

The phenomenological understanding of the body as the primary medium of experience is well established within contemporary psychotherapy theory. Rather than revisiting these foundations in detail, the present paper takes this perspective as a point of departure for examining how bodily awareness functions as a therapeutic factor within specific clinical contexts. From a phenomenological standpoint, the body is not an object among others, but the lived ground through which perception, affect, and meaning emerge as a global, prereflective organisation of experience (Merleau-Ponty, 2012; Fuchs, 2020).

Within this framework, bodily awareness work does not aim to instrumentalise the body or to treat it as a site of intervention. Instead, it supports direct engagement with embodied experience as it unfolds through sensation, movement, rhythm, and intercorporeal resonance. These dimensions belong to the amodal and prereflective level of experience, providing access to layers of subjectivity that precede explicit reflection (Fuchs, 2020).

This orientation is further deepened by Vermes Katalin's concept of the responsible body, which emphasises that bodily experience is inherently relational and responsive rather than neutral or self-contained (Vermes, 2023). From this perspective, bodily awareness entails an ethical dimension: subjectivity emerges through bodily exposure, responsiveness, and mutual affectation within lived relational contexts that are structured at a global experiential level.

Preverbal Subjectivity and Embodied Self-Experience

Developmental and relational theories converge in recognising that the sense of self is rooted in prereflective, embodied experience. Daniel Stern's account of early self-experience highlights how affective vitality, bodily presence, and relational attunement shape amodal patterns of self-organisation long before the emergence of narrative identity (Stern, 2002). These prereflective dimensions remain operative

throughout adult life and continue to influence how individuals experience their bodies, emotions, and relationships.

Disturbances of self-experience – such as fragmentation, bodily alienation, or instability – may therefore be understood as disruptions in the global organisation of embodied subjectivity, rather than as deficits of reflective cognition alone (Fuchs, 2020). Bodily awareness work in PMT engages this level of experience by allowing prereflective and amodal meanings to emerge without forcing premature verbalisation (Merényi, 2004, 2010; Incze, 2008, 2021).

Rather than treating preverbal experience as a developmental residue, this perspective understands it as an ongoing global mode of experience that remains available across the lifespan. Clinical work at this level therefore requires sensitivity to timing and containment, particularly when engaging experiential layers that precede symbolic articulation.

Implicit Relational Knowing and Embodied Interaction

Implicit relational knowing refers to prereflective, bodily organised ways of being with others, enacted through patterns of timing, rhythm, posture, proximity, and affective resonance rather than through explicit representation (Stern et al., 1998; Lyons-Ruth, 1998). While the embodied nature of relational knowing is widely recognised, its organisation at a global and amodal experiential level has particular relevance for bodily awareness work.

Within PMT, movement and bodily presence form the medium through which implicit, prereflective relational patterns become experientially accessible. Therapeutic change may therefore unfold through new forms of global embodied relating, rather than through interpretation alone (Fuchs, 2020; Incze, 2021). From a phenomenological-ethical perspective, such enactments may be understood as expressions of bodily responsibility: the capacity to remain responsive to the other within a shared global experiential field, without collapsing into fusion or retreating into defensive distance (Vermes, 2023).

Affect Regulation as an Embodied and Relational Process

Affect regulation is understood across psychodynamic and developmental traditions as a fundamentally embodied and prereflective relational process (Stern, 2002; Schore, 2012). Early caregiver-infant interactions regulate affective states through rhythm, tone, proximity, and movement, giving rise to amodal patterns of regulation that persist at an implicit level.

In psychotherapy, the therapist's attuned embodied presence may function as a containing environment that supports the toleration and integration of affective experience (Bion, 1962; Winnicott, 1999). PMT makes this dimension explicit by working directly with movement, posture, breath, and rhythm as carriers of affective life within a global mode of experience.

The contribution of PMT does not lie in redefining affect regulation as embodied and relational, but in clarifying how bodily awareness may function as a therapeutic factor at a prereflective and global experiential level – and under what clinical conditions such work supports integration rather than destabilisation.

Creativity and Experiential Reorganisation

Creativity has long been understood as a central dimension of therapeutic change, particularly within Winnicott's conception of transitional space and play (Winnicott, 1999). Within PMT, movement improvisation opens a space in which experience may reorganise at a global, prereflective level, without being prematurely fixed in symbolic form (Merényi, 2004; Incze, 2008).

Rather than introducing creativity as a novel therapeutic principle, this section situates creative movement within the global mode of experience. From this perspective, creativity supports amodal experiential reorganisation, allowing bodily sensation and affective vitality to be held together without implying regression or loss of symbolic capacity (Vermes, 2023).

Integrative Orientation

Taken together, these perspectives establish a shared theoretical ground for understanding bodily awareness work in PMT:

- the body as the primary medium of global, prereflective experience
- the self as rooted in amodal embodied subjectivity
- relational life as implicitly organised and enacted within a global experiential field
- affect regulation as an embodied, prereflective process
- creativity as a mode of global experiential re-organisation

Within this framework, bodily awareness work can be understood not as a technique applied to the body, but as a clinically sensitive practice oriented toward the reorganisation of global modes of experience. This integrative orientation prepares the ground for introducing the concept of the global mode of experience as a clinically orienting framework for understanding both the therapeutic potential and the limitations of bodily awareness work.

BODILY AWARENESS WORK IN THE CLINICAL PROCESS

The Body as the Medium of Therapeutic Experience

In PMT, the therapeutic process unfolds primarily through the lived body, which functions as the medium of perception, affect, and relational presence (Merleau-Ponty, 2012; Fuchs, 2020). Rather than treating bodily experience as an object, PMT approaches it as the prereflective ground of subjectivity. The patient's way of moving, inhabiting space, sensing weight and rhythm becomes a direct pathway into implicit layers of self-experience and relational organisation (Stern, 2002; Lyons-Ruth, 1998).

Within this perspective, bodily awareness work does not aim at behavioural control or correction. Instead, it supports a gradual re-inhabiting of the body as an experiential medium, opening access to meanings that are first lived and only later articulated in language (Merényi, 2004; Incze, 2008, 2021). This clinical orientation emerged from the experiential tradition of Hungarian Psychodynamic Movement and Dance Therapy, where decades of movement-based therapeutic practice preceded and gradually informed its theoretical articulation. The systematic methodological and theoretical integration of this clinical experience has been developed primarily through the work of Merényi (2004, 2010), with subsequent contributions further elaborating specific phenomenological and clinical aspects of bodily awareness work (Campos, 2008; Incze, 2008; Simon, 2022; Vermes, 2006).

From a phenomenological-ethical standpoint, this re-inhabiting also entails a shift in bodily responsibility: the body is no longer experienced merely as an instrument or object of observation, but as a responsive presence within the therapeutic encounter. As Vermes Katalin (2023) emphasises, bodily experience always unfolds in relation to an other, and therapeutic work engages this relational exposure as a core dimension of change.

In this sense, therapeutic work in PMT engages the body at a global, prereflective level of experience, where bodily sensation, affective tone, and relational orientation are lived as an integrated whole before being verbally articulated.

Affect Regulation and Bodily Presence

Affect regulation is inherently embodied and relational (Stern, 2002; Schore, 2012). Early caregiver-infant interactions regulate bodily states through rhythm, tone, proximity, facial expression, and movement, establishing foundational patterns for later emotional life. These patterns persist largely at an implicit level (Lyons-Ruth, 1998).

In psychotherapy, the therapist's attuned embodied presence may re-engage this regulatory matrix (Bion, 1962; Winnicott, 1999). PMT makes this dimension explicit by working directly with movement, breath, vitality affects and postural tone – all of which participate in the modulation of affective intensity (Fuchs, 2020; Merényi, 2010; Incze, 2021). Earlier clinical and theoretical reflections have highlighted that such bodily modulation functions not as a technique applied to affect, but as a relational process unfolding within shared embodied presence (Campos, 2008; Merényi, 2004, 2010; Incze, 2023).

Patients frequently describe change not first in cognitive terms, but as a shift in embodied state: greater rootedness, slower rhythm, more permeable yet intact boundaries. These micro-transformations support self-coherence and the capacity to tolerate emotional experience without fragmentation. Within a phenomenological framework, such changes may also be understood as reorganisations of embodied responsibility – shifts in how the person can remain present to affect without withdrawal or defensive disembodiment (Vermes, 2023). Affect regulation thus appears not merely as emotional control, but as a capacity for bodily staying-with experience in relation to another.

From this perspective, affect regulation in PMT unfolds primarily at a prereflective and amodal level of experience, where bodily rhythms and affective vitality are regulated before emotional states become symbolically differentiated.

Stern's Vitality Affects

Daniel Stern describes vitality affects as dynamic qualities of experience – surging, fading, bursting, lingering – that are neither simple emotions nor

pure cognition, but felt temporal-energetic contours of aliveness (Stern, 2002). They constitute a bridge between body and meaning.

In PMT, changes in rhythm, weight, tempo, or movement contour may transform vitality affects – and with them, the person's felt sense of being-in-the-world. Therapeutic change therefore often emerges not from explicit interpretation, but from a re-patterning of lived vitality, supported within the relational field (Fuchs, 2020; Incze, 2021). From Vermes' perspective, these vitality shifts may be understood as temporal reorganisations of embodiment, in which lived time regains continuity and responsiveness. The regulation of vitality thus becomes inseparable from the ethical dimension of remaining bodily present within shared time.

Reorganisation of Relational Patterns

Stern and colleagues describe implicit relational knowing as prereflective knowledge of "how to be with others" – enacted in gesture, timing, posture, and affective flow, rather than verbally represented (Stern et al., 1998; Lyons-Ruth, 1998). This dimension is embodied, procedural, and relational.

Because PMT works directly through bodily presence and movement, it offers a privileged context in which implicit relational knowing can be re-experienced and transformed. Subtle co-regulation – shared rhythm, proximity, mirroring, pausing – allows new relational expectations to be enacted and stabilised within the intersubjective field (Fuchs, 2020). Earlier theoretical work has emphasised that such embodied enactments form a critical interface between implicit relational knowing and symbolic integration, particularly in body-oriented psychodynamic approaches (Incze, 2023; Incze, 2025).

In many therapies, this takes the form of micro-moments of contact: a breath matched, a movement softened, a posture released in the presence of another. Over time, such experiences contribute to a more coherent sense of self-in-relation (Incze, 2021). Phenomenologically, these moments may also be understood as instances of bodily answerability: the capacity to respond to the other without collapsing into fusion or retreating into defensive distance (Vermes, 2023). Relational change thus unfolds as a transformation in how the body remains exposed, responsive, and coherent within interpersonal space.

Such moments may be understood as brief activations of a global mode of experience, in which relational contact is lived bodily and affectively as a coherent whole rather than through reflective self-monitoring.

Creative Process and Meaning-Making

Bodily awareness work inherently activates the creative process, understood as the organism's capacity to reorganise experience (Incze, 2008). Movement improvisation opens a transitional space where preverbal affective life may find expression without being forced into premature interpretation (Winnicott, 1999). This understanding of creativity as a bodily-relational process has been elaborated in earlier clinical and philosophical work, where creative movement is viewed as a mode of experiential reorganisation rather than aesthetic production (Incze, 2021; Incze, 2025).

Meaning in PMT therefore emerges from embodied exploration, rather than being imposed externally. Verbal articulation follows as a reflective integration – respecting the primacy of lived experience (Merleau-Ponty, 2012; Stern, 2002; Vermes, 2006, 2023). Vermes' analysis of improvisation underscores this process by framing creative movement as an ethically attentive engagement with emergent bodily meaning. Improvisation allows experience to take form in time without being fixed, supporting a mode of therapeutic change that privileges responsiveness, openness, and lived continuity over symbolic mastery (Vermes, 2006, 2023).

Integrative View

Across these dimensions, PMT can be understood as a therapeutic approach in which:

- psychological life is embodied and prereflective (Merleau-Ponty, 2012; Fuchs, 2020)
- affect regulation is relational and implicit (Stern, 2002; Schore, 2012)
- relational knowing is enacted through the body (Stern et al., 1998; Lyons-Ruth, 1998)
- creativity supports transformational reorganisation (Incze, 2008, 2021)
- all within a containing therapeutic relationship (Bion, 1962; Winnicott, 1999; Merényi, 2010).

Within this embodied-relational framework, PMT may also be understood as a practice of bodily responsibility, in which therapeutic change unfolds through the capacity to remain present, responsive, and ethically attuned within shared embodied time (Vermes, 2006, 2023). On this basis, bodily awareness

work in PMT can be situated within specific clinical contexts, indications, and methodological considerations.

CLINICAL APPLICATIONS AND METHODOLOGICAL FRAMEWORK OF BODILY AWARENESS WORK IN PMT

Psychodynamic movement and dance therapy (PMT) can be understood as a therapeutic approach in which the process of change unfolds within the medium of bodily presence, movement, relational engagement, and symbolic meaning-making. In this embodied space, implicit, preverbal layers of self-organization and relational knowing become directly accessible and potentially transformable (Stern, 2002; Lyons-Ruth, 1998; Merényi, 2004, 2010; Incze, 2008, 2021). This understanding is further informed by critical reflections on the contemporary "corporeal turn," which emphasise that working through the body entails not only expanded therapeutic possibilities but also specific methodological and ethical responsibilities (Incze, 2023, 2025).

Among the key therapeutic factors of PMT is the processing of emotional experience through the body, understood not as mere expression but as a lived event within the body as an experiential medium (Merleau-Ponty, 2012; Fuchs, 2020; Vermes, 2006, 2023). Emotional life manifests in rhythm, posture, gesture, spatial use, and the affective resonance of the group. Verbal reflection thus becomes a natural continuation rather than a replacement of embodied experience. From a phenomenological-ethical perspective, bodily processing also entails responsibility toward what emerges: sensations, affects, and relational movements are approached not as material to be mastered, but as experiences to be met with attentiveness and care (Vermes, 2006, 2023). Earlier philosophical-psychoanalytic work has highlighted that this ethical dimension becomes particularly salient when bodily experience is explicitly foregrounded in therapeutic settings (Incze, 2025).

Another central factor is the holding and containing function of the therapeutic group or dyad, in which the relational field offers safety for bodily-affective exploration (Bion, 1962; Winnicott, 1999; Merényi, 2010). Within this environment, affect regulation is supported not only cognitively but through shared rhythm, presence, and intercorporeal attunement (Stern et al., 1998; Fuchs, 2020). Containment here may be understood not merely as structural holding, but as an embodied ethical stance: the therapist's bodily presence provides a responsive field within which experience can unfold without being prematurely intensified or withdrawn from – a distinction emphasised in critical discussions of body-oriented psychodynamic practice (Incze, 2023).

Bodily awareness work also activates self-regulatory processes. Shifts in breathing, tone, grounding, and proprioceptive awareness contribute to stabilisation and the emergence of self-coherence (Incze, 2008, 2021). Here the body functions not merely as a site of symptom expression, but as an active regulatory medium. Phenomenologically, such regulation involves the capacity to remain bodily present to experience – neither dissociating from it nor being overwhelmed by it – a capacity closely linked to what Vermes describes as bodily responsibility toward one's own lived states (Vermes, 2023). This understanding resonates with philosophical accounts that frame bodily regulation as an ethically situated mode of self-relation rather than a purely technical skill (Incze, 2025).

A further therapeutic factor is the strengthening of self-coherence and embodiment. As bodily experience becomes more differentiated and integrated, implicit meanings can be symbolically articulated and woven into narrative identity (Stern, 2002). This contributes to a restored sense of continuity of self-experience within a secure intersubjective field (Fuchs, 2020). Embodiment in this sense does not imply closure or self-sufficiency, but a more stable openness to relational engagement grounded in bodily presence.

Finally, the creative process – movement improvisation, play, and embodied exploration – opens a space for new experiential and meaning structures to emerge. Creativity here is not an aesthetic aim but a reorganising psychic force rooted in bodily life (Incze, 2008, 2021). Improvisation allows experience to take form in time without being fixed, supporting a mode of therapeutic change that values responsiveness, timing, and ethical attentiveness to what is emerging rather than goal-directed control. This view of creativity as an ethically attuned bodily process has been further elaborated in philosophical reflections on embodiment and therapeutic practice (Incze, 2025).

Taken together, PMT may be conceptualised as a therapeutic approach in which the body is the primary medium of intersubjective, affective, and symbolic experience (Merleau-Ponty, 2012; Fuchs, 2020; Vermes, 2006, 2023). Within this framework, bodily

awareness work appears not as a technique applied to the body, but as a relational practice grounded in the responsible presence of both patient and therapist.

Clinical Fields of Application – An Embodied Perspective

PMT is particularly indicated in conditions where preverbal, embodied layers of experience play a central role in psychological functioning, including trauma, dissociation, affect regulation difficulties, psychosomatic problems, narcissistic vulnerability, and stabilised phases of psychotic illness (Stern, 2002; Schore, 2012; Merényi, 2004; Incze, 2021). In such contexts, therapeutic work that addresses bodily experience directly offers access to implicit dimensions of self-organisation that may remain unavailable to purely verbal approaches. Critical discussions of the corporeal turn underscore that precisely in these clinical fields, bodily awareness work requires careful differentiation between therapeutic activation and potential overstimulation (Incze, 2021, 2023). From a clinical perspective, bodily awareness work in PMT may be understood as engaging the global, prereflective organisation of experience, which has specific implications for indication, timing, and contraindication.

Contraindications and Clinical Cautions in Bodily Awareness Work

Certain acute or severely destabilised conditions – such as manic states, acute psychosis, severe disturbances of reality testing, uncontrolled addictive states, or acute suicidal crisis – may temporarily limit the safe application of bodily awareness work (Incze, 2021, 2023). In these contexts, ego boundaries and affect regulation are already fragile, and a bodily focus may risk further destabilisation.

From an ethical-phenomenological perspective, such cautions highlight the importance of timing, dosage, and responsiveness (Vermes, 2023). Working with the body entails exposure and openness; when the capacity to remain bodily present is compromised, therapeutic responsibility may require restraint rather than activation. The pacing and containment of embodied work therefore demand careful clinical judgment and ongoing attunement. This ethical demand has been explicitly articulated in critiques of unreflected applications of body-focused interventions within psychodynamic contexts (Incze, 2023, 2025).

Methodological Framework of Bodily Awareness Work – A Phenomenological Perspective

This methodological orientation also reflects the long-standing Hungarian PMT tradition emphasising the careful structuring of bodily experience through instructions, containment, and reflective integration (Merényi, 2004, 2010). The therapist's embodied presence, attunement, and containment form an essential dimension of the intersubjective field (Fuchs, 2020).

Movement, improvisation, and bodily awareness support the emergence of implicit meaning; verbal reflection integrates rather than dominates (Stern, 2002; Incze, 2008, 2021). Within this framework, therapeutic technique is inseparable from ethical stance: bodily awareness work requires sensitivity to rhythm, interruption, and withdrawal, as well as to moments when experience calls for grounding rather than exploration. PMT thus creates a therapeutic space in which implicit self-organisation becomes safely accessible for transformation, without violating the person's capacity for bodily presence and responsibility – a concern that has been foregrounded in recent philosophical–psychoanalytic analyses of embodied therapeutic practice (Incze, 2023, 2025).

Concluding Perspective

Seen from a phenomenological standpoint, PMT approaches therapeutic change as the transformation of embodied being-in-the-world. Through bodily awareness, relational presence, and symbolic articulation, implicit layers of experience may reorganise within a securely held intersubjective field. From this perspective, PMT may be understood not only as a clinical method, but as a practice of embodied responsibility, in which therapeutic change unfolds through the capacity to remain bodily present, responsive, and ethically attuned within shared experiential time – a position that situates PMT within broader contemporary reflections on embodiment and responsibility in psychotherapy.

THE GLOBAL MODE OF EXPERIENCE AS AN INTEGRATIVE CONCEPT

Working definition

The global mode of experience refers to an amodal, prereflective organisation of lived experience in which bodily sensation, affective vitality, perceptual

modalities, and the organism's sensuous engagement with the world are experienced as an integrated whole unfolding within a coherent temporal flow. It is characterised by a slightly altered, yet stable state of bodily awareness in which experience is lived directly rather than analytically observed. Although this mode may connect the individual to early, implicit bodily-affective layers of experience, reflective capacity and orientation to the reality of the here-and-now remain fundamentally preserved. The term encompasses the integrated sensory, affective, and bodily qualities of lived experience, including those primordial forms of sensuous engagement that developmentally precede the later differentiation of cognition, affect, and sexuality. The global mode of experience thus designates a form of experiential integration that supports experiential coherence, creativity, and therapeutic change without loss of differentiation or symbolic functioning.

This distinction is clinically important. Regression may be understood as a temporary return to an earlier developmental level, often accompanied by a partial withdrawal from the reality of the here-and-now. By contrast, the global mode of experience may provide access to early embodied layers of experience while preserving reflective capacity and orientation to the present. In this sense, it represents not a developmental regression but a distinct mode of organising lived experience (Incze, 2023).

The concept of the global mode of experience is introduced as an integrative theoretical contribution grounded in clinical observation, Stern's developmental perspective, and phenomenological description. It seeks to articulate a mode of experiencing that precedes reflective differentiation, yet remains fully operative in adult psychological life, creativity, and psychotherapy. Rather than denoting a specific mental state or technique-induced condition, the global mode of experience refers to a characteristic organisation of lived experience in which bodily sensation, affective vitality, and perceptual orientation are experienced as an undivided, dynamically coherent whole.

Phenomenologically, the global mode of experience is characterised by an amodal quality of experience. Sensation, affect, movement, and temporal flow are not yet separated into distinct experiential channels, but are lived together within a shared experiential field. Affect is not recognised as a named emotion, nor bodily sensation as an object of observation; instead, both are present as qualitative tonalities of aliveness – intensities, rhythms, tensions, expansions, and contractions. Experience is thus organised less through categorical meaning and more through felt coherence, continuity, and vitality.

From a psychodynamic and developmental perspective, this conceptualisation builds particularly on Daniel Stern's accounts of amodal perception and vitality affects. Stern emphasises that such prereflective integration is not confined to early infancy but remains an ongoing dimension of subjective life, particularly salient in moments of emotional intensity, creativity, relational attunement, and therapeutic change. The global mode of experience, in this sense, does not replace reflective or symbolic functioning but provides the experiential ground upon which such functions can emerge or reorganise.

This understanding is further supported by Herman Witkin's distinction (Witkin et al., 1962) between global (field-dependent) and analytic (field-independent) modes of perceptual organisation. In a global mode, perception is embedded within a holistic experiential field, and meaning arises from the overall configuration rather than from isolated elements. Importantly, Witkin's work does not conceptualise global organisation as inferior or immature, but as a distinct and enduring mode of processing that coexists with analytic differentiation. Integrated with Stern's perspective, this suggests that the global mode of experience represents a legitimate and ongoing form of experiential organisation rather than a regression to an earlier developmental stage.

Clinically, the global mode of experience may be observed when patients describe feeling "more inside the experience," when bodily sensation and affective tone are present without immediate narrative framing, or when movement, rhythm, and gesture carry meaning prior to verbal articulation. Such moments often involve a temporary softening of rigid self-observation or defensive control, allowing experience to be lived before it is explained. Crucially, this does not imply loss of ego boundaries or symbolic capacity; rather, differentiation is momentarily backgrounded to allow for experiential integration.

This framing also resonates with contemporary models of embodied cognition and predictive processing, which conceptualise perception and meaning as emerging from continuous, embodied processes of integration and regulation. Within this perspective, the global mode of experience may be understood as a configuration in which bodily and affective signals are integrated with relatively reduced top-down constraint, enabling flexible adjustment rather than rigid prediction or defensive

avoidance. Such integration supports adaptive reorganisation without necessitating regression or cognitive disintegration.

The global mode of experience must therefore be clearly distinguished from regressive functioning. While regression involves a loss of differentiation, agency, or reflective capacity, the global mode of experience preserves these capacities in the background, allowing them to be re-engaged following experiential integration. Similarly, it differs from fusion or dissociation: experience remains coherent and embodied, not fragmented or merged. The clinical task lies in supporting access to this mode under conditions of sufficient containment, timing, and affect tolerance.

Finally, the global mode of experience should be understood as a general dimension of human experience rather than a phenomenon exclusive to body-oriented psychotherapy. While Psychodynamic Movement and Dance Therapy explicitly engages this mode through movement, bodily awareness, and creative exploration, similar experiential organisations are present in everyday activities, artistic processes, contemplative states, and across diverse psychotherapeutic approaches. In this broader sense, the concept functions both as a theoretical addition and as a clinically orienting framework that bridges phenomenological description, psychodynamic understanding, and contemporary cognitive perspectives on therapeutic change.

CLINICAL VIGNETTES

The following clinical vignettes illustrate how shifts toward a more global level of experience may emerge within bodily awareness work across different clinical contexts. Rather than demonstrating a uniform technique, the cases highlight how bodily awareness functions as a therapeutic factor whose effects depend on timing, containment, and the patient's capacity to tolerate and integrate prereflective experience. At the same time, they indicate the clinical considerations and limits within which access to a more global organisation of experience may support integration rather than destabilisation.

6.1. Grounding and Self-Coherence in Anxiety

A woman in her thirties entered therapy with chronic anxiety, persistent bodily tension, and difficulty locating emotional states internally. Her clinical presentation was characterised by elevated arousal and hypervigilance, indicating a need for stabilisation rather than expressive exploration. In the early phase of treatment she moved with minimal variation in rhythm or weight; her posture remained elevated and guarded. Given this profile, bodily awareness work was introduced as an indicated intervention for anxiety regulation, with explicit attention to pacing and containment.

Therapeutic work prioritised grounding and contact with bodily support through gentle orientation to breath, sensing the ground, and slow, repetitive stepping. Over time, she reported that her body felt "less vertical and defended," and her movement widened into the surrounding space. Episodes of acute anxiety decreased, and she described an increasing capacity to "stay with myself rather than escape into tension." In this case, bodily awareness functioned as a therapeutic factor by strengthening prereflective self-coherence. Importantly, the work remained focused on stabilisation; premature expressive or symbolic exploration would likely have been contraindicated at this stage of treatment.

Affect Regulation and Relational Presence in Borderline Dynamics

A young adult with longstanding difficulties in relationships and affect tolerance presented with rapid shifts between agitation and collapse, consistent with borderline dynamics. Her clinical presentation indicated both the potential benefit and the risk of bodily awareness work: while embodied engagement could support affect regulation, insufficient containment risked affective flooding. Early sessions therefore emphasised the establishment of safety, predictability, and relational containment.

The therapeutic focus rested on cultivating tolerable bodily rhythms – gentle rocking, paced walking, and brief sequences of shared movement – rather than expressive intensity. During body awareness work in pairs, she experienced that movement continuity supported affect regulation and reduced abrupt shifts between activation and withdrawal. Gradually, relational contact could be sustained for longer periods without fragmentation. In this context, bodily awareness functioned as a therapeutic factor by supporting access to a more integrated experiential organisation. However, this was contingent on careful timing; more intense improvisational work remained conditionally indicated and required ongoing assessment of affect tolerance.

Embodied Grounding in a Stabilised Phase of Psychosis

A middle-aged man with a history of psychosis entered PMT in a stabilised phase of illness. Although acute symptoms were not present, his clinical history indicated vulnerability to disorganisation, making symbolic or imaginative exploration potentially contraindicated. He described his body as "distant," with fluctuating sensations of size and density, pointing to disturbances of bodily self-experience.

Therapeutic work therefore focused on grounding, orientation, and predictability: sensing weight through the feet, exploring simple movements, and establishing repetitive rhythmic sequences. The therapist deliberately refrained from symbolic interpretation or expressive movement, recognising these as contraindicated at this phase. Over time, the man increasingly reported feeling "more inside my body," with a reduction in confusion and improved everyday functioning. Here, bodily awareness functioned as a therapeutic factor by supporting the re-establishment of embodied continuity, while respecting the clinical limits necessary to prevent destabilisation.

Reclaiming the Body from Objectification in Narcissistic Vulnerability

A highly accomplished professional sought therapy following relational difficulties marked by emotional detachment and a performance-driven identity, suggestive of narcissistic vulnerability. His clinical presentation indicated that bodily awareness work could be beneficial, provided it did not reinforce self-monitoring or perfectionistic control. Early sessions therefore avoided aesthetic or performance-oriented movement, which might have functioned defensively.

Therapeutic work focused on cultivating internal bodily sensation and curiosity without evaluative framing. Through the gradual introduction of movement improvisation, fragments of playfulness emerged, and the patient began to describe the body less as an object to be assessed and more as "a place I can return to." This shift supported access to previously defended affective registers and enabled greater relational authenticity. In this case, bodily awareness functioned as a therapeutic factor by counteracting objectification; however, attention to pacing and vulnerability was essential to avoid shame activation or defensive withdrawal.

Clinical implications

The presented vignettes illustrate that bodily awareness functions as a therapeutic factor across diverse clinical presentations when applied with careful attention to indication, timing, and containment. At the same time, they underscore that bodily awareness work is not universally or uniformly applicable. Its therapeutic potential depends on the patient's capacity to tolerate prereflective experience and on the therapist's ability to assess when embodied engagement supports integration and when it risks destabilisation. From this perspective, bodily awareness work in PMT requires continuous clinical judgment regarding pacing, intensity, and contraindications, rather than the application of fixed techniques.

Clinical Indications Illustrated by the Case Vignettes

- Anxiety disorders and chronic hyperarousal (Case 6.1)
  - Indication: grounding-oriented bodily awareness to support affect regulation and prereflective self-coherence
  - Clinical focus: pacing, containment, avoidance of premature expressive work
  - Contraindication: early activation of symbolic or high-intensity movement
- Borderline dynamics and affect regulation difficulties (Case 6.2)
  - Indication: bodily awareness as a co-regulatory therapeutic factor within a contained relational field
  - Clinical focus: rhythm, continuity, relational timing
  - Contraindication: insufficient containment leading to affective flooding or fragmentation
- Stabilised phases of psychotic illness (Case 6.3)
  - Indication: grounding and bodily orientation to restore experiential continuity
  - Clinical focus: predictability, repetition, minimal symbolic load
  - Contraindication: symbolic, imaginative, or interpretive interventions during vulnerable phases
- Narcissistic vulnerability and bodily objectification (Case 6.4)
  - Indication: bodily awareness to counteract objectifying self-observation and support authentic presence

– Clinical focus: curiosity, playfulness, non-evaluative bodily attention
– Contraindication: performance-oriented or aesthetic framing that reinforces defensive control or shame

Practice points

Bodily awareness functions as a therapeutic factor in Psychodynamic Movement and Dance Therapy when applied in accordance with clinical indication, timing, and containment. Across clinical presentations, grounding and prereflective integration are often indicated prior to expressive or symbolic work. The therapist's ongoing assessment of affect tolerance and bodily self-coherence is essential in determining when embodied engagement supports integration and when it risks destabilisation. Bodily awareness work is therefore not a uniform intervention but a context-sensitive clinical practice requiring continuous judgment regarding pacing, intensity, and contraindications.

METHODOLOGICAL AND CLINICAL REFLECTIONS, LIMITATIONS, AND DIRECTIONS FOR RESEARCH

From Method to Clinical Stance: Methodological Reflections on Bodily Awareness Work in PMT

Psychodynamic movement and dance therapy (PMT) occupies a distinctive position among psychotherapeutic approaches in that the body is not an adjunct to psychic life but its primary experiential medium. PMT does not approach embodied experience as an object to be analysed, but as a lived field in which psychological, relational, and symbolic processes become manifest. The therapeutic task is therefore less one of interpretation than of clinical accompaniment, containment, and the facilitation of emergent meaning within the relational field.

From a phenomenological perspective, this orientation is congruent with the view that the self is always already embodied and intersubjective. PMT places particular emphasis on the implicit and preverbal dimensions of experience – those aspects of subjectivity that precede reflective knowing yet profoundly shape it. The cultivation of bodily awareness allows these layers of implicit self-organization to become experientially available without forcing premature symbolization (Incze, 2008, 2021). Verbal reflection is invited, but it follows rather than precedes lived experience.

At the same time, PMT requires a high degree of clinical sensitivity and self-awareness on the part of the therapist, particularly in situations where bodily awareness intensifies affective or relational processes. The therapist's own embodied presence forms an active dimension of the therapeutic process. Methodologically, this raises questions regarding therapist training, supervision, and ethical stance – especially in relation to bodily boundaries, affective resonance, and the handling of implicit communication. From a phenomenological-ethical perspective, this sensitivity may be understood as a form of bodily responsibility: the therapist's task is not to manage or control embodied processes, but to remain responsively present to what emerges within the shared field of experience. Rather than prescribing uniform procedures, PMT relies on an ethically grounded, reflective clinical praxis, guided by phenomenological attention to the unfolding encounter.

Clinical Limitations, Contraindications, and Ethical Challenges of Bodily Awareness Work

Like all therapeutic modalities, PMT has limitations. Its central reliance on the body as an experiential medium renders it less easily standardisable than manualised approaches; the uniqueness of each therapeutic relationship and the subtlety of bodily phenomena complicate attempts at rigid operationalisation (Incze, 2021). While this openness constitutes a methodological and clinical strength, it also restricts the ease of empirical evaluation.

PMT further requires a certain level of psychological stability to safely tolerate and integrate bodily experience. As discussed earlier, acute psychotic or manic states, severe disturbances of reality testing, or uncontrolled addictive behaviours may temporarily limit the appropriateness of bodily awareness work. From an ethical and clinical standpoint, such limitations underscore the importance of timing, dosage, and restraint: bodily awareness entails exposure, and therapeutic responsibility may at times require limiting or postponing embodied exploration rather than intensifying it. Although the clinical and theoretical literature on PMT is substantial, systematic outcome research remains relatively limited. The implicit and prereflective nature of therapeutic change challenges traditional outcome measures that prioritise verbal self-report and conscious insight. There is therefore a clear

need for research methodologies capable of capturing embodied, relational, and processual dimensions of change without reducing them to isolated variables.

Finally, socio-cultural contexts shape the lived meaning of the body and relational norms of proximity, expression, and interaction. PMT must therefore remain attentive to diversity and to the ethical implications of embodied presence in therapy, recognising that bodily responsiveness and responsibility are always situated within cultural and historical contexts.

7.3. Clinical and Process-Oriented Directions for Future Research

Future research in PMT may move along several complementary trajectories. One involves process-oriented qualitative studies exploring how shifts in bodily awareness, affect regulation, and self-coherence as therapeutic factors emerge over time within the therapeutic relationship. Phenomenological and narrative-analytic methodologies are particularly suited to this task, as they remain close to lived experience while allowing for careful theoretical articulation.

Another trajectory concerns mixed-methods and outcome research integrating quantitative measures with indices of relational and embodied change. Developments in affective neuroscience and embodied cognition – for example, findings related to mirror neuron systems and implicit affective communication – may provide useful bridges between subjective experience and neurophysiological processes (Rizzolatti & Sinigaglia, 2008; Schore, 2012), provided these approaches remain grounded in lived experience and do not reduce it to explanatory mechanisms.

A further direction lies in continued theoretical integration. PMT occupies a position at the intersection of phenomenology, psychodynamic theory, developmental psychology, and relational models of psychotherapy. Concepts such as implicit relational knowing, intercorporeality, embodied responsibility, and the intersubjective field may support a more nuanced understanding of how embodied therapeutic processes unfold in clinical practice.

Finally, research on therapist training and the embodied development of clinicians may clarify how presence, attunement, ethical sensitivity, and the handling of contraindications evolve within PMT practice.

7.4. Concluding Clinical Reflections

PMT invites us to recognise that psychological change is enacted not only in thought or narrative, but in the very way individuals inhabit their bodies – both in relation to others and in moments of bodily self-attunement. By approaching the body as an experiential medium rather than an object, PMT offers a clinically grounded way of engaging those layers of experience that are first lived in the body and only subsequently articulated in language.

In this sense, the concept of the global mode of experience fulfils the integrative aim outlined at the outset of the paper: it provides a shared conceptual reference through which phenomenological descriptions of prereflective experience, psychodynamic clinical observation, and considerations of therapeutic indication and limitation may be held together without reducing embodied change to regression or technique.

From a phenomenological perspective, bodily awareness work may thus be understood not merely as a clinical technique, but as a relational and ethical practice. Following Vermes' notion of the responsible body, therapeutic change can be conceived as a transformation in how individuals remain bodily present and responsive within lived experiential time. This perspective clarifies why bodily awareness work can function as a powerful therapeutic factor, while at the same time requiring careful attention to timing, containment, and contraindications in clinical practice.

Within this context, the concept of the global mode of experience is introduced not as an abstract theoretical construct, but as a clinically relevant framework for understanding both the therapeutic effects and the potential risks of bodily awareness work in Psychodynamic Movement and Dance Therapy. As an amodal, prereflective organisation of experience in which bodily sensation and affective vitality are lived as an integrated whole, the global mode of experience articulates the experiential level at which bodily awareness facilitates creative reorganisation – and the conditions under which this process may become destabilising rather than integrative.

The promise – and the clinical challenge – of PMT lies in remaining faithful to this embodied, relational, and creative orientation while continuing to articulate its methods and effects, including indications and contraindications, in dialogue with contemporary psychotherapy research. By offering a

phenomenologically grounded and clinically sensitive conceptual language, this paper aims to contribute to a more nuanced understanding of how bodily awareness functions as a central therapeutic factor within psychodynamic movement and dance therapy.

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REFERENCES

1. Bion WR. Learning from experience. Heinemann, London, 1962.
2. Campos A. A test valósága és a fantázia tere a pszichodinamikus mozgás- és táncterápiában. Pszichoterápia 2008;17(6):379–385.
3. Fuchs T. Ecology of the brain: Embodiment and enactivism in psychiatry. Oxford University Press, Oxford, 2020.
4. Incze A. A testtudati munka mint a testi kreativitás mozgósítója. Pszichodráma Újság 2008; tavasz: 40–47.
5. Incze A. A pszichodinamikus mozgás-és tánkterápia hatótényezői és a munkamódok szerepe. In: Merényi M., Korbai H. (szerk.). A pszichodinamikus mozgás- és táncterápia. L'Harmattan, Budapest, 2021: 87–103.
6. Incze A. „Corporeal turn" – inkább szaltó vagy bukfenc a testi fordulat a pszichoanalitikus terápiákban? 2023; Imágó, 12(2), 104–114.
7. Incze A. A filozófiai „testi fordulat" a pszichoanalízis történeti szálai mentén. Lélekelemzés 2025, 20(2): 76-93.
8. Jacobs TJ. On countertransference enactments. J Am Psychoanal Assoc 1986; 34: 289–307.
9. Lyons-Ruth K. Implicit relational knowing: Its role in development and psychoanalytic treatment. Infant Ment Health J 1998; 19(3): 282–298.
10. Merényi M. Mozgás- és táncterápia. Pszichoterápia 2004; 13(1): 4–15.
11. Merényi M. Az instrukciók születése a pszichodinamikus mozgás- és táncterápiában. Pszichoterápia 2010; 19(2): 84–93.
12. Merleau-Ponty M. Phenomenology of perception. Gallimard, Paris, 1945. (Hungarian edition: Atlantisz, Budapest, 2012.)
13. Pető K. Implicit relational knowing: New perspectives on understanding therapeutic effectiveness. Psychiatr Hung 2003; 4: 217–225.
14. Rizzolatti G, Sinigaglia C. Mirrors in the brain. Oxford University Press, Oxford, 2008.
15. Schore AN. The science of the art of psychotherapy. W. W. Norton, New York, 2012.
16. Simon J. Improvizáció és pszichoanalitikus tér. Imágó Budapest 2022;11(1):51–62.
17. Stern DB, Goodman G. Reenactment: Psychoanalytic perspectives. Psychoanal Dialogues 2013; 23(6): 569–578.
18. Stern DN. The interpersonal world of the infant. Basic Books, New York, 1985. (Hungarian edition: Animula, Budapest, 2002.)
19. Stern DN, Sander LW, Nahum JP, Harrison AM, Lyons-Ruth K, Morgan AC, Bruschweiler-Stern N, Tronick EZ. Non-interpretive mechanisms in psychoanalytic therapy: The "something more" than interpretation. Int J Psychoanal 1998; 79: 903–921.
20. Vermes K. „Időt adó improvizáció": The formation of the experience of time in dance therapy groups. Café Bábel 2006; 52: 63–70.
21. Vermes K. A felelő(s) test. Exkarnáció és inkarnáció ritmusai. L'Harmattan, Budapest, 2023.
22. Winnicott DW. Playing and reality. Tavistock, London, 1971. (Hungarian edition: Animula, Budapest, 1999.)
23. Witkin HA, Dyk RB, Faterson HF, Goodenough DR, Karp SA. Psychological differentiation: Studies of development. Wiley, New York, 1962.

A globális élménymód a pszichodinamikus mozgás- és táncterápiában – A testi tudatosság, mint terápiás hatótényező: hatások és klinikai megfontolások

A testi tudatossággal való munka egyre központibb szerepet kap a pszichodinamikus és testorientált pszichoterápiákban, elméleti integrációja azonban továbbra is széttagolt a fenomenológiai, fejlődéslélektani, relációs és klinikai megközelítések között. A tanulmány a pszichodinamikus mozgás- és táncterápiában (PMT) alkalmazott testi tudatossággal végzett munka integratív értelmezését kínálja, a testet nem beavatkozás tárgyaként, hanem a megélt tapasztalás, a kapcsolati jelenlét és a jelentésalkotás elsődleges közegének tekintve. A fenomenológiai, fejlődéspszichoanalitikus és klinikai elméletekre támaszkodva a tanulmány amellett érvel, hogy a PMT-ben a terápiás változás elsősorban prereflektív, megtestesült folyamatokon keresztül bontakozik ki, amelyek megelőzik az explicit reflexiót és a szimbolikus artikulációt. Kiemelt figyelmet kap az affektusszabályozás, az implicit kapcsolati tudás, a kreativitás és az etikai felelősség, mint a terápiás folyamat testi és relációs dimenziói. E különböző perspektívák integrálására a tanulmány bevezeti a globális élménymód fogalmát, amelyet az élmény amodális, prereflektív szerveződéseként határoz meg, ahol a testi érzetek és az affektív vitalitás integrált egészként vannak jelen. A fogalom Daniel Stern amodális percepcióról és vitalitásaffektusokról szóló leírásaira épül, és a testi tudatosság egy enyhén módosult, ugyanakkor stabil élménymódjaként kerül értelmezésre, amely a felnőtt tapasztalás során is hozzáférhető marad. Bár kapcsolódhat a tapasztalás korai, implicit rétegeihez, nem regresszió, mivel az itt-és-most realitásához való orientáció és a reflektív kapacitás alapvetően megőrződik. A tanulmány bemutatja, hogy a globális élménymód nemcsak pszichoterápiás helyzetekben, hanem a mindennapi megtestesült és kreatív tapasztalásban is jelen lehet. A pszichodinamikus mozgás- és táncterápia olyan terápiás megközelítésként jelenik meg, amely különösen érzékeny e mód felismerésére, megtartására és integrálására egy gondosan tartott klinikai keretben. A globális élménymód klinikailag orientáló és integratív fogalomként való pozicionálásával a tanulmány hozzájárul a megtestesülésről, a kreativitásról és az etikai felelősségről folytatott kortárs pszichoterápiás diskurzusokhoz, árnyalt megértést kínálva arról, miként bontakozhat ki a terápiás változás a megélt tapasztalás szintjén végbemenő kreatív újraszerveződés révén.

Kulcsszavak: globális élménymód, pszichodinamikus mozgás- és táncterápia, amodális percepció, testi tudatosság, prereflektív tapasztalás, prediktív feldolgozás