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THE ART AND SCIENCE OF SOMATIC PRAXIS

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Editorial
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I have been thinking of this issue, Volume 13#2, as the "congress issue" for quite some time, as it is being published simultaneously with the 10th European Association for Body Psychotherapy and 14th International Scientific Committee of Body Psychotherapy Congress, September 11-14, in Lisbon, Portugal. I have attended many of these congresses over the years and have found them incredibly nourishing and inspiring each time. The theme this year is "The Body in Relationship: Self, Other, Society", marking body psychotherapy's evolution, paralleling that of relational schools of psychotherapy and psychoanalysis, from a "one-person" psychology focused on the internal dynamics and bodily expression of the patient to a "two-person" psychology focusing also on the relational aspects between therapist and patient. These developments I find hopeful and encouraging for the future of our profession and for that of allied helping professions such as medicine, wherein doctors are being encouraged, as a part of their own self-care as well as their technical expertise, to pay more attention to their own presence in clinical encounters (Figley, Huggard, & Rees, 2013). I am reminded of a paper by Angela Klopstech. Drawing on Martha Stark's (1999) book entitled *Modes of Therapeutic Action*, Dr. Klopstech demonstrated, in her typically lucid manner, how Bioenergetic technique had been evolving from a focus on emotional, cognitive and energetic blocks in the patient, through the therapist's active inclusion of him/herself in providing a corrective experience for the patient, to a third alternative in which the therapist participates countertransferentially in the patient's transferential enactment in the session.

This issue and the next will introduce three new editors. In this issue, Asaf Rolef Ben-Shahar introduces what I hope will become a frequent feature of the IBPJ: The Somatic Colloquium. (His recently published book, *Touching the Relational Edge*, will be the focus of a review article on relational body psychotherapy by Aline LaPierre, scheduled for publication in this Journal in 2015.) Our next issue, devoted to research in body psychotherapy, will be guest edited by Jennifer Tantia, research chair of the USABP. And, Debbie Cotton, body psychotherapist and naturopath, has joined the Editorial Committee. In addition to taking care of her newborn son, Debbie has given the Editor valuable assistance copy editing on a tight deadline. She will be taking on more responsibilities in the coming months as the demands of motherhood allow.

We begin the issue with an illustration of the art of our craft. Lydia Denton combines clinical acuity with a whimsical sense of play in "A Fairy Tale or the Strange Case of Rose". An otherwise high functioning patient comes to her missing a body part. In their quest to reclaim it, the therapist utilizes ego state theory along with EMDR and psychodynamic theory. The therapist's wry sense of humor is even occasionally matched by the patient.

In Part II of "Shadows in the History of Body Psychotherapy", Courtenay Young and Gill Westland suggest some of the challenges faced by the body psychotherapy training organizations and communities as essentially outlying fiefdoms attempt to form a cohesive and rigorous topography in relation to the wider field of psychotherapy and somatic psychology while remaining true to a strong tradition of embodied and experiential practice and training methodologies. Sometimes they speak generally, and at other places in their article detail problems, pitfalls and traumatic events of which they

have knowledge. As they conclude in this second part, the authors as well as the Editor invite discussion of all aspects of these two articles, perhaps most easily accomplished on the Somatic Perspectives forum (www.somaticperspectives.com).

After attending their fascinating presentation at the last EABP conference in Cambridge, I asked Eric Wolterstorff and Herbert Grassman to write it up for the IBPJ. Entitled "The Scene of the Crime: Traumatic Transference and Repetition as Seen in Alfred Hitchcock's *Marnie*", the authors analyze the film as a case history. As they explicate their interesting theoretical stance, they pose the main character, Marnie, in the role of patient and suggest a course of treatment for her. Their contention is that a participant in a traumatic event involving what they characterize as "in-group trauma," must integrate the four roles literally or implicitly present: savior, victim, bystander and perpetrator, in that order. In order to heal, the participant must be able to inhabit each of these roles, no matter which one he/she in fact played. In order to facilitate that process, the therapist must be able to work with the traumatic transferences that ensue without allowing it to destroy him/herself, the client or their relationship. Not an easy task, they concede, but imagining Marnie as patient, they detail each step in the process.

I really enjoyed reading Manfred Thielen's carefully crafted article on "Body Psychotherapy for Anxiety Disorders". Bringing together a cogent discussion of the Reichian tradition initiated by Freud with later Bioenergetic additions, he critically traces treatments of anxiety on through psychodynamic conceptualizations to pre- and peri-natal research along with the contributions of infant research and finally to Humanistic Psychology's perspective. Having set the tone in his brief historical overview and theoretical discussion, he concludes that anxiety is a whole body experience and illustrates all that he has introduced in two case vignettes.

Greg Johanson provides us with a thoughtful introduction to and overview of the possible interfaces between somatic psychotherapy and science and research. With an extensive bibliography, the article details issues such as how research is used clinically, how training institutes can function as both generators and consumers of research and how findings in what he refers to as "cognate" fields such as neuroscience, developmental studies, multicultural and spiritual arenas can contribute to the practice of body-inclusive psychotherapy. The author is guided by considerations in the philosophy of the science of "what it means to be human" as well as principles from the sciences of complex, non-linear adaptive systems. The significance of neuroscience as "explanation" or "re-description" of clinical observation is also taken up by Nick Totton and some of his commentators in our final offering.

With this issue, we introduce a feature which will appear frequently in subsequent issues: Somatic Colloquium, orchestrated, edited and introduced by Asaf Rolef Ben-Shahar. Dr. Rolef Ben-Shahar asked Nick Totton to contribute our first offering, which is commented upon by David Boadella, Stanley Keleman, Will Davis and Akira Ikemi, after which Totton offers a final comment. In his carefully constructed, well expressed and richly referenced offering Totton makes a cogent case for embodiment as the "matrix of relating" and goes on to say that, "It is only when the privileging – though not the contribution – of the rational and the verbal is wholly surrendered that embodied relationship can be integrated". Stanley Keleman and David Boadella comment briefly, reminding the reader of their own work and points of view. Will Davis and Akira Ikemi seem to enjoy entering more into challenging dialogue with Totton, who responds in kind in his closing remarks.

This colloquium came to mind when I was privileged to view a brilliant physical theater piece last weekend, entitled "What You Counted and Carefully Saved", created and directed by the profoundly gifted Sita Mani with her students from The Studio in New York. A "work in progress," it merged profoundly personal elements from the creator as well as the actors with a deep commitment to the physical expression of emotion, utilizing music, dance, poetry and humor. It was in fact the privileging of the embodied in this powerful dramaturgical piece that has made it reverberate in my own body as I have sought to be an embodied presence for and to my patients and students this week. How wonderful to see a parallel process in theater art and psychotherapy: two sides of a golden coin.

Our cover, which is also the 2014 Congress logo, was designed by Dora Theodoropoulou, a Greek student of Biosynthesis and PhD candidate at the National Technical University of Athens.

Jacqueline A. Carleton, PhD
New York City
August, 2014

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INTERNATIONAL BODY PSYCHOTHERAPY JOURNAL THE ART AND SCIENCE OF SOMATIC PRAXIS

A Fairy Tale
Or the Strange Case of Rose
By Lydia Denton, LCSW

Received 20 October 2013; accepted January 2014

Abstract

This paper presents an integrated approach to the treatment of a young woman with a dissociated body part. The author suggests that in order for this young woman to claim her missing body part, a combination of techniques needed to be used. These methods are: Eye Movement Desensitization Reprocessing (EMDR), ego state therapy, and a close attention to both transference and countertransference. The patient is introduced and her family background is described. Vignettes from sessions are presented followed by a discussion of selected theoretical perspectives employed.

Keywords: dissociated body part, dissociation, EMDR, trauma

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Prologue

Once upon a time, there was a beautiful princess named Rose. Rose lived in a castle with her mother, the Queen, her father, the King and her brother, the Prince.

Rose loved her mother and father very, very much, and she felt quite privileged being their daughter. She, as a princess, did what princesses do: she ate sugar cakes and drank sweet milk, and played in the enchanted woods with her brother.

She also daydreamed a lot. She dreamt of love and romance and candlelit dinners with the prince she would one day marry and with whom she would live happily ever after.

One day something terrible happened, shattering Rose's world. Her school — a school for princesses — being rather avant-garde for the times, decided to offer a new kind of class to its twelve-year old pupils. The title had a dreadful, foreboding ring to it: "Sex Education for Young Girls".

After the second explicit slide of female genitals, Rose fainted, as if pricked by a magic needle. From that point on, she became very confused. You see, Rose believed that she was a young girl without a vagina.

Rose asked herself over and over again, why would the school betray her with those horrid slides? All of this nonsense made Rose very unhappy. She stopped playing in the woods, and she even stopped eating sugar cakes. She became sullen and morose and rarely left her room. Her parents, the King and Queen, were perplexed if not bewildered. They wondered silently whether their sweet, gentle daughter had been hexed by a spell from the band of malevolent witches and goblins that lurked in the dense mist surrounding the castle.

Rose steps into my office and is indeed very beautiful. A young woman of twenty-five, she has the luscious chestnut hair, cream-colored skin, and aqua blue eyes of a princess. She tells me how close she is to her mother, her father, and her brother. And she tells me that she cannot have sex, even though she is very much in love. This is the poignant dilemma that brings her into therapy for the first time. As the session unfolds, she reveals that her parents and her grandparents on both sides belonged to a cult, first in Australia and then in New York City.

The combination of a sharp mind, a shimmering imagination, and an illogical environment with untenable messages, created in Rose this bizarre narrative[1]. For her, a missing body part is what makes sense. As her therapist, I need to submit to a "folie à deux" with this young woman and do not raise my eyebrows as she tells me with aplomb, "How could I possibly masturbate since there's nothing down there?" Interestingly, Rose thoroughly enjoys the hands of her boyfriend on her body. She is aroused, though not orgasmic. When I meet her, she is governed by the conviction of living a perfect love affair. Phillip is her prince; he is the chosen one with whom she will live happily ever after. However, she does recognize that she needs help: her prince is pressuring her for sexual intercourse.

During our first year together, Rose weeps automatically. I notice it is a procedural reaction to my probing her. Discomfort is very easily triggered and manifests this way: her face transforms into an extremely pronounced pout her bottom lip comes out and she shakes her head, refusing to talk, as tears cascade down her cheeks. I suddenly have a recalcitrant child in front of me and I feel irritated instead of nurturing. I can only imagine how unsexy she is when this conspicuous self-state shows up during a sizzling sexual exchange with Philip. I brace myself for the inevitable.

A few months into treatment, she comes in sobbing, "He just broke up with me. How could he? We were so in love! We were meant to be." By failing to enchant her prince, Rose is made to give up what was irrefutable: the chimerical dream of perfect love.

And thus I begin the slow work of escorting Rose through, and eventually out of, a maze of intergenerational injunctions that have kept her captive in time, like an irresistible hypnotic spell. It is only once the younger parts' perspective was truly recognized, that the sovereignty of her symptoms could begin to loosen.

Background

Let us begin by exploring the organization Rose's family belonged to, Moral Rearmament or MRA. MRA is a spiritual movement founded in 1938 by Frank Buchman, an American protestant evangelist. His mission was to bring moral recovery and lasting peace to the nations. Buchman (1949) declared, "MRA is the good road of an ideology inspired by God upon which all faiths can unite." The movement is based on four Absolutes, Honesty, Purity, Unselfishness, and Love. Buchman displayed many of the characteristics that are common in cult leaders: the leader is always right, there is only one way, there is an "us vs. them" mindset, and there is a demand to surrender to the beliefs of the cult. The doctrine states that "you cannot trust your own mind or your own thoughts," and therefore you must turn to the cult for guidance.

[1] Self-states are dissociated, sequestered from each other, allowing the person to function without having to notice the inherent contradictions.

Buchman was obsessed with the idea of sex as sin. A virulent homophobic, he would demand young men's public confession of their sexual transgressions. The decree of Absolute Honesty followed by Absolute Purity encouraged house parties that concentrated on disclosing sexual issues, particularly masturbation.

A controversial figure his whole life, Buchman died in 1961. Less sinister individuals took over and the movement thereafter softened. In 2001 it was renamed the Initiatives of Change, which is now a global organization that holds consultative status with the United Nations.

Rose's grandparents on both sides were Methodist MRA members in Australia. Her parents belonged to MRA in New York City until their mid-forties when Rose was fourteen. Their home, situated close to the United Nations, was never theirs, but a place to give and receive unconditional hospitality to any visitor stopping by. Every morning the family would sit together in silence and wait for God to speak to them. Every morning they would remind themselves of the Four Absolutes. Every night Rose's parents would abide by the rule of complete chastity. The birth of Rose, their second and last child, dictated the denouement of their sexual life. The church proclaims that sex can only be allowed with the goal of procreation. Once the children are born, all sexual activity is to end.

A former cult member once told me, "Mental damage comes from a dogma difficult to undo." With such impenetrable rules, paradoxically, boundaries become mystifying. Rose's overt symptom could be understood as the concrete solution to overwhelming confusion between what is mine and what is theirs, what must be kept outside and what is not allowed inside. There is no conflict, her delusion loudly states, because there is the absence of a body part that would suggest it. "Since I don't have a vagina, the dialectic between in and out doesn't even have to exist." How powerful the mind can be when it successfully overrides what the eyes blatantly see and what the body blatantly feels: robust hallucination of sorts vigorously maintained and perpetuated by a young girl's interpretation of doctrinaire beliefs.

This version, unique to Rose, becomes psychically and somatically embedded in her as a child and then an adolescent. So much so, that the basic question, at age twelve and onward, "What is sex?" is never asked. Instead, Rose escapes by fainting. In this case, can we consider her fainting to be an old fashioned hysterical reaction; precisely the way hysterics fainted in the repressed cultures of the 19th and early 20th centuries?

I was able to convince Rose to go for a gynecological exam. The carefully chosen doctor, a specialist in phobias, called me after meeting her. Her words, "Lydia, I have never met a young woman who despite my showing her, believes she does not have an opening!"

At age twenty-five, Rose's belief system clashes with her body's natural receptivity to sexual pleasure. At the hands of Phillip she awakens, but unlike Sleeping Beauty who is brought out of a spell into warmth and triumph with a kiss, Rose's awakening leads her into conflict.

As in Sleeping Beauty, the fairies at Rose's christening bestow on her beauty, grace, and wit. But in this fairy tale, even her mother is cursed. The Wicked Witch of Religious Dogma confiscates her desire and replaces it with renunciation. At age thirty-four, this young woman, Rose's mother, forfeits sex for good. As Muriel Dimen (2003) says, "If female desire is defined by procreation, it is in fact nullified." She adds, "Sex stands at the crossroads of nature, psyche and culture and therefore is profoundly evocative" (p. 205). Could it be that Rose's malleable unconscious colludes and collapses into her mother's by

eradicating from awareness the body part linked to pleasure? A splendid and heartbreaking gift to her mother, in which arousal is expunged and lust is disallowed. Thus woman and child can safely remain peacefully in the enchanted woods, where all is pure, virtuous, and immutable.

In *Psychoanalytical Theories of Development* Robert Tyson (1990) states, "The girl's associating her genitals with an opening with potential space inside prepares the way for a vaginal representation. Since the girl's genitals and their associated sensations are such integral parts of her body, her developing body image will include a sense of genital awareness however diffuse or vague." He adds, "Heightened genital sensations lead to a fascination with the body, both her own and others. The girl localizes the genital area and learns how to bring about sensual excitement involving the vagina" (p. 259). Having suppressed these developmental tasks, Rose, at age twelve, is a good girl, a pious child with no vagina.

Initially Rose appears eloquent and fluent. A graduate of a prestigious college, she wants to be a professional writer. As the sessions unfold, long moments of silence begin to occur. Upon inquiry, Rose tells me, "I must find the right words and that takes time." Providing an answer seems laborious, cumbersome, and at times debilitating. In the countertransference, I start to feel like a callous taskmaster. Could it be that to ask is to thrust forcibly into the unknown crevices of her mind? During these extended silences my reverie is let loose and I wonder if there is a danger of slipping into a "something else" where representation is censured.

The implacable grip of puritanical views held by the family at large gave Rose no space to explore. Is her silence saying, "I cannot have my own mind? I have to run my thoughts through a preordained code?" What is fundamentalism, but an unwavering attachment to a set of irreducible beliefs? There is little room for new thought, and deviation becomes a threat.

Rose tells me, "I can write, but I cannot tell a story." Spontaneity is defiance. To dissent is to betray. Rose's own mind is held hostage by loyalty and allegiance to her tribe.

And so, the story cannot be written.

The Work

My work with Rose begins with me consoling her. She is heart-broken, unable to understand Philip's decision. She feels like crushed glass, fragmented and mangled. Her parents always modeled a perfect marriage. They met at nineteen, fell in love, and continue to be in love thirty years later. They are a unit, bonded by mutual devotion and religious worship. Left by her man, Rose is injured and now, unlike her parents. With no manual for this anomaly, she is disoriented.

"I tried so hard to not make a mess and now I have."

"A mess?" I ask.

"Yes, I have been so much my parents' daughter. There's lots I don't know. I was taught many things and yet never told anything."

I say, "So the space got filled up by fantasy."

She responds, "Yes, and it worked for a while. Being in therapy means there are flaws, and that is new and intrusive." She pauses. "Perfect love does exist! I have seen it in my parents, so why didn't I find it? All the books I read as a child said the same thing, 'you wait

for the right prince.' Philip was the right one, he was my only chance."

For Rose, grieving Philip is a lot more than mending her heart. It is about recalibrating and remapping, and it is about daring. Can she dare to love as deeply as her parents and yet on different terms?

Rose and I become acquainted with her younger parts: their dreams, their qualms, and their unique understanding of what love is. I am reassured to find out through this exploration that Adult Rose is aware of having a vagina. However her rank is low amidst egostates (Watkins & Watkins, 1997) that are intransigent and vehement. A year later, after much stabilization and resourcing, we both feel she is ready to face her phobia head on. I use a method called EMDR[2] developed by Francine Shapiro (1987) that helps the brain process, upsetting memories through bilateral stimulation of the left and right hemispheres.

Here is my work with Rose.

I ask her to bring up an upsetting image:

"I am lying naked on my bed looking at myself with a mirror. The sheets are dark red and there are candles on the table. The music playing is from the singer 'Imagene'."

What is the worst part of this image?

"The fear of exploring."

What does this say about her?

"I cannot trust myself."

What is the emotion that comes up as she brings to mind this image?

"Fear."

Where does she feel this fear in her body?

"Stomach."

On a scale of one to ten (Subjective Unit of Distress, SUDS) how upsetting is this image?

"Four."

We continue:

R: "She does not want to look. She's afraid."

Th: "What is she afraid of?"

R: "She doesn't want to tell you." Her mouth starts sticking out in an exaggerated pout. "Why do I have to do this?" She cries.

Th: "How old are you, Rose?"

R: "I don't know. My feet feel so small. I can't do this. It's too scary." (She sounds very young.) "I don't want to think about this. I feel cold."

We stop.

Rose tells me after, "I went very young. It didn't make sense for her to do this."

Next session:

R: "No SUDS. It's hard to get any image. Not real." She pouts, then sobs.

Th: "Why so sad?"

[2] EMDR is an adaptive information processing model helping to reconnect neural pathways that have become dissociated. Since memories are not necessarily conscious, the benefit of EMDR is that it includes identifying and processing body sensations; a key element for working with Rose.

R: "I don't know! Nobody can help me. I don't know what a vagina is." I encourage her and tell her I am here to help.

R: "I don't know who you are. I am not talking." She pouts and refuses to speak.

We stop. Once into Adult Rose she comments, "I couldn't come back, felt so young, like seven or eight" She does not want to grow up.

"It's so much easier not to. Having a vagina means I could reproduce and be a woman. Such a responsibility, the physicality of myself."

The next session she tells me, "The younger parts[3] don't want to hear or think about the words vagina, sex, masturbation. Words Mom never said. The message was, 'you are not ready for this.' But the time never came. My parents are a unit, impenetrable, and never alone because they are with God or each other. Such strict guide lines. So I had this huge imagination inside the strict rules."

We try processing some more but to no avail. The younger parts rule[4] and refuse to cooperate. I clearly need to take a different kind of action. Aware of how much the child was never given crucial information, I propose to Rose that she find a book on sexual education for young girls, so I can read it to her. She comes into the next session having carefully selected *Ready, Set, Grow! A "What's Happening to My Body?" Book for Younger Girls* (Lynda Madaras, 2003).

I ask her if she would like for me to sit on the floor next to her. She loves that idea. I introduce myself to Young Rose and start reading. The energy immediately shifts in the room. Rose, now a child of eight, is intently listening to every word and seems transfixed by the illustrations. As we sit side-by-side, body-to-body, I muse on the intensity of the now somatic transference between us. Therapist and patient, mother and child, woman and girl.

Adult Rose comments, "This is completely new information for her. She likes this very much. She loves the individual attention you are giving her, but, she still wonders: who is this lady reading this weird stuff?"

I tell the eight year old that I am a body coach, here just to explain things. She seems content with that qualification, and then orders me to read the first chapter again.

The next session, Rose reports that a friend gave her a vibrator. She tried it and was surprised by how good it felt. To her relief, the child parts did not object. A few days later, I receive a text that she had her first orgasm. She is incredibly excited and I am the first person to know.

Emboldened by this turn of events, Rose begins to speak to the eight year old: "This is your body. I am going to teach you to love it. Don't feel guilty and don't feel shame."

She reports the following dialogue with herself.

After looking at the popular book *The Joy of Sex* (Comfort, 2009) she got aroused. A younger part suddenly screamed, "STOP, none of this is ok!"

Adult Rose explains, "Sorry, but this is how it's going to be. I find this exciting." Young Rose threatens, "I am shutting down. I don't want to grow up, NO WAY!

[3] Rose could not integrate her sexuality. Direct access through EMDR is at first too overwhelming for her. The therapist needs to ally with the ego states, or child parts, that are acting out the family's prohibitions.

[4] An ego state may be defined as an organized system of behavior and experience, which is separated from other states by a boundary that is more or less permeable. (Watkins & Watkins, 1997)

Adult Rose demands, "And then what? Die? It is time. You are going to grow up!" but Young Rose screams, "NO!"

We get to the chapter in the book on vaginas. As the pages turn to explicit drawings, I glance at Rose. She looks very upset and refuses to talk. I coax her. She whispers, "Sex is a naughty word. I shouldn't know this. This doesn't help. There is no opening." She looks annoyed and quite unhappy.

The next session, she describes having continued to look at herself with a mirror and found it strange and difficult, but not as scary as she feared. I read to her the same chapter. "It is still hard to grasp that there's an opening," she tells me.

It is during this time that Rose begins having sex with her coworker Walter. Under his excellent tutelage, Rose emerges as a very sensual woman, if not a seductress. She thoroughly enjoys sharing with me the fun she is having in bed with Walter, despite the very clear stop signal at any attempt at penetration. Think of a rose with velvety petals so soft and lush, until you feel the thorns. She tells me, "He cannot come inside of me. Down there is too vulnerable and tender. It could be so easily injured. Hands approaching down there are bad."

Later she exclaims, "There's been a transformation in my life! I never used to talk or express myself, I used to avoid parties. Now, I can find my footing socially and be fun!"

Could it be that as her sensuality is witnessed and received by Walter, she is able to step into the world, now an embodied and voluptuous woman?

"I know that I'm hot," she tells me, her eyes sparkling. My eyes sparkle back and I delight at this hot, sexy, unabashed young woman.

Because she reports her vaginal muscles still being so tight, I suggest she practice Kegel exercises — a complicated task for Rose.

"I can clench, but not unclench," she tells me the following week. I propose she stare at a live sea anemone on her laptop, confident that her mirror neurons will do their magic. She follows through, and after a few times of trying she feels a release.

"This is amazing, I was able to unclench! And I can even touch myself and not feel weird about it!"

Confident that Adult Rose is now in charge, I suggest we return to the original EMDR target. I ask her to bring up the image. She goes silent, then:

R: "I'm getting really upset. This is so awkward. Where is my vagina? No way of doing this." Huge tears and the exaggerated pout are back.

Th: "What could possibly be so sad?"

R: "She doesn't know who you are. She doesn't like what you are doing."

Th: "What is her concern?"

R: "I don't know." She refuses to answer.

We stop.

She says, "This time she was twelve. She denies there's anything between her legs. That place does not exist, so who is this woman pushing her? This is so off limits. My Mom refused to say the word, 'vagina'."

I say, "If Mom can't name it, then I don't have one."

R: "Right! So the twelve-year old is the gatekeeper. How could I tell her about her vagina since Mom couldn't?"

This is my clue for taking action again. I say, "We are going to have the twelve-year old be less in charge and you, Adult Rose, are now going to be in charge." She looks relieved.

I ask Rose to bring in a book next time for the twelve-year old who will then be asked to sit in the waiting room while we continue processing.

The next session, Rose walks in with *To Kill a Mockingbird* (Lee, 1988) which she had read at age twelve. She puts the book outside and tells the part to sit there for forty-five minutes.

I ask her to bring up the image. I notice no tears or anger coming up. Adult Rose is in charge.

R: "I can bring up the image. I am touching myself, also, not just looking. It is half ok and half not ok, and that's ok."

R: "The idea of balancing both makes sense. That the gray area is ok, that's so new!"

Rose says afterwards, "This is a huge victory. I can hold two truths! It feels like an adult position. If it's not ok now, I know that in half an hour it will be ok! This time the image was so visual, like this is my vagina! Before, I couldn't even bring up the image." She jumps up. "It's been forty-five minutes. I have to go get the twelve-year old in the waiting room!"

Next session.

She smiles as she brings up the image. "I see myself inserting a finger and its ok. I want a witness. This is such a big deal. I want people to be there with me to celebrate. I know you are and that feels great, but I want Walter, my close friends, and many others."

I ask for SUDS, zero.

PC: "I can trust my body."

Th: "What does that mean about you that you can trust your body?" Long silence.

R: "That I am free. That felt terrifying for a second, then I thought, 'no it's not!' It feels great. It means I can walk around not feeling crazy. I am free. This is the reverse of what I have felt for so long!" Then she adds, "Plus, it opens the door to the past and to accepting what my body did to protect me. Body, you did the best you could."

Next session.

Rose, laughing, tells me that the night before after some steamy sex, she had left Walter's apartment wearing a sundress — with no underwear. "It made me feel free and I giggled all the way home."

Discussion

In her paper "Vicissitudes of the Maternal Transference in the Working of Sexual Inhibitions", Barbara Marcus (2004) writes, "I propose that the mother's capacity for joy to convey her own pride and pleasure in her female body, its sexual and procreative capacities, and to confer the privilege of passion on her daughter is a requisite for a girl's full, pleasurable possession of her body and her sexuality." She adds, "When development proceeds well, the girl overcomes her fears of loss of control over her openings and her reproductive choices and comes to value her capacity for interiority" (p. 680).

In the transference with me, Rose becomes more and more exhibitionistic. She reads my face and scans for reactions of sensual delight she never got from her mother. By approving explicit and uncensored sexual terminology, I interfere with the dissociative

construct she grew up with. Thus, she is able to map out a new mental library that is in itself libidinized, and without shame.

In my countertransference, I enjoy her awakening and I am at ease with the explicit content. I draw this from a French culture in which I was raised where sexual references are the norm, if not constant. Being sexually graphic in France is procedural!

In addition, because Rose is securely attached to both parents, she is easy to work with, despite having a dissociated body part. Our alliance is playful and solid. Therefore, we can approach the issue as a "we" rather than from a lens of caution or prudence. Rose follows all my directions, not as a good little girl, but as a patient aligned with her unappeasable wish to crack the code.

Donnel Stern (2007) describes how the child is dependent on his parents to symbolize experience for him, "When the parent cannot feel or bear a certain experience, the child is deprived of what he needs and cannot create his own mind. Over time, this kind of "not me" experience becomes dissociated for the child." Stern calls it a "stable, foundational kind of dissociation" (p. 754).

Sitting on the floor and reading a book to Rose's younger self gives her permission to imprint new information without crossing the line. In fact, did I risk competing too much with her mother; an unforgivable infraction for some of our patients? Labeling myself as a body coach, I can safely educate her without the peril of problematic rivalry.

Finally, McDougall (1989) states, "In the first sexual exchange between the two bodies of mother and her infant, the mother's unconscious reactions to sensual arousal are already being transmitted and the infant is beginning to form a sexual identity" (p. 38).

Ego state work (Watkins & Watkins, 1997) allowed me to access Rose's unconscious. Through direct interaction with the younger parts, her body as a whole can finally come online. In our work together, she becomes a parent who can fearlessly name a shunned body part. She becomes a parent who sets limits, for example, sending the twelve-year old to the waiting room. She even becomes a parent who calls the shots. With that new hierarchy in place, she can be free.

Rose, a young woman with a vagina.

BIOGRAPHY

Raised in France, Lydia Denton graduated as a clinical psychologist from the Sorbonne, Paris. She came to the United States in 1985. She graduated from the Ackerman Institute and received her LCSW from New York University. She completed her analytic training at the Institute for the Psychoanalytic Study of Subjectivity (IPSS). She is presently a supervisor at the National Institute for Psychotherapies (NIP) and the Institute for Contemporary Psychoanalysis (ICP). She is a certified EMDR clinician and has training in Energy Psychology and Somatic Experiencing. She has a private practice in Manhattan and can be contacted at nouch301@gmail.com.

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Shadows in the History of Body Psychotherapy: Part II

Courtenay Young with Gill Westland

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Abstract

This article is intended to open up a discussion and to begin to name, to reflect on, and gradually start healing some of the wounds arising during the development of body psychotherapy, particularly during the period 1960-2000. It highlights several inherent problems in individuals single-handedly pioneering new methods, and several systemic difficulties in the organization of the original training courses. These 'shadows' are not unique to body psychotherapy and similar examples can be found in many other modalities of psychotherapy and in many other communities. They have implications for the wider professional field and also for the future development of our field of body psychotherapy and, once named and owned, can be utilized more positively. Because of its length, the article has been split into 2 parts.

Keywords: Body psychotherapy, shadow, history, abuse, healing, ethics

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In Part I, we looked at various topics: 'Acknowledging the Shadow'; 'The founding fathers of body psychotherapy'; 'Risks within body psychotherapy'; "Post-war shadows of body psychotherapy'; and 'Psychotherapy regulation' and tried to develop the history of body psychotherapy looking at some of the charismatic founders of the various body psychotherapies in the wider context of their times. In this part, we look at some of the inherent issues within different psychotherapies, psychotherapy organisations, and the body psychotherapy communities and training organisations.

Part II:

Inherent Factors within Psychotherapy

Psychotherapy Pioneers Healing Themselves

Psychotherapists develop their own healing systems from their own imagination and their own injuries: their theory is to some extent nearly always autobiographical (Wright, 1991). Their training organisations become psychic containers, within which to explore their own inner worlds further. The shadow aspects of these individuals – insofar as any of these are not properly resolved – often thus became embodied as part of the organisations that they have created. These shadow aspects can hold traumas and internal conflicts, as well as forms of creativity. All founders of psychotherapies have their human limitations and there will therefore be - de facto - gaps in the form of psychotherapy that they develop. In other words, no therapeutic method will be a complete system and the answer for everyone.

Sometimes body psychotherapists have clearly named the territory of their difficulties, their ways of protecting themselves, and their internal struggles. An example of this is Ron Kurtz (1988), who writes, "Being a psychopath, I assumed I was a psychotherapist". This was before he became a psychotherapist. Kurtz has also been described as "uncredentialed", "visionary", "highly charismatic", and "His attention was genuine and complete" (Bageant, 2012, p. 179).

Gerda Boyesen, the founder of Biodynamic Psychology, has been variously described as a "star", representing "a non-feminist and yet self-conscious femininity and motherliness" and had a "great attraction for both women and men", having "icon status, even during her lifetime" (Freudl, 2006, p. 62) and yet, acting out the epitome of the "good mother", she could also on occasion (and particularly when challenged) easily become the rejecting, "bad mother". This had devastating consequences for some of those expelled or rejected, depending on the extent of their positive transference. Gerda Boyesen said frequently that she didn't work with negative transference.[i]

When a person reaches a certain point where he/she happens to think that s/he has developed a psychotherapy method, the old paradigm was for him/her also to assume that no one else could give *him/her* psychotherapy in his/her particular way, and so s/he tended to stop having his/her own personal psychotherapy, and *his/her* psychotherapy work also became largely unsupervised. So, all of his/her personal explorations, as well as any unresolved conflicts and struggles, then became somewhat institutionalised into the trainings and methods. These then can start to hold both the unique creativity of the founder as well as his/her own internal conflicts, traumas and defensive patterns. This is a definite shadow.

Guggenbühl-Craig (1971, 1983) writes about the 'shadow' side of the archetype of the healer/shaman etc., and its usefulness, which often gets constellated in psychotherapy as well. He has highlighted the potential for splitting the healer archetype in therapeutic work, where, through unconscious projection, the client can become weak and unwell and the psychotherapist becomes the healthy one. This is perhaps more of a group phenomenon, rather than an individual one. The concept that each healer (also) has to be wounded (Rippere & Williams, 1985), and the whole "Chiron" archetype, can also be challenged by the concept of Apollo Medicus,[ii] who subverted the folklore of the wounded healer, insofar as it was not his own suffering that empowered him to heal (Fumos, 2010). So, this archetype also needs to be challenged, as it can become a shadow of its own.

Power, as a dynamic, also comes into play with the client or with the psychotherapist subjugated to the power of the other. It is now being more fully recognised that both the client's and (most importantly) the psychotherapist's own issues get played out constantly within the therapeutic relationship, but it is only recently that this has become openly recognised within body psychotherapy, by the development of relational body psychotherapy (Young, 2012b).

Subjectivity

Psychotherapy emphasises subjectivity: psychotherapy is an inter-subjective encounter. It is a craft, and possibly even an art (Young & Heller, 2000). It is not a science, although it is gradually becoming slightly more scientific, or becoming more aware of science (especially neuroscience). However, this subjectivity opens the way for the personal perspective of a founder to have full reign. The founders of body psychotherapy were nearly all very gifted; they also broke the mould, frequently dedicated their lives to their creative work, and worked extremely hard (Young, 2008; Young, 2010). Many have died quite elderly and some are even now still working. Many have rightfully received awards and recognition for their lifelong dedication and contributions to the field. Often, they had very genuine aspirations (and

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some little success) of making the world a much better place.

Body psychotherapy (like many other humanistic trainings were, and still are) is taught mostly experientially, by demonstration, repetition, case discussion and supervision, so that the ways of working with others therapeutically become absorbed in a very embodied manner. This is in contrast to the more rigid 'manualised" forms of therapy: where you have to do it "by the book" and where there are standard syllabi, forms, tests, training standards, and pass criteria.

An apprenticeship style of training was very popular, especially between 1970 and well into the 1990s, and, to a certain extent, still is. As the students progressed through and out of their training, they took on more responsibility and the more able graduates of these trainings were often chosen (by the founder) to become trainers in turn, and to pass the founder's training methods on to others.

Whilst this lineage of training has some advantages, psychotherapists can often become somewhat like carbon copies of the founder. In the training of body psychotherapists, there was much less emphasis on any academic requirements, and virtually no external assessors or examiners, so the only "judge" of being a (good enough) therapist was the original founder. The trainee might have become very good in the founder's method, but there was no objectivity as to whether he/she was actually a good psychotherapist. It is only with the development of a set of Core Competencies (EAP, 2013) within psychotherapy that we can begin to edge toward any degree of objectivity. Some competencies for body psychotherapy are in the process of being developed (Boening, Westland & Southwell, 2012).

Job opportunities were also quite limited in the 1990s, and many graduates therefore tended to work as trainers and therapists in the centre in which they trained, or in clinics set up by the founders, as these places provided referrals and an assured income, as well as maintaining (sometimes required) contact with the founder. This was often quite a cosy set-up until the original trainee (now being an experienced therapist and possibly trainer) wanted to leave and set up somewhere else in his or her own right. What rules or restrictions might apply? Or are these ripe trainees "duty-bound" to continue doing therapy and training as a carbon copy of the original founder? Some founders registered copyright on their therapy and training methods, or gave it a registered trademark. These sorts of controls may ensure a degree of purity or control, but they can also stop any organic development and growth or extension of the methodologies into other fields.

Additionally, setting up another centre or clinic might even be seen as being in "competition" with the founder, on whom they were still dependent for professional recognition in the founder's method. The established system therefore tended to perpetuate itself – or the independence-seeking trainee became "deviant".

There were several instances of founders "excluding" people (former trainees) from their own psychotherapy organisation because of a "natural" parting of the ways, in body psychotherapy, as well as in other forms of psychotherapy. Unfortunately, founders sometimes even "fell out" with favoured trainers (or visa versa), and those apparently being "groomed" for greater responsibility were disappointed not to receive it, as the founder could not just "let go". Gossip, strife and splits into factions started to develop within several body psychotherapy modalities (as well as existing in many other types of psychotherapy), especially where there was a charismatic-type of founder. So, a methodology of, "This is how to do it" would become, "Do it my way". Depending on the core-strength of the founder, this might even turn into a narcissistic structure.

Tensions within Organisations

Some sort of collaborative "grouping" – in order to create an identity and a degree of solidarity – has definite advantages. However, the "group" that is created then has to be very careful whom it lets "in". It is no good just letting in everybody (at first), only to set up criteria later that would exclude current members. The Hans Krens affair had the potential to cripple body psychotherapy in Europe, and it was only because he was obviously so antagonistic towards EABP, who had rejected him (in 1994) and later his school (in 2000), that a healthy "separation" was clearly apparent when the "fall" ultimately came in 2006/7 (see Endnote 9).

The freedom to try out new ideas in organisations, unconnected to universities and hospitals, brought exciting developments but also some inherent problems. The founders, quite rightly, wanted to see graduates practising the particular form of psychotherapy that they had developed. However, where narcissistic patterns of relating were in the ascendant, what was often missing was the graduates practising this form of body psychotherapy *in their own way,* whilst, at the same time, being true to the method. Body psychotherapy has to be embodied and personalised for the unique meeting between this particular therapist and that particular client. If the graduate attempts to do it in the exact way of the founder, it is likely to be ineffective and inauthentic. The graduate, not being the founder, cannot possibly work exactly like the founder. The "general" and the "particular", as described by Thich Nhat Hahn (2001), have become confused. If the graduates take on different influences, and develop the work in their own way, is this still the sort of body psychotherapy that they were trained in? Will the founder accept it, or will the founder – as has sometimes happened – reject the graduate and their developments?

However, we can get lost in generalisations, and, maybe, we need to stick to more specific examples:

Narcissism. The term 'narcissism' is relatively imprecise and is often used pejoratively, but in its broadest sense it involves an overwhelming interest in oneself and not in others (Jacoby, 1991). Freud (1914) defined this as the libido invested in self-regulation, but it can also mean something like Kernberg's (1975) *disturbance* of narcissism, which indicates an over- or under-indulgence of the narcissistic wounds. Lowen (1985) sees narcissism as a thread running through nearly all of the characterological defence systems.

Our reason for mentioning it here is that founders, training organisations and associations involved in body psychotherapy can (unconsciously) enact, or re-enact, several elements of narcissism. These can be in the form of excessive contraction and control, or over-inflation. There can be a blown-up sense of specialness that is not understood, or feelings of anxious inferiority.

Sometimes, graduates became enmeshed in loyalty to an idealised founder and any individual uniqueness of their practice became sacrificed. Sometimes, individuals developed beyond an organisation and methods and needed a different psychic container for their creative journey. There was often a painful process of leaving a valued organisation, which nevertheless no longer met the inner trajectory of change. Lowen and Pierrakos both developed Bioenergetic Analysis together out of Reich's work, deliberately changing it and making it more acceptable, but these two also seem to have been able to stay amicable even when they went their separate ways. Pierrakos went on to develop Core Energetics, strongly influenced by his wife Eva and her more spiritual 'Pathwork', whilst Lowen continued with Bioenegetic Analysis, supported also by his wife.[iii]

However, body psychotherapy has also had its fair share of publicly enacted battles, full of rage, hurt, shame and humiliation, when narcissistic needs for symbiotic perfection were seemingly being challenged. The overwhelming narcissistic need for entitlement (Mason & Kreger, 2010) can be relatively easily crumbled, and it is not always as robust as it appears. These sorts of painful histories can linger on many years later, and can continue to permeate the profession of psychotherapy (and body psychotherapy) today without the latest graduates being able to have much purchase on some of the original dynamics that they are unconsciously being led into re-enacting.

The adulation of the students, or clients, can be used (or abused) to boost the ego of the "teacher", and thus s/he is often encouraged (or indulges him/herself) to make wider and deeper claims in order to get increased adulation: so, if the founder has some aspects of a schizoid personality disorder, an incipient form of a cult can be formulated with a form of aggrandisement so the teacher becomes a "Teacher", or "Leader", not just a very "gifted" individual. Sometimes the therapy itself receives a "preciousness" that it does not really deserve. Again, this "risk" is evident in any form of belief system, philosophy, religion, sect, cult, education, or social organisation, and is not particularly restricted to body psychotherapy (Boyd, 2010).

The more exaggerated aspects of such narcissistic components seek admiration to bolster unconscious low self-esteem and to cover self-doubt and shame. Where there is more unconscious identification with the resigned version of narcissism, there is a tendency to take solace in withdrawal, but also to feel exquisitely sensitive at the merest hint of disapproval. The more exaggerated or outgoing aspects of narcissism hope for recognition, but constantly anticipate rejection and being ignored: the individual, or group, looking for admiring reflection (from the therapist) is also a part of this dynamic. These dynamics are not a good basis for a psychotherapy training organisation.

In reality, the individual (or group) can get little nourishment from admiring followers, and yet the admiration is always sought or even demanded. When this dynamic is active around an individual leader, eventually the leader is found wanting by some of the followers. Greater disillusionment sets in as the leader is found to be imperfect, leaving the follower with a sense of inner emptiness and rage. Others remain loyal to the founder, or to the original grouping, and continue to play their part in the narcissistic dynamic. For an organisation, the group identity can often be maintained only by defending against a common enemy: the critic.

For the field of body psychotherapy, this could be the medical model, psychiatry or psychoanalysis (which rejected Reich), mainstream academia, or any psychotherapist who does not work with any form of embodiment. This can become complicated when there is both a real and an imagined attack going on. This dynamic reached a peak within body psychotherapy in the 1960s through 1980s, but began to change significantly during the 1990s, especially as body psychotherapy developed a greater mainstream identity (with the development of EABP and USABP). It also began to become more accepted in Europe, through liaison with the European Association of Psychotherapy (EAP), the UK Council for Psychotherapy, and other exterior professional bodies. In the USA, it is a pity there is not (yet) a somatic psychotherapy division of the American Psychological Association, like there is for humanistic psychology (APA Division 32).

Schizoid or Schizophrenic[iv]. "Madness in great ones must not unwatched go" (Claudius, in Hamlet). Stevens and Price (2000) offer a closing discussion about the schizophrenic

components in many cults, and in their prophets, and how the negative symptoms of schizophrenia (apathy, loss of motivation and withdrawal) are often not particularly apparent in the cult leaders, though much more so in their followers. One can therefore hypothesise that the existence of "followers" acts as a sort of preventative, which serves to inhibit the negative symptomatology (often quite narcissistic and/or paranoid) in the leader. Any form of sustaining support can make the difference between high morale and complete psychological collapse. If the followers are isolated, there is then only the support of the leader that keeps them afloat. Isolation can be physical, emotional or ideological:

> As he (the prophet) gratifies their spiritual hunger, he visibly swells with self-validation and renewed self-esteem, finding rich nourishment in their love and rapt attention, putting himself as he does so beyond the reach of the alienation and the despair that is the lot of the schizophrenic patient (Stevens & Price, 2000, p. 200).

We (the authors) are not saying that any of the founders of the various body psychotherapy modalities were, in any way, schizophrenic, or developed their methodologies into specific cults, but we do hold that observations about this phenomenon are very interesting and can give another, possibly deeper, way of thinking about the dynamics within various organisations, especially psychotherapy and body psychotherapy ones.

Private Businesses and Risk-Taking

Body psychotherapy trainings, approximately from 1960 to 1990, were often grouped around a particular (often charismatic) individual, and were often private businesses, sometimes even trade-marked, registered and franchised. Sometimes this mix of personal, training, and therapeutic components had a significant (though covert) conflict of interest. Students were accepted on the criteria of the prevailing principle of that time: that we all have the potential to develop. There was also much more of an emphasis on personal development, rather than training in body psychotherapy for a new career. Nevertheless, there was leniency around any particular histories of mental illness, so that an individual was sometimes accepted, who might not have had the emotional robustness for the training but, as an extra student, boosted the organisation's income. This was a time of more risk-taking than we are used to nowadays, and risks were almost certainly taken that (perhaps) compromised the integrity of some organisations and thus the quality of their subsequent therapists.

Trainings in psychotherapy and body psychotherapy were then much less formalised than they are now and were never, ever, 'manualised'. Individuals kept on training until they felt (or were judged) ready to practise independently. Some trainees had no intention to practice, just to develop personally. Development was ongoing and each person developed at his or her own particularly individual rate (irrespective of the course structure), and so "training" could take what seems a long time by today's standards.

It is (perhaps) interesting to note that, in this context, psychotherapy (and body psychotherapy) trainings should now all be of a four-years duration, with a *post-graduate* level of entry (or the equivalent). In common with ALL professional trainings, this would mean that any individual, after three years (or the equivalent) of a university first degree could enter into a professional training (in psychotherapy or body psychotherapy) consisting of four years of post-graduate study and experience, and then emerge as a professional competent to practice.[v]

Excluded Minority Psychotherapies

Body psychotherapy in the past has functioned as a somewhat underground movement (Boadella, 1980), possibly out of necessity. In the 1990s, body psychotherapy trainings and practitioners were then able to band together and project onto an attacking external world, which apparently did not understand it: this is a classic case of the "underdog" with the "truth". Body psychotherapy is only, in recent times (post-2000) becoming a mainstream branch of a "recognised" profession: realistically, we are still in a transition process.

Kathrin Stauffer (2012) recently opened the possibility of exploring this sense of external lack of recognition, and its internal sense of deficit amongst body psychotherapy practitioners, at the last EABP Congress for body psychotherapy. It is likely that the exploration will find components of low self-esteem, poor sense of worth, and even some shame. It is easy to criticise the conventional psychotherapy establishment for its lack of recognition and acceptance of body psychotherapy, and it is therefore quite easy to slip into a "counter-culture" of getting-by and "decrying" conventional standards, or not fulfilling acceptable conditions, or (not even) undertaking proper research. But, we now need to embrace these challenges, not just from the outside, but also from the inside.

The world of psychotherapy, especially in Europe, is becoming much more professional, much more scientific ("evidence-based"), and also much more academic. Standards are changing quite rapidly and, to date, body psychotherapy has met some of these challenges and has tried to bring itself up to the newly applied standards. However, there are currently no training standards applied (for example) by the United States Association of Body Psychotherapy (USABP), though the EABP training standards may be used as a guideline; there is no "established" set of professional competencies, and there is no established "acceptance" of body psychotherapy as a "legitimate" form of psychotherapy.

Body Psychotherapy Methods

Another 'shadow' element in body psychotherapy resides in the actual methods themselves, which are not intrinsically problematic, but without checks and balances, as we have seen, can be potentially abusive or just illusory. We have already mentioned the inherent "risks" within body psychotherapy (Young, 2006a). Sometimes, it is possible that the methodologies and techniques have been applied without any form of differentiation or discrimination. There was generally very little teaching, within these methods, about the contra-indications for any particular method. In particular, breathing techniques, cathartic methods, touch techniques, and deep tissue work can – sometimes – be quite problematic, depending on to whom, and how these techniques are being implemented. There is therefore much more systematic work that needs to be done, detailing and researching in this area.

A greater introspection and comparison of the actual methods themselves has to be left to other authors. Hopefully, they will compare the benefits, as well as the various disadvantages, of each of these distinctive methods within body psychotherapy. Here, we are trying to identify trends rather than actual or specific examples, but the proliferation of different methods within body psychotherapy is, in itself, quite notable.

All of the European Association of Psychotherapy (EAP)'s psychotherapy modalities have to be scientifically validated by answering a set of "15 Questions". The proliferation of body psychotherapy modalities meant that, initially, the EAP would not accept body psychotherapy as a mainstream method within psychotherapy without requiring that each modality within body psychotherapy also substantiate its own set of answers to the 15 Questions (Young, 2006b; Young, 2010), which was – significantly – not required of any other "mainstreams" within psychotherapy.

In the 1990s, EABP had also managed to establish Training Standards, Membership Criteria, improved Ethics Guidelines and principles, as well as a process to assess and accredit body psychotherapy training institutes according to whether they deliver on these training standards.

Changes since the 1990s

In Britain, several body psychotherapy training organisations have always been accepted into the UK Council for Psychotherapy (UKCP). These (3 or 4 Member Organisations) are located with the Humanistic and Integrative Psychotherapy College (HIPC). All HIPC trainings are required to teach some knowledge of other forms of psychotherapy, not just their own.

Since the late 1990s, body psychotherapy organisations have become more transparent, and trainings have operated with much more open systems of organisation and training standards. Now, psychotherapy trainings are set at a minimum of four years from start to finish, are normally at post-graduate level of entry (or equivalent), and have to meet recognised standards, as set by the professional associations in line with European-wide professional standards. Internally, these trainings have begun to be less hierarchical, and to have management committees as well as student and trainer involvement in decision-making processes. Some organisations also include non-training staff on their governance committees. Curricula have been developed and even put into manuals. Trainings have become more selective regarding their prospective students, with a view to training them to be professional body psychotherapists. Codes of Ethics and Practice, Complaints Procedures, and External Moderators and Examiners are now fairly standard within many body psychotherapy organisations. Trainings still remain very experientially biased, but with the addition of some specific academic requirements. Engaging in training, solely for personal development, has largely disappeared, although personal development remains a significant part of the training in order to become a body psychotherapist. However, some of the risk-taking has gone, especially as society has become generally much more cautious.

Other Developments

Way back in the 1970s, David Boadella founded one of the first body psychotherapy journals, *Energy and Character*, which enabled a proper dialogue between methods and training organisations, and was also somewhere to publish fairly seminal articles – but it is not, and has never been, a peer-reviewed journal, nor was it properly scientific. Now, there are two or three professional, scientific, peer-reviewed journals that are starting to cover this and allied fields.

Methods of working with clients have become much more refined. There is far more sophistication when, for example, working with traumatised clients, and it is now accepted that when working with specific client groups like this, or with clients who have been sexually abused, additional specialised training is often desirable and even necessary, and furthermore that some clients may not be suited for body psychotherapy.

There is also much more awareness of context, and need for the actual resources in the daily life of clients. We are, after all, all largely working towards self-empowerment for our clients, and thus the elevation of the therapist into an all-powerful position, as "healer",

"guru" or wonderful clinician, is thus somewhat counterproductive. Emphasizing what the person has got, or has done (rather than what they have not done, or not got) is a good first step.

Body psychotherapists in the UK still work mostly in private practice, and much less in the various training institutes, once they are qualified. Job opportunities are opening up for body psychotherapists, and some are even found working in the UK National Health Service in departments of clinical psychology, mental health institutions, or with patients from oncology and transplant surgery. They still remain a little bit invisible, as they are often employed as technicians, counsellors and psychologists, rather than explicitly as body psychotherapists, but there is a definite movement of change (for the better) here. Professional registration is a necessary requirement.

Conclusion

For the future of body psychotherapy, as a whole, we are hopefully finding a way of acknowledging and living with many of these shadow aspects, by both honouring the lineage and the gifts of our pioneering founders, and also by not denying some of the other often (very personal and detrimental) hurts, pain, mistakes and conflicts in the developing history of these body psychotherapy methods and our combined methodology. This is, perhaps, the only way that we can bring all these disparate things together and eventually integrate them within a better professional continuum. In doing this, we are not stating that body psychotherapy is, in any way, less ethical than other forms of psychotherapy. We are just trying to put our own house in order: first by acknowledging some of the untidiness and deficiencies; and secondly, (hopefully) by indicating where the mops and brooms are.

BIOGRAPHIES

Courtenay Young trained in Body Psychotherapy over 30 years ago, with Gerda Boyesen, David Boadella, and with significant inputs from John Pierrakos, and later Stan Grof and Arnold Mindell, amongst others. He is now an accredited psychotherapist, working within humanistic, transpersonal and body-oriented modalities and also working as a counsellor and psychotherapist in the National Health Service in Scotland. He has served on the Boards of the United Kingdom Council for Psychotherapy (UKCP), the European Association of Body Psychotherapists (EABP), and the European Association for Psychotherapy (EAP). He has recently been heavily involved in a project to establish the Professional Competencies of a European Psychotherapist for the EAP (www.psychotherapy-competency.eu). He has written a number of articles for the EAP's *International Journal of Psychotherapy*, for the *USABP Journal*, the *Journal of Body, Dance & Movement in Psychotherapy,* and *Energy & Character,* and has also written other articles in other journals as well as chapters in books. He has had one book published, *Help Yourself Towards Mental Health* (Karnac Books, 2010) and has published another, *First Contacts with People in Crisis and Spiritual Emergencies* (AuthorHouse, 2011). He also publishes a series of collections of Body Psychotherapy articles on various topics, as a director of Body Psychotherapy Publications. He is currently editing the English-American version of the *Handbook of Body Psychotherapy & Somatic Psychotherapy* with Gustl Marlock and Halko Weiss, due to be published by North Atlantic Books in 2015.

Gill Westland is Director of Cambridge Body Psychotherapy Centre (CBPC) and a UKCP registered Body Psychotherapist, trainer, supervisor, consultant and writer. She has worked as a Body Psychotherapist for many years and has been training Body Psychotherapists for the past 30 years. She worked originally as an Occupational Therapist in the National Health Service in Mental Health at the Maudsley Hospital, London, and then at Fulbourn Hospital, Cambridge, as a clinician and then as a manager, clinical supervisor and teacher. She is a full member of the European Association for Body Psychotherapy (EABP); an External Examiner for the Karuna International Institute in Devon, U.K. and the London School of Biodynamic Psychotherapy, London, U.K; and a supervisor on the M.A. Body Psychotherapy programme at Anglia Ruskin University, Cambridge, UK. She is also co-editor of the journal, *Body, Movement and Dance in Psychotherapy* (Taylor and Francis). The Body Psychotherapy training offered at CBPC is rooted in a psycho-spiritual perspective.

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Endnotes

[i] Both authors were in the same body psychotherapy training group (1979-1983) at the Gerda Boyesen Centre for Biodynamic Psychology & Psychotherapy in Acton, London and witnessed occasions such as this. We are therefore – in this instance – not speaking theoretically but experientially and thus feel that we can be more explicit here.

[ii] *From a"Project Muse' review by Winthrop Whetherbee*: "Fumo devotes a long chapter to Ovid's treatment of Apollo as a "human" god, showing how rarely he appears in a positive light, how often his powers (as healer, teacher, or lover) prove ineffectual and his authoritative posturings absurd. When he appears in the middle of the Ars amatoria to deliver the Delphic injunction "know thyself," what he goes on to propose are effective means of self-display—narcissism rather than self-knowledge (51–52). As physician, he has a prominent role in the Remedia amoris, but his remedies turn out to be incitements to renewed passion (68–69). Yet Ovid plainly identifies himself with Apollo, who becomes patron, alter ego, and role model for Ovid's own "narcissistic and often self-defeating activity" as poet (48)." *Accessed 25-Jan-2014: muse.jhu.edu/login?auth=0&type=summary&url=/journals/studies_in_the_age_of_chaucer/v034/34.wetherbee.html*

[iii] Lesley Lowen collaborated with her husband Alexander Lowen in *The Way to Vibrant Health*"(1977) published by Harper Colophon.

[iv] Schizophrenic (here) is not used in the narrow psychiatric sense, but much more in the characterological sense: of the schizotypal (schizoid) personality disorder. There is on-going controversy about the use of this word and the pathologization of 'normal' human differences.

[v] These criteria are what is largely accepted as the post-graduate 'specialist' professional training requirements for most professions. They form the basis of the European Union's training requirements for the 'liberal professions (CEPLIS) and have been incorporated into the training standards of the EAP and thus all member organisations (including UKCP and EABP).

The Scene of the Crime: Traumatic Transference and Repetition as Seen Through Alfred Hitchcock's Marnie

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Abstract

This essay presents an integrated approach to treating traumatic transference dynamics. Our theory integrates findings from the family therapy literature, principally the contributions of Murray Bowen; new understandings about memory from the field of neuropsychology, most clearly expressed in the writings of James Grigsby; and insights into the behavior of the autonomic nervous systems of people after they have been stressed or traumatized, as modeled by Peter Levine. Our work integrates these three literatures into an approach to addressing the complex interpersonal dynamics that arise when psychotherapists work with clients who have experienced a particular class of traumas which we call "in-group traumas", which is to say, those clients who have a history of involvement in traumatic incidents in their families, schools, churches or other tightly knit groups. Because of the close and ongoing nature of relationships in these groups, memories of traumatic experiences in such environments can be more complex than memories of car accidents, surgeries, or even an attack by a stranger. We propose a way to conceptualize these memories of "in-group" traumas. To do so, we rely on five ideas: 1) It is useful to simplify people's behavior during a traumatic event into four roles: Savior, Victim, Bystander, Perpetrator. A single individual might play more than one role, even during the same event. 2) Individuals playing any of these four roles can develop posttraumatic symptoms. 3) Traumatic reenactment can be accounted for through the mechanism of projective identification. 4) During a traumatic event, we remember not so much what happened to us alone, but rather our subjective interpretation of the entire traumatic event itself; we remember the scene of the crime. 5) Healing from a complex relational trauma requires integrating all four posttraumatic roles and, through them, the whole of the traumatic event. Identifying with one of the roles and disidentifying with the others, as is usual, leaves clients with a superficial misinterpretation of what they actually remembered because, during the original traumatic event, they also remembered what they imagined at that moment to have been the experience of others present. To conclude, we describe the implications of this interpretation for clinical interventions. Throughout, we use a (fictional) case study accessible to any reader, Alfred Hitchcock's 1961 psychological thriller, *Marnie*.

Keywords: trauma, group dynamics, traumatic transference and countertransference, traumatic reenactment and projective identification, posttraumatic memory space, Alfred Hitchcock

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Marnie: A Story

The woman walks briskly down the train platform, a gold purse tucked up under her arm. Carrying a suitcase, she appears calm and confident. The scene switches to a small business, where the distraught owner is being interrogated by the police. Visibly upset, he indicates an open, empty safe. How could he have so misjudged his missing secretary? She seemed so proper and earnest. Later, the same woman, again seen from the back, stands in a hotel room, calmly sorting the contents of one suitcase into another, exchanging social security cards. She dyes her hair blonde. At last, we see her from the front, in her new outfit. Only later do we learn her identity, Marnie, the title character of Alfred Hitchcock's 1964 psychological thriller.[1]

In a famous interview, Hitchcock revealed to François Truffaut that making films was the only way he could work through his own anxiety (Truffaut, 1985). For our purposes, this is the key sentence of the interview because Hitchcock, like no other director, manipulates the anxiety of the film watcher. In Marnie he feeds us clues: a purse, a suitcase, a key. So it is for people with traumatic memories; we fixate on details: an image, a word, a smell. Watching *Marnie* we shift from detail to detail, with only a sense that somehow they will fit together. Hitchcock plays with our perspective. We are *observers*, caught up in a search for meaning, helpless to change what we see. We feel the mounting fear of the *victim*, trapped in our fates. We feel the impulse of a *savior* to resolve the tension.

Set against the protagonist of Marnie appears the character of Mark Rutland as the antagonist. The ambiguous casting of Sean Connery as Rutland is simultaneously unnerving and reassuring, as he is familiar to the audience as both a womanizer and a champion, in any case a man of action. He hunts Marnie and, step-by-step, acts both to capture and to heal her. To bring her close to him and to protect her from discovery by the police, he blackmails her into marrying him. She is terrified of any sexual relationship with him and attempts suicide. For the kleptomanic Marnie Edgard, bound to Rutland, it appears there is no escape from the web in which she is trapped.

Marnie begins as a cipher, giving us only clues as to her psyche: she panics when she focuses on the color red or during storms. She hides her other crimes, her past, her childhood, her profound early trauma, only to have it pulled from her, one revelation after another, by Rutland. As the film progresses, we learn more and more about her. Finally, we learn that many years before, Marnie's mother, Bernice, worked as a prostitute. When a sailor would come to visit, Bernice would wake and move her daughter, little Marnie, to free the bed. One night, when Bernice thought a sailor was going to molest Marnie, she hit him, causing him to fall on her. Marnie, only six years old and afraid for her mother, grabbed the fireplace poker and struck the fallen man repeatedly, killing him. As the film closes in the apartment near the docks with Rutland, Marnie and her mother, all is revealed and felt in full. Marnie's conflicted feelings toward Rutland seem to be resolved. As Marnie and Rutland drive away, the sky is clear above the docks and sea. The storm has passed.

[1] Marnie, with Tippi Hedren and Sean Connery playing the leads, is based on Winston Graham's book of the same name.

A Theory of Traumatic Transference[2]

As psychotherapists, we meet with clients who report stories that involve close relationships and violence. Because of the close relationships, these kinds of traumatic memories are often more complex than less relationally intimate traumas, such as most car accidents or surgeries or attacks by strangers. In this article, we propose a way to conceptualize memories of these kinds of familial[3] traumatic events — those that involve members of our family, school, neighborhood, club or community. Throughout, we use Marnie's story as illustration.

To deal with the memories of close or "familial" traumas, we will rely on five ideas. First, it is useful to simplify people's behavior during a traumatic event into four roles: those of Savior, Victim, Bystander, Perpetrator. Keep in mind that a single individual might play more than one role, even during the same event. Mark Rutland, for example, was both a Perpetrator (he blackmailed Marnie into marrying him and pressed her to reveal her past) and a Savior (he protected Marnie from the police, pressed her to reveal her personal history and misdeeds, and comforted and supported her as she integrated her traumatic past). Second, individuals playing *any* of those four roles can develop posttraumatic symptoms. Bernice was a Bystander to Marnie's murder of the sailor while here Marnie was the Perpetrator. Posttraumatic transference occurs because we remember others present at the traumatic scene. Both Marnie and her mother remember each other and the sailor. Third, traumatic reenactment can be accounted for through the mechanism of projective identification. This will be shown below through Marnie's behavior in the film. Fourth, we remember not so much what happened to us, but rather the traumatic event itself; we remember the scene of the crime. Finally, therefore, healing from a complex relational trauma requires integrating all four posttraumatic roles and, through them, the whole of the traumatic event.

Typically, we choose to identify with one of the roles, usually the role we actually played, and disidentify from the others. This leaves us with a superficial misinterpretation of what we actually remember, because we also remember what we imagined at that moment to have been the experience of the others present. This remembering of the whole scene occurs whether or not we want it.

Our traumatic memory stores our perception of the experience, including all four roles, regardless of which role(s) we played personally. Figure One represents this as "the memory space":

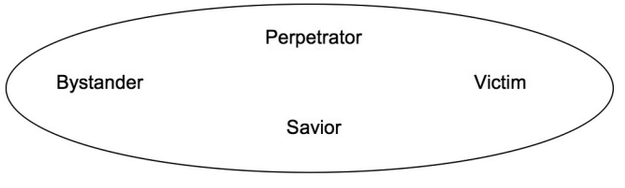

Figure 1: The Posttraumatic Memory Space, the "Scene of the Crime"

[2] The authors wrote this essay after a talk given at the European Association for Body Psychotherapy conference in Cambridge, September 2012. It expands on a five-page note that accompanied the talk, in which the authors introduced an understanding of traumatic transference stemming from family traumas, and of transferential and countertransferential dynamics in the therapeutic setting. As with the presentation, the notes and this essay are based on an integration of traditional transference and countertransference dynamics, neuropsychological research of the past twenty years about memory systems and attachment, and the traumatology literature. Fine-grained citations to these literatures are available in the first five chapters of Wolterstorff's dissertation, A Speculative Model of How Groups Respond to Threats, available at http://storffgroup.com/monograph.php. The intent of this essay is only to introduce the theoretical model underlying this particular approach.

[3] Or school, church or other "in-groups", in which we have been members for months or years.

Here are the five ideas in more depth:

1. Savior, victim, bystander, perpetrator. Traumatic events are remembered in a vivid, distorted fashion, in which the essential elements of the event are impressed in memory and persist over time. Meanwhile, secondary elements of the event decay, and are reinvented, progressively simplified and distorted through confabulation each time the event is recalled.

Traumatic memories contain physical sensations, the positions of the body, what was seen, and impulses, emotions, and thoughts from the moments of an event. Marnie's memories of her fateful night are associated with the sound of thunder (there was a storm that night) and the color red (of the dying sailor's blood).

If the people present at the scene of the trauma were part of our daily lives, we store the memories of each of them in an abbreviated, stylized form, as a Savior, Victim, Bystander or Perpetrator. We remember traumatic scenes in different ways, through different memory systems, which not only involve thoughts and feelings but also autonomic nervous system states, physical sensations, impulses and images. There is nothing magical about these four roles; they are shorthand categories into which we simplify what took place in a traumatic event. A different language or culture might split the Bystander role into Bystander-as-Victim (wanting but unable to help and watching in horror) and Bystander-as-Perpetrator (able to help but choosing not to) — and so on. For the purposes of therapy it does not matter how these roles are characterized by our language and culture. What is important is that they encompass and simplify the behavior of other actors in the traumatic event, like actors in a play: the hero, the bad guy, and so forth.

2. Traumatic transference. Although most of the trauma literature is devoted to the posttraumatic symptoms of Victims, each posttraumatic role is accompanied by symptoms. Saviors can express compassion fatigue. Saviors and Bystanders can suffer from survivor guilt, or observer trauma. The most severe posttraumatic dysfunctions (addiction, suicide and, perhaps, reenactment) occur with Perpetrators. Exposure to a traumatic event can engender posttraumatic symptoms in all those present.

After a trauma, people may act differently in relationships. They may experience greater difficulty in trusting others ("Are you going to hurt me?") or in defending themselves ("Please don't hurt me."). Helping people to regain the ability to trust and to set boundaries and defend themselves is often the task of the trauma therapist. Most trauma therapists are familiar with traumatic transference: "You'll save me" or "You understand because this happened to you, too" or "You just sit there and watch me suffer. You don't really care about me" or "I don't trust you." Marnie has difficulty trusting anyone. Bernice can only seem to love the little neighbor girl, who perhaps appears to her as Marnie was before the night of the murder.

Traumatic transference is possible because individuals remember what they imagine to have been the experience of the other people present at the traumatic scene. Just as we do in everyday interactions when we imagine the experience of others to create rapport, to understand, and to learn to predict their behavior; when dealing with trauma we also internalize what we perceive to have been the experience of the other people present at the scene of the trauma. We learn all of the behaviors that occurred: the behaviors of the Savior, Victim, Bystander and Perpetrator, regardless of which behavior we enacted ourselves. In doing so we remember these four different orientations toward the world; we learn in turn how the world appears when we are a Savior, a Victim, a Bystander and a Perpetrator, as well as the posttraumatic stance of each role.

When individuals are reminded of a traumatic event, they recall the traumatic scene, and try to fit the current scene into the frame of the past traumatic scene. As a six-year-old might imagine playing the prostitute, Marnie's scam with employers is to play the perfect employee, earnest, hard-working and attractive. In exchange, she "pays" herself by removing money from the company's safe, then goes on to change her identify, to prepare herself for her next client. This is the lens through which she experiences Rutland. Her frigidity protects her from more associations with the night of the murder (her mother's prostitution), but keeps her psyche partially frozen at its six-year-old emotional state, which keeps her emotionally immature and unable to integrate and heal the trauma.

As with Marnie, our projection of the past onto the present can be either helpful or harmful. Consider three variations of what might happen from the point of view of the Victim role. If we grew up in a home in which our father beat our mother and we find ourselves entering an intimate relationship, we may be reminded of our childhood and the potential for abuse. If, indeed, our potential partner has a history of becoming physically abusive in intimate relationships, our memories from the past are an advantage to us. (This may have helped Marnie avoid dangerous relationships before the period of her life we see in the film.) We are a step ahead of the game and can prepare ourselves to flee or otherwise protect ourselves. But, if our potential partner means us no harm, yet we act as if they do, our behavior can be seen as crazy or paranoid. We might refuse the relationship to our own greater isolation and loss. (An example is the scene in the movie in which Mark Rutland meant well and was good to Marnie but she could not reciprocate.) The most dangerous dynamic (for us), is when the person means us no harm, but has tendencies to violence. Our fearful behavior can provoke or, over time, entrain the other person to assault us. This occurs in a hundred small ways: We might avoid confrontation, allowing unpleasant interactions to fester. We might acquiesce to requests we would normally refuse. Our partner, in innocence, might keep pushing to find a mutually acceptable boundary. By not standing up for ourselves, we support an evermore imbalanced kind of interaction that can lead to a power imbalance, which may invite disrespect, thus increasing the potential for abuse. The entire time we might be aware of the dynamic but may not know how to extricate ourselves from the situation. We remember the interactions in the family we grew up in as the script of a play. This is the play we understand and that is our default interpretive lens. (Until the final scene, Marnie is unaware of how her trauma-script has shaped her life. Throughout the film, she searches out and recreates the scene of the crime, each time a danger to herself and those close to her.)

Just as in the Victim example above, the same dynamic can trigger us into the role of the Perpetrator, Savior or Bystander. If, when we were small, our parents struck us in anger, when we are later parents and angry, our childhood memory will be triggered and we can experience the impulse to take the Perpetrator role, to strike out and hit our child. (Marnie was only a child. Her mother was the prostitute, yet Marnie plays the role of the prostitute in her kleptomania.)

Or if, as children, we were part of a mob that bullied another child while adults stood by and did nothing, years later, as an adult, if we came upon a similar scene, we might find ourselves standing to the side, frozen into a Bystander stance.

The least problematic version of this dynamic is when we are triggered into the Savior role, but even then we might be delusional and project the past inappropriately onto the present and attempt to save people who do not need saving, who do not want our help, or, at the least, we move to help without appropriate sensitivity.

3. Traumatic reenactment and projective identification. Psychoanalysts have long argued that an unintegrated traumatic event compels us to revisit it, to return to the scene of the crime, to traumatically reenact. A girl abused throughout childhood finds herself romantically attracted to abusive men. A man repeatedly abandoned in childhood is left, without warning, by his wife, then again ten years later by his second wife, then again seven years later by his third wife, and twice more by his business partners.

Consider the mechanism through which this might occur: projective identification, which describes how one internalizes a *relationship*, not simply one's role in the relationship. We remember the mother-child *interaction*, and not simply our experience as a child. In non-traumatic transference, the memory of a relationship embeds itself through repetition, through our *procedural* memory. When we internalize a traumatic relationship, the memory embeds itself through significance, through our *event*, or *episodic*, memory. When we encounter a situation reminiscent of the earlier traumatic event, our memory of the original event becomes the lens through which we interpret our situation in the present moment. When we interact with others through this lens of memory, we not only transfer the original scene onto the present moment and transfer posttraumatic roles onto those around us, we also choose, are *drawn to recruit* others, and *entrain* others to enact roles from the original trauma. Our mind asks, "Are you the Savior? Or the Victim? Or the Bystander? Or the Perpetrator"? Like a stage director, we assign people to the roles of our original trauma, and begin to interact with them as if they were the actors in the scene. Finally, if what we remember is the set of interactions that together make up the traumatic event, *it does not matter which role we originally played*, whether we were the Savior, Victim, Bystander, or Perpetrator.

More viscerally, Marnie recreates her mother's prostitution and the night of the murder through her relationship with her horse. Twice we see Marnie, after seducing and stealing from an employer (through which act she plays her mother, the prostitute), going to a stable to ride her kept horse (through which she plays the sailor). The third time we see her ride Forio, she sees red, panics and rides the horse too hard; he breaks a leg and is writhing in pain. Hysterical, she knocks at the nearby farm door, borrows a pistol, and shoots her beloved (positioning herself as the Perpetrator).

4. The scene of the crime. The traumatic memory is a memory of the scene of the crime. We remember the role each person played in the traumatic episode.

Here is a hypothetical scene: Father (the Perpetrator) abuses his son (the Victim), while his younger daughter (a Bystander) watches, until the mother (the Savior) intervenes to stop it. All four people, comprising all four roles, hold the scene in their memories, including what they perceive to be the feelings and thoughts of those holding the other roles. The daughter holds in her memory what she imagines her brother, father and mother were feeling and thinking, and so on.

All four people will carry their subjective versions of the traumatic memory, including each of the four roles, and will have a complex of posttraumatic symptoms. Reenactment through projective identification is only one possible posttraumatic symptom shared by all four roles. Other symptoms can be shared to varying degrees by all as well: anxiety, intrusive imagery, avoidance, dissociation and traumatic transference.

5. Healing requires accepting the reality of, and integrating, all four posttraumatic roles. What does this mean for therapy? If the interpretation we suggest in this essay is accurate, to relieve our symptoms it will be necessary to integrate the memory of all four roles, in turn, as if we were each of those people. The Bystander must integrate the experience of the Victim. The Perpetrator must integrate the experience of the Savior. And, yes, the Victim must integrate the (previously imagined) experience of the abuser. Integration does not mean forgiveness or

compassion. It means seeing and consciously knowing a disowned part of you own mind, one that exerts control over us until we have absorbed and digested it.

Below, we will imagine ourselves as therapist, and that Marnie has approached us as a client, and will discuss how we would work with her. First, we must address the difference between the real-world healing process through which Rutland guided Marnie, and the artificial therapeutic container in which we as psychotherapists do our healing work.

The Therapeutic Container: Managing Power, Sex and Intimacy

Sean Connery's character, Mark Rutland, guides Marnie's therapeutic process. Just as we lead our clients into their own darkness and help them to integrate their pasts, so Rutland leads Marnie. If we practice deep transferential therapy, we must love and commit to our clients, as Rutland commits to and loves Marnie. Transferentially based therapeutic relationships are asymmetric. In session, we have more power than our clients; in many ways, they are our children. Rutland (who is referred to by his last name) has more power than Marnie (who is called by her first name). When she is triggered into a traumatic state, he cares for her as he would a scared, wounded child. Finally, Rutland is willing to play the Perpetrator (he blackmails her into marrying him and repeatedly forces her to face her fears), the Bystander (he stands to the side and allows her to betray him and herself by attempting to rob his company), the Victim (it is his company that is robbed, and his reputation that is damaged by his adoption of her) and the Savior (he pays her debts, rescues her from the police and from her own self-destructive behavior). As therapists working with traumatic transference, we must hold a strong, loving container, in which the client will see and accuse us of being their Perpetrator or Bystander, of being a Victim like them, or of being their Savior. The transferences will come and go while we maintain our engaged, loving stance with them. Rutland succeeds in healing a profoundly traumatized woman under his care. We would be fortunate to be as successful in therapy with our clients.

Yet, there are differences. Rutland commits himself fully to Marnie. As therapists, we work with many clients. We would only be able to work with one client if we were to commit as fully as Rutland does. As therapists, we must find ways to effect or support healing in our clients within the structure of regular, short meetings. However heartfelt our commitment is, our efforts are limited by the therapeutic contract.

Second, Rutland confuses sexual and romantic love between two adults with the guiding and caretaking love of a parent for his child. Because Mark Rutland and Marnie Edgard are both adults, his confusion is problematic but not damaging. In assuming responsibility for her mental health and manipulating her toward healing, he claims an adult position (thus he is identified as Mr. Rutland) and patronizes her (while she is identified as child Marnie). Their contract was established (however forced by Rutland) as a sexual one between two adults. His infantilization of her begins later and distorts but does not violate their contract. In contrast, our contract with our clients begins with and is properly based on a parental-like asymmetry of power. For us as therapists, to enter into a sexual relationship with our clients is likely to be experienced as an act of incest, an act through which we betray our responsibility to care for our clients because of our own immaturity and lack of impulse control. The damage caused by a single such betrayal will outweigh any number of hours of helpful therapy.

An Example of the Therapeutic Process with a Marnie as Client

In this example, we present a therapeutic process we and our students have employed, cautiously and with much anecdotal success. The techniques some of you might recognize

from the psychoanalytic and group therapy literature applied to traumatic transference in a one-on-one setting. We do not recommend that readers adopt these approaches unless they feel themselves competent—and have been assessed as such by experts—in working with trauma, transference and countertransference, and are receiving supervision. A common observation by psychoanalysts for the past century, which our experiences as clients and therapists, students and trainers, have confirmed, is that working directly with transference without adequate technical skill, self-awareness, mindfulness and humility can be retraumatizing to all involved. The protocol is stated clearly below, perhaps giving the impression that the authors assume omniscience or omnipotent authority. Rather, the intent is to clarify the therapeutic strategy and the intention of the therapist in the moment, and to explicitly frame each transferential intervention, in order that both therapist and client can more easily differentiate between present and past in the client (transference), and therapist in him/herself (countertransference).

In our protocol, we work with traumatic transference through a sequence of four steps. First we support a client in integrating the Savior role, then the Victim, then Bystander and, finally, the Perpetrator role.

The integration process requires the client empathize with each role, noticing the physical sensations, impulses, emotions, images, and thoughts that arise. To empathize does not mean to *sympathize*, or to excuse or forgive. Rather, to empathize is to put oneself in the place of others, to imagine their histories, thoughts, and feelings. As human beings, we instinctually empathize, however skillfully or poorly. Instinctually, we empathized with the others at the scene of the trauma. Our empathetic impressions from the scene of the crime are stored within us. To integrate and heal from the experience requires, in part, that we recall our empathetic impressions from the moments of the trauma.

As people who resemble Marnie come to us as clients, we will use her as an example. If she were a client, she would likely come to us unclear about why and how she acts out; confused about how to interact with other people and avoiding intimacy; suffering severe panic attacks; socially isolated and unable to feel her own emotions; and compelled to enact her strange kleptomaniaical ritual (which she does not realize reenacts the original traumatic scene of her childhood). Here are the four steps we could lead Marnie, or any client, through to integrate her early traumatic memories and relieve her of her negative symptoms.

Step one: Integrate the Savior. Ask your client the question, "If you faced that situation again, how could you make sure the outcome would not be terrible?" He should have an answer before you continue. Then invite him to reimagine the situation, now with a solution. Have your client practice this reimagination until he feels confident his solution, if a like situation were to arise, would prevent a recurrence of the trauma. If your client cannot imagine a solution, tell him that you can; then offer solutions, one after another. In doing so, you, as therapist, are holding the Savior role. Be confident and hold out hope until your client embraces a solution. Once your client has a solution, let go of the Savior role and let your client take it on. If you continue to embrace the role of Savior, it will keep your client weak. Let him be the Savior, not you.

With Marnie, we ask, "If you were to face that situation again, with the sailor and your mother, how could you make sure the outcome would be better"? Her answer is simple, though perhaps difficult for Marnie to grasp; Marnie is an adult now and will never be a young child again, completely dependent on the adults around her. The situation *cannot* recur. We would invite Marnie to reimagine the situation, but with her now as an adult. This

would be an easy task for Marnie because she now lives the solution every day. She is an adult and supports her mother financially so there is no risk of her mother turning to prostitution again and thus endangering herself or any children dependent on her. We would invite Marnie to dwell on this realization while being mindful of her physical sensations, impulses, emotions and thoughts until her body relaxes and her thoughts quiet. She might be well aware of how she now plays the Savior — or this way of thinking about her life might confuse or upset her. If she is not able to accept that she is doing well for herself and protecting her mother from a traumatic reenactment, we will hold that awareness and stubbornly persist in recognizing her strength and value until she owns these qualities herself. We persist with her until she fully accepts how she plays the Savior role in her life. Once she does so, we will stop embodying and acting from the Savior role so as to allow her to hold the role more fully.

Next, we invite her to embrace how she played the Savior at the original scene of the crime. She thought the sailor was going to hurt her and her mother, and she protected them both by killing him. She is alive and her mother is alive. Her actions were successful. This is not to say that her actions in killing the sailor were morally right or conducive to an ideal solution. That complex moral consideration will come later. Right now, what is important is for her to embrace the truth that the solution worked. Neither she nor her mother was beaten, raped or killed by that sailor, any sailor, or any other male since. Again, we as therapists will embrace the success of the killing, however brutal, until she does as well. Once she does so, we will no longer need to champion this painful truth.

Finally, we invite her to empathize with anyone else present at the original scene of the crime that played the Savior role. Her mother played the Savior. Through her work as a prostitute, she kept herself and her daughter sheltered and fed. Also, afterward, she testified in court that she had killed the sailor, not her daughter. She protected Marnie from the police and the court system (as Mark Rutland was to do for Marnie two decades later). As therapist, we will empathize with Marnie's mother until Marnie herself can empathize with this aspect of her mother.

Marnie might now understand better why and how she acts out. She might be a little less confused about how to interact with other people and is perhaps becoming less avoidant of them. However, she still probably has severe panic attacks, is socially isolated and unable to feel her own emotions and, despite her dawning self-awareness, is still compelled to reenact the original scene of the crime.

Step two: Integrate the Victim. Ask your client what damage the original trauma and its aftermath have done to him: "How might your life have been different if the original trauma had never occurred?" Invite him to reimagine his life, year by year, and his significant relationships, and how those might have been had the trauma never occurred. As with the Savior role, if your client cannot fully feel the role of Victim, demonstrate the role for him. As therapist, feel and express the grief for a life not lived because of the traumatic events. In doing so, you are holding the Victim role for your client. Keep holding the role until your client begins to feel his own grief. Once he can, let go of your grief. Allow space for him to fully feel his.

With Marnie, we ask, "How might your life have been different if the original trauma and its aftermath had never happened?" She might first answer that she wouldn't be hunted by the police or trapped in a marriage with Rutland. After more reflection, she might wish for a simpler life, without theft and the need to repeatedly change her identity. She might imagine that her mother, instead of being cold and critical, would act lovingly toward her. She might

imagine that she could have had friends during her childhood as well as now, and that she might have a close, trusted relationship with a partner. She might feel that she has lost the life being lived by the little girl Marnie envies, who lives next door to her mother and to whom Bernice is kind— the little girl who smiles and is open, trusting and full of life. If Marnie cannot feel what she has lost, we would feel, express, and so demonstrate this grief until she can feel it herself. We persist with her until she accepts what she has lost. Once she begins to feel her loss, we can drop the Victim role, to allow her to hold it more fully.

Next, we invite her to embrace how she played a Victim at the original scene of the crime. As a little girl, Marnie was afraid of the sailor. When the sailor fell on her mother and injured her, he indirectly hurt Marnie as well because, as a young child, she was utterly dependent on her mother. Marnie was doubtless overwhelmed by the danger and violence of the scene. More directly, Marnie experienced the Victim role after the murder, when she lost her mother's affection. Her mother became oppressive, cold and controlled, and Marnie, in addition to becoming compelled to protect her mother, became obsessed with the endeavor to regain her mother's love. As therapists, it is our role to feel and express this pain of a life unlived until Marnie can feel the pain for herself.

Finally, we invite Marnie to empathize with anyone else present at the original scene of the crime who was a Victim. Her mother was a Victim, simply through her profession as a prostitute for drunken sailors. When the sailor threw her down, she was badly hurt and needed a cane for support for the rest of her life. After her mother took responsibility for Marnie's crime, Bernice was surely condemned socially, and this would have contributed to the isolated life we see her live during the film. The sailor was a Victim, too. We do not know his intention toward the six-year-old Marnie, or toward Bernice when he pushed her away and then fell on her. Nevertheless, whether what occurred was no more than a rough misunderstanding or an attempt at molesting or harming Bernice, the sailor was bludgeoned to death. Though he was perceived as a threat and Perpetrator by Bernice and Marnie, the only person killed was the sailor. Thus he embodied the archetypical experience of Victim. As therapists, we will empathize with Marnie's mother, as well as with the sailor, until Marnie herself can.

After integrating the Victim, Marnie now might understand herself better and interact better with others. Her panic attacks might now be milder and less easily triggered, but she might well still be isolated socially, unable to feel her own emotions (except grief) without help, continually still compelled to reenact the original scene of the crime.

Step three: Integrate the Bystander. Ask your client, "Who, by getting involved, might have helped this situation, yet did not?" Invite your client to reimagine his life, and how it might have been different had someone stepped in to help him. If he cannot, consider and name those who carried the responsibility for the traumatic events by virtue of not helping. Name them and note their absence until the client feels their absence, and empathizes with them. This role of Bystander can be particularly difficult for the therapist to assume, since we as therapists are actively engaged with the memories of our clients, but are Bystanders to the actual events of the hundreds of traumatic stories we hear. We must accept our own helplessness, and be willing to hold the position of those who did not help at the time of the original trauma.

With Marnie, we ask, "Who, by getting involved, might have helped this situation, yet did not?" Invite her to reimagine her life, year by year, her significant relationships, and how her life might have been different had someone stepped in to help her. If she cannot do this,

make suggestions. For example, where was her father? He bears indirect responsibility for her mother's profession and thus the dangers of that night, and for her mother's harsh treatment of Marnie thereafter. Persist with the idea of her father's neglect and its consequences until she begins to feel his abandonment of her. Once she begins to feel the abandonment, she may turn on you, the therapist, and blame you for your passivity, detachment and incompetence. It is your task to allow her projections on you to arise, come to full strength, and fade. Eventually Marnie will feel her projected mixture of the detachment, guilt and relief of her father, who was not at the original traumatic scene. She might withdraw from her relationship with you. Once she thus assumes the Bystander role, it is time for you as therapist to drop the role and stay engaged with her while she detaches from you, thereby allowing her to hold the Bystander role more fully.

Next, we invite Marnie to embrace how she played a Bystander at the original scene of the crime, when she stood by helplessly as the sailor crippled her mother. We will invite and express feelings of helplessness until Marnie is able to.

Finally, we invite Marnie to empathize with anyone else present at the original scene of the crime who was a Bystander. Her mother was. Her mother saw her little daughter beat the sailor to death. The sailor was a Bystander, when he entered the apartment and saw a little girl sleeping in the bed where he would lie with her mother. Marnie's father was present at the scene by his absence — meaning that in the milieu of the film, the United States in 1964, it would have been normal for a child to have had a father, and expected that the father would protect his wife and child. If most of Marnie's neighborhood or school peers had fathers, she would have felt the absence of hers. If her father had remained in Marnie's life, it is probable that none of this would have happened. As therapist, we empathize with Marnie, her mother, the sailor and Marnie's father until Marnie can herself. When she can empathize with the various Bystanders, we will drop the role of the Bystander, thus enabling her to integrate it fully.

Marnie might continue to understand herself better and, in her life out of therapy, she might interact better with others. Her panic attacks might be gone. She might have begun to form social relationships and to feel more emotions. Yet possibly still she may continue to be compelled to reenact the original scene of the crime.

Step four: Integrate the Perpetrator. Ask your client, "Who directly contributed to this trauma"? Once again, if the client can't say, make suggestions. As therapist, consider and name those who perpetrated terrible actions as part of the traumatic event. Name those actions, gently, until the client feels them and is able to empathize with each person who was a Perpetrator. Once the client recognizes and can empathize with the Perpetrator, let go of the role. Allow space for your client to feel how he is a Perpetrator.

With Marnie, we ask, "Who directly contributed to the trauma?" If she cannot answer, make suggestions. The sailor contributed because he pushed, fell on and crippled her mother. Her mother contributed because she struck the sailor with the fire iron. Marnie contributed because she picked up the iron and bludgeoned him to death.

Next, invite Marnie to embrace how she played the Perpetrator at the original scene of the crime, as she struck the sailor's head with the fire iron. We help Marnie to feel her single-minded aggression until she is able to do so without our help.

Finally, we invite Marnie to empathize with anyone else present at the original scene of the crime who was a Perpetrator. We persist in the idea that she can empathize with each act of perpetration because she *had* empathized with those who took those actions, back during the moments of the original trauma. Once she begins to fill the role of Perpetrator, she may

turn on you and blame you for hurting her, by making her feel these terrible feelings or for some other reason, real or imagined. It is your task, as therapist, to allow her projections on you to rise and fall. Eventually she will feel the isolation and aggression of the Perpetrator. Once she has thus assumed the role, it is time for you, as therapist, to drop the role and stay engaged with her while she cuts off from you and (verbally) attacks you. Allow her to hold and integrate the Perpetrator role fully.

Now, at the completion of therapy, Marnie presumably understands herself better. Her social relationships hopefully continue to improve and deepen. She might continue to feel and explore her emotions. Her compulsion to reenact the original trauma might be gone.

Training and Countertransference

Since traumatic transference can lead to destructive relational dynamics in therapy and a client's personal life, it is important to work with it directly. You can master the ability to work with traumatic transference with less broad training than would be necessary for full psychoanalytic mastery. Instead of dozens of transference dynamics, traumatic transference is limited to the four transferences described in this essay — Savior, Victim, Bystander, Perpetrator — though those four transferences are particularly strong.

Working with traumatic transference requires working with each role in a different way. Psychotherapy with a client who is unable to assume the Savior role, or who is overly attached to the Savior role, is managed differently from psychotherapy with clients for whom the presenting role is Victim, Bystander or Perpetrator. Addressing each role requires different technical skills.[4]

More importantly, addressing each role requires the therapist to be able to embrace or let go of each of the four roles when and in a manner beneficial to the client. This is not an easy skill to master, and requires the therapist to learn about her own traumatic and characterological countertransferences. The therapist needs to learn the limits of her own ability to move into or out of the four roles. She needs to learn her attachment or repulsion to each of the four roles. She needs to learn what circumstances trigger her toward or away from each role. Then, with this self-awareness, she needs to do the difficult, time-consuming inner work necessary to embrace and let go of each role. This is a process, both deeply unsettling and rewarding, that requires years of focused effort. Once she has done much of her own work with transference, she will be able to meet, mirror and guide her clients toward the integration of the traumatic memories that shape and drive their lives and relationships.

Implications

As therapists, we bring our own counter-transferential tendencies, our own history of relationships and our own traumas to the therapeutic relationship. The stronger our counter-transferences are, the less fluid we are, and the less capable we are of working skillfully with our clients. Therapists commonly find some roles attractive and others repulsive. For example, therapists who are uncomfortable with negative transference may have a difficult time allowing clients to view them as unhelpful, incompetent, or antagonistic, yet allowing and not resisting these negative transferences may be necessary for the client's relational healing to occur. If the therapist insists on persisting only in

[4] Which are outside of the scope of this essay.

the (Savior) role of the competent, loving, attuned parent, the negative transference roles which clients carry with them but have not yet integrated into their psyches migrate to other relationships in their lives. In other words, in this case, the therapist assumes the Savior role in the client's psyche, and the client's intimate partners are left holding only the Bystander and Perpetrator roles, which stress and can ruin those relationships. The significance of this dynamic cannot be overstated, for our clients' lives and our own, for our private practices, and for the field as a whole.

In short, traumatic transference is both real and powerful, and can be destructive. Like Marnie and most of our clients, some of us have found ourselves in terrible relational dynamics, which we have created, chosen or acquiesced to. Sometimes our traumatic reenactments are simply stressful, but other times they become new traumas in themselves. Recall the horror Marnie expresses when she must kill her beloved Forio to end his pain. Consider the pain and regret many of us feel when we find ourselves in our own dilemmas, in which any choice we make will have bad, or even terrible, consequences.

Finally, working with traumatic transference can be unpleasant and confusing. It is important for us to keep a sense of perspective, so as not to lose ourselves in the client's drama, nor to fully separate ourselves from the client. Gentle humor can help to leaven the mood and strengthen our mindfulness. How does our guide, Mr. Hitchcock, manage this balance, while he is immersed in his filmmaking and his characters' lives and working through his own anxiety? One way is his personal appearance in his later films. Like an extra, he passes through the background of the scene of crime. In this way he winks at us. He invites us to simultaneously enter and stand apart from the film as we watch it. Did you notice him in *Marnie?*[5]

BIOGRAPHIES

Eric Wolterstorff, received his PhD in sociology, with a specialization in how groups respond to threats, from the Union Institute and University (2003). He studied for years under traumatologist Peter Levine, body-based psychotherapist Pat Ogden, rolfers Peter Melchior and Emmett Hutchins, and group conflict facilitators Arnie Mindell and Max Schupbach. The heart of his work is to understand how large groups and societies can address their group-response-to-threat dynamics, to overcome collective past traumas (such as wars, natural disasters, environmental destruction) and to proactively respond to national threats.
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[5] Here's a hint: He made his move in the first five minutes of the film.

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Body Psychotherapy for Anxiety Disorders

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Abstract

In this paper, an overview of anxiety theories including the latest findings from perinatal and infant research will be explored from a holistic perspective. The body psychotherapy approach to anxiety problems will then be illustrated with case vignettes.

Keywords: anxiety theory, Freud, Reich, psychodynamics, infant research, body psychotherapy in practice.

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This article discusses both theory and clinical work with patients who suffer anxiety, from the perspective of body psychotherapy. Along with the symptoms of depression, those of anxiety are the most often seen in the psychotherapy treatment office. As is the case with all psychic and psychosomatic symptoms, they cannot be treated in an isolated way, as they are usually the expression of an underlying personality problem and have therefore a comorbid aspect. While special methods and techniques for anxiety exist in body psychotherapy, these are only instruments and as such secondary in a relational and process oriented psychotherapy. Before describing the body psychotherapy treatment concretely in the form of case vignettes, the theoretical concepts of anxiety will be dealt with in a historical context. My main focus is on the rational core (Holzkamp, 1973) of the various theories of anxiety, whereby I concentrate on the psychodynamic, humanistic and body psychotherapy approaches. The learning theory basis for the development of anxiety, which has been widely adopted in behavioral therapy, is only briefly touched upon. This is because body psychotherapy has traditionally seen itself as belonging to the spectrum of depth psychology, from which it has originated, and further because since the seventies it has developed increasingly in the direction of humanistic psychotherapy. A discussion of the behavioral position would require a paper of its own and cannot be included in this context.

I will start from the beginning of modern psychotherapy with the founder of psychoanalysis, Sigmund Freud, and with his erstwhile student, Wilhelm Reich, the founder of body psychotherapy. Important in Freud's early theory is that the energy of the anxiety is viewed as originating from a sexual or an aggressive impulse; Wilhelm Reich (1897-1957) took up this idea and developed it further.

1) Freud's theories of anxiety

Sigmund Freud's (1856-1939) early theory of anxiety (Freud, 1895) assumes that in its first

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years the child already has sexual and aggressive impulses, which press for gratification. According to his view at the time the child turns to the mother with these impulses, who reacts according to her own psychosexual development and the social norms of the time with insecurity, rejection, ridicule or punishment. According to Freud, such experiences can cause a blocking of the sexual impulses in the child, which in turn leads to an excitation blockage. The child experiences this as anxiety, which causes the sexual impulses to be converted and thus become less threatening. Faced with possible punishment, the child feels less threatened by anxiety than by the sexual impulse.

In a later version of his anxiety theory Freud elaborated on the signal function of anxiety (Freud, 1926), He believed anxiety to be a sign of threatening situations both in the outer and inner world of the patient. Real anxiety is the fear of what is happening in the outside world and is therefore considered healthy. In contrast, neurotic anxiety develops in relation to inner impulses that are perceived as dangerous. From a psychoanalytic viewpoint, there is a special form of anxiety known as "super-ego anxiety" (Brenner 1976, S. 114 ff.) If one's conscious actions are in opposition to the norms of socialization and one doesn't fulfill the internalized standards of the "super-ego", then one is afraid of punishment, corresponding to the earlier withdrawal of love used by our parents.

2) The Reichian concept of anxiety

Until the end of the 1920s, Reich was a close student of Freud, who demonstrated his esteem for Reich by endorsing him as leader of the technical seminar of psychoanalysis (1924-30) in Vienna when he was still a young man. He espoused Freud's first anxiety theory and, like him, believed that anxiety and sexuality originate from the same basic energy. "When this same excitation, which emerges in the genitals as a sensation of pleasure, reaches the heart system, it is experienced as anxiety, the complete opposite of pleasure" (Reich, 1987, p. 103). If this energy moves from the inside towards the outside, through stretching and expanding, this leads to sexual impulses; if it moves from the periphery towards the center, then it turns into anxiety.

Reich didn't agree with Freud's second theory of anxiety; in his opinion real anxiety also has a psychoneurotic basis and conversely psychoneurotic anxiety has an actual neurotic core. He was now interested in providing clinical proof for his theory that anxiety and sexuality have the same energetic basis. In 1924, he treated two women with heart problems in which the heart symptoms decreased and the heart anxiety receded when they became genitally aroused. Reich believed, in accordance with contemporary physiological knowledge, that pleasure was connected to expansion and anxiety with contraction; these were for him the primordial polarities of vegetative life (Reich 1987, p. 215). Expanding, stretching and dilating processes are controlled by the parasympathetic and contracting processes by the sympathetic nervous system.

Reich saw not only the connection between anxiety and sexuality but also that between anxiety and aggression. In his essay "From Psychoanalysis to Orgone Biophysics" (Reich, 1933, 1989, p. 389 ff) he demonstrates how suppressed and split off feelings are embodied in a "muscular armor" through chronically contracted muscles and restricted breathing, and how chronic emotional defenses manifest as "character armor". Within his character the patient may develop a compact defense mechanism, which on the one hand serves as protection against external stimuli and on the other tries to control the libido impulses, which surge up continually from the id. By binding and defending against anxiety and other feelings, the armor is constantly supporting a neurotic balance (p. 79).

Reich further shows that when this armor is loosened through character analytical work,

first the repressed aggression and then the anxiety are released. "If in the character analysis we succeed in releasing the aggression, which is held in the armor, then anxiety emerges. Therefore anxiety can be transformed into aggression just as aggression can be transformed into anxiety." (Reich,1989, p. 451). This insight of Reich's, a result of his clinical experience, is of great significance for body psychotherapy work with anxiety, as will be shown later in the case studies.

In his work "*Character Analysis*" (Reich, 1933, 1989) Reich differentiates among several character types, who vary in their response to anxiety. The rigid character can suppress anxiety with the help of muscular armoring of chronically tense hypertonic muscles, which the schizoid character cannot achieve. The latter is too unboundaried, has a weak defense system and the musculature is more permeable and hypotonic. Anxiety is bound into the basic structure of the schizoid character, as a result of weak or negative attachment experiences with primary caregivers. In many cases the mother has rejected or even hated the child at birth. Through experiences of emotional rejection, injury and even humiliation, the child has no basic trust in the world and a tendency to perceive others as threatening and a source of anxiety. Rather than suppressing painful feelings the schizoid person splits them off.

Reich's insights on anxiety and anxiety disorders were further developed by his successors, above all by Alexander Lowen (1910-2008), the founder of Bioenergetics. He adopted Reich's character typology, refining and developing it and augmenting it with the "oral character" (cf. Lowen, 1985). Lowen took Reich's ideas of a free flowing energy in the body and the possibility of experiencing "oceanic feelings" (Higgins & Raphael, 1967, 1984, p. 88) as his starting point. Reich had already demonstrated clinically that a change in breathing can help transform anxiety into pleasure (Reich, 1942, 1987, p. 254 ff). Lowen followed this up and found in his clinical practice that as people gave up their defenses and opened up both psychically and bodily to the suppressed excitation created by the anxiety that pleasure, the polar opposite of anxiety, gradually appeared. At the level of the body, the anxious muscular contraction is replaced by a pleasurable expansion. Conversely, greater emotional openness may heighten the potential for hurt and therefore when the soul-body processes are reopened in body psychotherapy, a new strategy for dealing with anxiety and pain must develop simultaneously. Otherwise, there is a danger of repeating the old injuries and traumata. Thus it is essential that the patient have realistic control over the process. Lowen recognized that the one-sided opening up of soul-body processes makes a person too vulnerable.

Over the decades in his clinical practice, Lowen found that many of his patients were anxious about sexuality. They were afraid of letting go, of falling and especially of the "petit mort" of orgasm. This sexual anxiety can be associated with fear of ego loss (cf. Lowen, 1989, p. 129 ff). He took Reich's overemphasis on the sexual drive and its suppression in the genesis of anxiety and broadened it into the concept of a general life-energy impulse, which means that through anxiety, not only sexual but also vital life impulses, are suppressed. Another fear that he noticed in his bioenergetic analyses was that of madness, which often manifests itself as a fear of psychosis or of going mad. Often anger is equated with madness; by blocking (pushing down) the excitement, the patient attempts to avoid madness and the dangers of exploding or bursting (p. 129 ff.).

John Pierrakos (1921-2001) co-founder of Bioenergetics, Gerda Boyesen (1922-2005) founder of Biodynamics, David Boadella (1987), Stanley Kelemann (1992), George Downing (1996) et al. have all contributed further to the concept of anxiety in body psychotherapy. Unfortunately there is no room here to discuss their contributions further (cf. Röhricht, 2011, p. 133ff).

3) Psychodynamic theories of anxiety

Modern textbooks, which are usually of a behavioristic orientation, either do not address the issue of how excitation or energy lies at the root of anxiety, or the answers they do provide are typically not adequate. However, in depth psychology and psychodynamics, the correlation between aggression and anxiety plays a major role.

Fritz Riemann (1902-1979), who wrote Anxiety - *Using Depth Psychology to Find a Balance in Your Life* (2002), a classic of depth psychology, anxiety theory and therapy, argues similarly to Reich, that anxiety and aggression are closely related. It is probable that anxiety and frustration lead to aggression. Frustration is, according to Riemann, the archaic form of anxiety in early life. The infant can only express anxiety in the form of frustration, through screaming, kicking, flailing about; in motoric reaction and abreaction (Riemann, 2002, p. 31). In psychodynamic therapy, in addition to the original model of anxiety as the accumulation of instinct repression, there are currently three models of anxiety:

a) conflict model: anxiety as a consequence of conflict
b) structural weakness model: anxiety as a consequence of weak ego structure
c) attachment theory model: anxiety as separation anxiety (cf. Hoffmann, 2009, p. 16 ff.).

The basis of the conflict model is Freud's signal theory, which states that demands from both the conscience (superego) and the id, which pressures the ego from both sides, cause conflict (Freud, 1895). Intrapsychic conflict is seen as the central source of anxiety. According to Freud's second theory (cf. Hoffmann, 2009, p.16), anxiety is the last resort in preventing a traumatic overstimulation of the ego and is in this case more akin to panic (Freud, 1926). The development of anxiety is closely related to early childhood phases:

- fear of losing the object - separation anxiety
- fear of losing the love of the object
- fear of punishment for a breach of the rules and taboos of the outside world
- conscience or super-ego anxiety
- fear of losing body integrity.

The basis of the structural weakness model is ascribed to deficiencies in the child's development. This may be through traumatic early experiences, poor environmental or constitutional factors, which have severely affected the ego and the self, therefore causing a "weak ego" or "ego-fragility". The individual doesn't have enough resources to defend against or compensate for anxiety and feels threatened and diffusely fearful. In psychoanalytic thinking, impairment in ego development is often associated with narcissistic personality disorder and also with borderline states (cf. Hoffmann, 2009, p. 35-36).

The attachment theory model of anxiety is based on the work of Bowlby (Bowlby, 1975, 1995). Anxiety is seen as a reaction to threats to the fundamental attachment relationship. Fear of losing the object or separation anxiety is the predominant fear in early childhood.

Someone with an insecure attachment pattern didn't have a warm, supportive and secure relationship in early childhood; instead they suffered deprivation and separation. As an adult, such a person has problems forming and maintaining healthy attachments, because it is difficult for them to develop trust in others. In threatening situations, the fear of loss and abandonment surfaces. This model focuses on the anxiogenic effects of insecure attachment and separation.

If we consider the three aforementioned psychodynamic theories in light of Reichian discoveries on anxiety and character, we find that important aspects of these models were already contained in Reich's *Character Analysis* (1933, 1989):

a) Early childhood conflicts and the manner in which the primary caregiver deals with instinctual needs, especially those of a sexual and aggressive nature, play a central role in the development of pathological anxiety. How the contradictory demands of the id and the superego are managed in early childhood development can also lead to pathological anxiety in problematic cases (Reich, 1933, 1989, p. 246ff.)
b) In his work on the schizophrenic character, Reich demonstrates how ego fragility has a profound effect on the defenses against anxiety, which are extremely weak and the person thus correspondingly anxious. There is a lack of adequate defense and compensation possibilities (Reich, 1933, 1989, p. 520ff.).
c) Early disorders, such as the schizoid, are an expression of deprivation, hurt, humiliation and lack of security in childhood – the child's fears of losing the primary object or of punishment are internalized in the character in the form of anxious behavior in relationships.

In the light of this, I will attempt to integrate these different theories and expand on them within a body psychotherapeutic approach.

Anxiety is mirrored on the physical, the muscular and the vegetative level. Breathing plays a central role in the perception or suppression of anxiety. Reich highlighted the diaphragmatic block as the main bottleneck in suppressing unwanted feelings, the release of which was for him the "gateway" to the feelings and to the unconscious. With the help of the breathing and the loosening or release of bodily, muscular and vegetative blockades, a new way opened up for Reich to the psyche and to mental illness that transcended the verbal level. Accordingly, pathological anxiety could be treated not only with words but also, or primarily, in a non-verbal way— through the body.

4) Further development through pre-, peri- and postnatal psychology and infant research

In 1942, Reich had begun to study the development of babies, particularly the earliest stages of infanthood. He noticed that at a few weeks old his son Peter was already afraid of falling. Reich thought this was the consequence of a disturbance in the interaction between Reich's wife and their son: Peter had an "oral orgasm" while breastfeeding and this had irritated his mother, who drew back a little from him emotionally. Reich encouraged his wife to accept the oral orgasm, and her contact with her son markedly improved. Reich himself did gentle falling exercises with him, which gradually alleviated the fear of falling (cf. Thielen, 2010, p.197). Reich had already realized that anxiety can develop in earliest childhood.

5) Findings of pre- and postnatal research on the genesis of anxiety

One of the most important pioneers of pre- and perinatal research is Stanislaw Grof (b. 1931). He worked first as a psychiatrist in the former Czechoslovakia and later in the United States. Trained in psychoanalysis and at a time when working therapeutically with LSD was still legal, he identified four matrices of the perinatal phase from several thousand therapy sessions using LSD. He recognized the perinatal phase as the source of extremely deeply anchored anxieties and panic states, which couldn't be resolved or alleviated through conventional psychotherapy. Grof's innovative ideas have in the meantime become common knowledge in psychodynamics and prenatal research. Ludwig Janus, for example, who sees himself in the tradition of psychoanalyst Otto Rank, writes, "…. Grof's description of the (perinatal) process is today generally accepted" (Janus, 2000, p.19). People whose experience is defined by the second basic perinatal matrix[2] are overwhelmed by increasing levels of anxiety and feel as if their lives are in danger. Generally, they can't explicitly recognize a reason for this and have a tendency to a paranoid interpretation of the world. As an additional complication in the second and third matrices the cord can be twisted around the neck of the fetus, causing fear of suffocating and dying. When these people hyperventilate in later life, this can bring up these fears again. Grof (1985) worked with many anxiety patients who had already tried psychoanalysis or another form of psychotherapy without having been able to alleviate the anxious symptoms, because biographical work alone is not enough. Only through working with the peri-and post-natal experiences were they able to find relief.

The origins of anxiety can be found even earlier than the perinatal phase. Prenatal researchers such as Emerson, Chamberlain and Renggli (cf. Harms, 2000) have studied the possibilities of disturbed interaction between the mother and the embryo or fetus from the beginning of conception. Prenatal psychology assumes that the fetus already has feelings before birth (Janus, 2000, p. 69). Therefore, anxiety, perhaps in a rudimentary form, may already exist in the womb. Anxiety would then be a discrete affect, which develops independently of sexual and aggressive impulses, unless the fetus already has these impulses. Anxiety seems to be a physiological process of excitation connected to displeasure. As Reich's example of the amoeba (Boadella, 1983) shows, displeasure is accompanied by contraction and pleasure by expansion. The anxiety of the fetus would then be accompanied by feelings of displeasure, by muscular contraction and a strong excitation.

The contribution of infant research to understanding the genesis of anxiety

There are numerous publications on the subject of the integration of infant research into body psychotherapy (e.g. Downing, 1996, 2006; Trautmann-Voigt/B. Voigt, 1996, 2002; Geissler, 1996, 1997, 2007, 2010; Petzold, 1994, 2003; Heisterkamp, 2002; Harms, 2000, 2008; Koemeda-Lutz, 2002; Diederichs/Jungclaussen, 2010; Thielen, 2002, 2006, 2008, 2010, 2013). I shall focus on the single aspect of how they have made a new contribution to the understanding of the genesis of anxiety.

Martin Dornes (1998) summarizes the findings of infant research on the development of anxiety in babies (Stern, 1992, et al.). There are natural conditions that cause fear in most species:

[2] The initiation of the birth process. The original equilibrium of intrauterine existence is disrupted by alarming chemical signals and then by muscle contractions. In regular intervals the fetus is tightly squeezed by spasms of the womb. The cervix is closed and the way to the outside is not yet evident (Grof, 1985).

being alone, darkness, sudden or unexpected sounds. Babies have predominantly realistic fears, which disappear when the triggering situation changes. "Long-term, chronic anxiety results from the link between this adaptive affective reaction and a chronic emotional predisposition with associations unrelated to the actual situation" (Dornes, 1998, p. 183).

Infant research shows that as the affect system develops earlier than the imagination, babies can't yet fantasize, so their fears are concrete. Imagined fears evolve out of a real sense of internal or external danger. Dornes differentiates between anxiety and fear, fear being the reaction to a perceived external threat and anxiety the reaction to a perceived internal danger (ibid, p.184). Fear usually appears at about the age of seven months, when the baby can actively move about. With this new skill, the infant can move away from the parents, which in turn puts his life in heightened danger.

The best-documented anxieties in infanthood are separation and stranger anxiety, both of which occur at about 7 to 8 months when the mother begins to leave the child alone for short periods. In psychoanalysis, these are often treated as one phenomenon, but Dornes finds this inappropriate: stranger anxiety occurs also when the mother is there, and not only in her absence as psychoanalysis claims. They are discrete processes that climax differently. According to Rene Spitz (ibid, p. 187), the infant can encounter strangers with a mixture of curiosity and caution and not necessarily with anxiety. At nine months babies turn to the mother for guidance in ambiguous situations or when conflicting emotions come up; the affect of the mother then determines the child's affect. This phenomenon is known as "social referencing" (cf. ibid, p. 189). In addition, there exists a biological or genetic disposition towards anxious excitability; there are babies who are easily comforted and those who are difficult to calm. A comparison of the findings of pre- and perinatal psychology with those of infant research throws up various contradictions. Prenatal psychotherapists see anxiety originating in the time before birth, whereas for baby research it begins around the age of seven months with stranger or separation anxiety. Separation anxiety is concerned with the fear of losing the beloved object: the mother or parents and the security, interaction and affect attunement they provide (Stern, 1992). If the caregivers misjudge a situation, this can intensify and reinforce the baby's anxious behavior and thus form the basis for neurotic and irrational fears.

Stern's model of RIGs (Representations of interactions that have been generalized) (Stern, 1992) offers an explanation of how the child can be infected by anxious primary caregivers. RIGs or generalized interaction experiences are stored by the infant in the preverbal phase. These RIGs encompass all the baby's senses. The body experience is extremely significant as the formation of these RIGs occurs in the child non-verbally. The baby stores, for example while breastfeeding, how the mother holds it, how she speaks, what she feels like, how she smells, how she looks, etc. and this process includes all the senses. The baby naturally absorbs the physical state of the mother as well. Cohn and Tronick (1993) and Gusella et al. (1988) studied the effect on the child when the mother suffers from depression. These studies have shown that the infant withdraws from the interaction and behaves in a depressive way itself (cf. Dornes, 1998, p.68). It seems reasonable to assume that babies react to anxious interactive behavior with the caregiver with an anxious reaction of their own, although as far as I know there is not yet any empirical evidence for this.

The body psychotherapist Downing (1996, 2006), who has pioneered the application of infant research to body psychotherapy, has developed the concept of micropractices, which is

compatible with Stern's concept of RIGs. Micropractices are the baby's bodily reaction and action forms in interaction with the caregiver.

> "For example: when an adult suddenly and unexpectedly invades its field of vision, the child recoils. This is a simple sequence of stimulus and response. One example of this would be when a child cocks its head and looks at the adult distrustfully from a certain angle. If it does this repeatedly then it is a bodily micropractice, which is variable and also purposeful. The micropractice is the child's bodily know-how (Downing, 2006, p. 335). It is accompanied by mental representations and has an emotional aspect, in this case the child's mistrust" (Thielen, 2010, p. 201-202).

Micropractices are special competencies, embodied skills. They comprise what is sometimes called procedural or implicit knowledge, a knowing "how" as opposed to a knowing "that".

When one of the parents has a chronically anxious style of interaction with the baby, which according to Stern (Stern, 1992, p. 212ff.) represents an emotional misattunement, this can lead to anxious micropractices in the child. From the idea of micropractices I have developed a physical exercise, which can enable the therapist to explore early emotional and bodily reactions to a misattunement with the patient. I have used this exercise in the case vignettes.

In summary it can be said that empirical infant research confirms and differentiates the development of anxiety in early childhood. Stern's concept of RIGs renders the internalization of affective misattunements, which include neurotic anxieties, understandable. Downing's micropractice concept shows how these misattunements become part of the body.

6) Humanistic psychotherapy and anxiety

Humanistic psychotherapy is in Germany the fourth basic orientation in psychotherapy next to psychodynamic, behavioral and systemic therapies (Kriz, 2005, p. 7ff). In Germany the German Association for Body Psychotherapy (DGK, German section of the EABP) is a member of the Project Group for Humanistic Psychotherapy (AGHPT). Because of its relational and process oriented character and to differentiate itself from the disorder oriented concepts of behaviorism, humanistic psychotherapy doesn't usually offer specific therapeutic approaches for anxiety. Rogers, the founder of Person Centered Psychology, understood anxiety as a person's feeling of threat to the structure of the self, which leads to a defensive reaction. Anxiety is a result of incongruence between the self-concept and the life experience of the person (Rogers, 1987, p. 30). For Rogers the self-actualizing tendency is essential for human growth. If this is hindered through real life situations then anxiety develops. At the root of panic attacks is the basic conflict between dependency and autonomy.

Eberwein, who has described the current spectrum of humanistic psychotherapy, its theories and techniques in his book *Humanistic Psychotherapy* (Eberwein, 2009) sees the greatest of the anxieties as the fear of fragmentation. It is the fear of the disintegration of the structure of the self, of the dissolution of identity. "When with the help of the therapist the client has gradually felt through the defense barriers and integrated repressed material, he then finds in the center of what was defended against, an inner dynamic, which is so threatening that he experiences it as unbearable. It is the almost indescribable experience of the loss of the self." (, p. 32-33).

When the ego or the self fragments, the person becomes psychotic, so the fear of fragmentation is similar to the fear, which Lowen described, of going mad. Particularly with clients who have a fragile ego or self this fear of fragmentation plays a central role and the main therapeutic line of action must be to strengthen, hold and contain the self. The varied experiences and concepts in trauma therapies, above all those that are body oriented such as Somatic Experiencing, have influenced body psychotherapy. Styles of work such as Bioenergetics, which focused on emotional expression, have changed enormously in the direction of a dialectical approach. For example, we can work with traumatized and developmentally wounded clients with fragile egos in a way that offers support and containment, which calms and grounds. With patients with stronger egos, who are more emotionally controlled, we can work in a more affective and emotionally stimulating way.

7) Anxiety as a whole-person experience

On this basis of the various concepts of psychotherapy, work with anxiety offers a rewarding challenge to try to integrate them all into a general holistic view, which maintains the significance of the physical, muscular and vegetative levels described in the preceding pages. Morschitzky (2009), who has written a comprehensive book on anxiety disorders, makes just this attempt to grasp anxiety as a whole-person experience. Although he comes from the behavioristic tradition and only marginally includes humanistic, especially body psychotherapeutic, concepts, in my opinion he brings together the various levels of the experience of anxiety, especially in the body, in a meaningful way:

- "Physical level: objectively measurable physiological factors such as muscle tension, tachycardia, constriction of the arteries, raised blood pressure, fast breathing, changes in the skin resistance level, altered brain waves, etc. Each anxiety reaction generates physical reactions and sensations.
- Subjective level (thoughts and feelings): dread, feelings of exposure and helplessness, anxiety-inducing thought patterns and consequent feelings, images of anxiety-inducing situations from the past or projections into the future and the misassessment of a situation as dangerous, triggering both physical reactions and behavior patterns.
- Behavior (motoric) level: observable reactions such as freezing with fright to the point of stupor, shivering or shaking, flight reaction and panicky movements, avoidance of anxiety-inducing situations and of eye contact." (p. 13)

Anxiety is a complex neurobiological event in which (not only) adrenaline is released, causing an increased heart rate. In danger situations ranging from a painful stimulus to the reactivation of an unconscious childhood trauma, the body reacts with the fight-or-flight response.[3] The potential for anxiety, as for other basic feelings, is genetically determined. The startle response, the fight-or-flight response and many other anxious reactions to key stimuli such as a sudden precipice or an unidentified danger are congenital (Morschitzky, 2009, p. 198). Anxiety, in the healthy sense, is a life sustaining reaction, signaling the presence of threat or danger and so prompting the individual to protect him or herself (cf. Butollo, 2000). For a therapy in which anxiety is the main focus to be successful the aforementioned three levels, despite their intermeshing, must be worked through according to their relative qualities.

[3] For further information on the neurobiological effects of anxiety please refer to the relevant literature (cf. Morschitzky, 2009)

8) Body-psychotherapeutic work with anxiety

When I perform a thorough case history and make a diagnosis and analysis of the basic biographical conflicts, I generally look at physical symptoms. If the ego, or better, self-strength of the patient allows, I first encourage her to explore the mental and physical anxiety symptoms. In the following case the patient suffered from panic attacks, which occurred when she was under pressure at work or involved in a private conflict. In addition, she suffered from agoraphobia and was afraid of traveling on the subway or on any train and of flying. She had been living with her boyfriend for a few years and as she was afraid of being alone in the evenings and above all of having to sleep alone, she was quite dependent on him. Apart from the anxiety she had a severe sleep disturbance and psychosomatic disorders such as problems with her digestive tract, psoriasis and joint pains. During the panic attacks, she hyperventilated, was afraid of fainting (which had happened once), and went through practically the whole range of typical symptoms such as: palpitations, perspiring heavily, shivering, breathlessness, a feeling of tightness in the chest, nausea, dizziness, shakiness, light-headedness and fear of losing control. The panic attacks were often triggered by contact with her mother, especially when there was a conflict between them.

As a child, she was very close to her mother. After her parents separated when she was 9 years old, the mother used her as a substitute partner. She treated the patient like a girlfriend, monopolized her and behaved towards her generally with no respect for boundaries at all, for example talking to her about her sexual preferences and problems. The mother herself suffered from anxiety and had passed it on to her daughter.

Shortly before the beginning of therapy there was a very difficult phase in the relationship: telephone calls or even just a text message from the mother could trigger a panic attack in the patient and she had thus practically broken off the contact for a couple of months. On the basis of a trusting and positive transference relationship, we worked on finding alternatives to her physical panic reactions. I explained to her that anxiety is expressed on the physical level in muscular contraction and tension. To reduce the tension, the overreaction, I suggested two exercises from the Reichian tradition and Bioenergetics. First, lying on her back on a mattress she stretched her legs up at a 90° angle with the knees extended as far as possible and the toes bent down towards the body. Her arms were also stretched up at 90° and the hands bent backwards as if supporting something. While she was in this position I had her breathe a little deeper and faster than usual into the belly and at the same time imagine a situation which would normally make her anxious. She was asked to hold this position, also known as "holding up the sky", as long as possible and then put the feet down and work the tension into the mattress with the arms and legs, turning the head at the same time (Reichian "running"). She "ran" very fast and became irritated and even angry at her mother. She was angry at having been instrumentalized as a substitute partner and felt used. She realized that she had always had to be considerate of her mother because she was ill, a pensioner suffering from anxiety, depression and psychosomatic illnesses. In the last few years the situation had worsened as she had been diagnosed with skin cancer and had even had a heart attack recently. Afraid that something might happen to her mother, the patient had for many years suppressed that anger she felt towards her; it had become a kind of murderous rage, which was gradually released in therapy. This suppressed and partially dissociated anger had turned auto-aggressively

against the patient herself in the form of panic attacks. These she experienced as her own fault, for which she blamed and reproached herself.

In the body psychotherapy work it became clear that, as with many other anxiety patients, her panic attacks were like an implosion, an attack of rage which has turned inwards. The task of therapy was therefore to co-operate with the patient in bringing them out towards an external object. Usually it concerns the primary caregivers, generally the parents. Body psychotherapy techniques and exercises are very useful in helping the patient to experience and to express the anger contained in the panic/anxiety.

For the patient in this case, expressing anger and rage was taboo in the socialization process she had been through, so in therapy she had to learn to identify and take possession of these feelings. Here, a whole range of body-oriented exercises, especially grounding from Bioenergetics, were helpful in making the connection between the muscular contraction, the pressure in the belly and the general uneasiness and feelings of irritability, anger and rage. It was especially effective if the exercise was constructed as follows: first a stress position to intensify the inner tension and make it more conscious, then a second step discharging it through physical and emotional expression. The patient discharged the pressure the anxiety produced through "running" or with a fit of anger, hitting and kicking on a mattress, or standing up and boxing or kicking against a foam rubber cube, or in the form of role playing directly against the mother or the father. She became increasingly aware that expressing anger, rage or even hate could be a viable alternative to a panic reaction.

In recent years, she had begun to build up a healthy and trusting relationship with her father, whom she would meet about once a week and with whom she also spoke intensively about her anxiety. When he had to undergo an operation for cancer she was worried about him, despite the fact that the prognosis was good. As a child, she had had a close and loving relationship to him, but after the parents separated, that deteriorated. She experienced him as volatile and even frightening. She also felt used by him as a substitute partner, with whom he sought comfort, support and physical contact. As an adolescent, the patient had almost no contact with him for several years and had the impression that he was hardly interested in her at all. She felt that he admired her attractive good looks, but that she didn't meet his standards intellectually and politically. On one occasion she spent a day with her boyfriend, her father and a friend of his out in the countryside, where she went for a walk with her father and his friend, who talked mainly between themselves about intellectual and political issues and she felt inadequate and left out. In the following evening she had a severe panic attack to the extent where the father almost phoned for an ambulance. As we worked though this situation in therapy we first re-enacted it and she began to feel the predominant physical panic symptoms. She realized that she was angry with her father and wanted to shake him or thump him on the chest and in the role-play she began to punch the foam rubber cube. She felt ignored and degraded by him and this made her angry, all of which was also connected to her childhood, especially as a teenager when she had felt disregarded and unappreciated. After working through this situation in body psychotherapy she was able to actually confront her father about it. In the process her father was able to understand her anger and disappointment and apologize for his behavior. He assured her that he acknowledged her intellectual abilities, although he would prefer to see her working in a different field. They

had further confrontations in which she even became spontaneously angry and was then for a short while afraid of losing him. Her father also showed his anger towards her and these irate confrontations were like a cleansing storm, after which their relationship improved considerably.

This case vignette illustrates clearly how the panic attacks originated in the experiences and contradictions of the patient's childhood. She couldn't solve the basic conflict between dependence and autonomy either in relation to her mother or to her father. The constructive aggression she needed in order to free herself from both parents, especially her mother, was blocked by fear of losing them. After the parents separated, she had felt particularly dependent on her mother with whom she lived, and felt blackmailed through her mental and physical illnesses to behave well. Out of fear of losing both the loved one and the love, she had to suppress or split off the rage about being emotionally blackmailed and used. She had directed the rage against herself auto-aggressively and this manifested physically in high excitation, palpitations, breathing difficulties and in anxiety and panic symptoms. As we succeeded with body psychotherapy in turning the aggression away from herself and towards the tormentors of her childhood, the panic attacks slowly diminished. With the aid of breathing techniques, especially deeper exhalation, she could overcome her phobias and learn gradually and at first anxiously to travel by subway and train and even by plane.

This example demonstrates the close connection between anxiety, panic and suppressed rage. It also shows that approaching the anxiety from a bodily perspective can offer an alternative to the anxious behavior. The physical symptoms, muscular contraction and vegetative pressure also hold the beginnings of recovery, namely muscular expansion and vegetative balance. The origins of the anxiety must be dealt with biographically and object-relatedly in and through the therapeutic relationship. The patient had a middle to weak structure and therefore fragmentation fears and the holding and containing work with biodynamic massage, which I usually integrate into my work, had an important place in the early phase of therapy (cf. Thielen, 2008, p. 251). We worked through the three levels described by Morschitzky (see above) and on the bodily level the patient learned to interpret the extremely high excitation and the strong internal pressure as somatic markers (Damasio, 1996) at first for anxiety and later for aggression. By turning the aggression towards the outside against the object, which had originally been the cause of the anxiety, she could transform it into aggression. On the subjective level she could recognize emotionally as well as cognitively that her anxiety was a function of the hitherto unresolved conflicts with her parents. By working through it she could transform the panic reaction into the ability to face up to conflict in an adult way. There were also changes on the behavioral level, the panic reactions slowly abated and then eventually disappeared and she could convert her previous avoidance strategy into a constructive, solution or compromise-oriented approach.

In a different case example the anxiety and panic problems were rooted in the patient's very early childhood, reaching as far back as birth. I have described this case in detail elsewhere (Thielen, 2010); in the context of this article I would like to concentrate on one aspect. The patient was in his early thirties and suffered from panic attacks mainly when alone at night or in conflict situations in which he had to assert himself. He also suffered from fear of flying and psychosomatic symptoms such as herpes zoster. During these feelings of panic,

he experienced a strong physiological excitation, muscular tension, breathing difficulties and obsessive thoughts.

In the initial phase of his therapy I used an exercise based on micropractices in order to reactivate memories from early childhood in relation to his parents, in this case to his mother, from procedural memory. Using specific breathing techniques and suggestions I guided him into contact with his first year of life. Then he was to imagine that my hand symbolized the hand of his mother and to react physically to it. I let my hand move slowly towards him vertically from about a meter away until it was touching his left forearm. He reacted at first anxiously and then aversively, pulling his arm away and breaking contact. As we spoke about it afterwards he said, that as "her hand" came nearer, he had felt manipulated, dominated and in part humiliated by his mother. In the next step I proposed that he express his aversion more offensively. He then had the impulse to push away my hand, which was the symbolical hand of his mother. As he did this against my resistance, he felt irritated at first and then became angry. He expressed this feeling towards the mother-object and then felt relieved. He was surprised about what he experienced in this exercise and astonished at how authentic it was. He could well imagine that this experience realistically mirrored his early relationship to his mother. We then began to reconstruct the roots of his feelings of panic and he himself had the idea that they could be connected to the pregnancy and to his pre-, peri- and postnatal experiences. This association was substantiated through joint sessions with his father's therapist and with his parents, which had taken place before we started therapy.

Again with the help of specific breathing techniques and visualizations, he could sense emotionally and associatively being in the womb and being born. During the imaginative birth process his fear of the dark and of getting stuck surfaced so strongly that we re-enacted the struggle with the help of an artificial birth canal. He had a great fear of not getting through and was extremely relieved when he managed it in therapy and the constriction in his chest area dissolved. Fragments from his implicit memory began to emerge and he realized the birth had been under anesthetic and that he was separated from his mother for some days afterwards. When he asked her about this she told him facts about the birth that he had in part already experienced in therapy. After birth he couldn't breathe of his own accord and had to be put on a ventilator under strict medical supervision for several days. This very early separation from his mother was related to the feelings of panic. These feelings were activated later through misattunements in which he didn't feel physically secure enough or emotionally accepted. His mother was anxious, insecure and emotionally unable to cope and sometimes touched him too roughly and he in turn felt rejected. His crying was an expression of a misattunement with the mother but she didn't react adequately to it; rather according to the principles of an authoritarian upbringing, he was often left to cry which further intensified his panic feelings. He developed the basic feeling of not being good enough, of not living up to her expectations. As a child later on all this was reinforced when he was often sent to his room alone as a punishment. The mother reacted by breaking off contact, which only strengthened his feelings of insecurity and panic. Between the two of them there was an insecure/ambivalent attachment; this manifested in his fear of her, in which he experienced her as volatile, moody and erratic. He felt that she punished him by withdrawing affection and by imprisoning him and in that, his negative feelings were judged evil and had to be suppressed.

This extract of a case history demonstrates that feelings of anxiety and panic can have their roots in pregnancy and in the birth phase. Therefore, effective psychotherapy has to go back to this time and with the help of non-verbal, body-oriented methods process the traumata, injuries and deprivations with emotionally corrective experiences and with nurturing, so that the anxiety and panic which emerges on the way can be overcome or, in the case of real fear, integrated (cf. Butollo, 2000).

Anxiety is not just a symptom or a disorder, but an energy, a danger signal which protects us and also an opportunity for growth, because the way forward lies directly through the fear. If we accept the challenge despite being afraid, we can transform the fear into courage.

BIOGRAPHY

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Somatic Psychotherapy And The Ambiguous Face Of Research[i]

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Abstract

The relationship between somatic psychotherapy, science, and research are explored, especially as they relate to Hakomi Therapy as one modality within the body-inclusive therapeutic community. It outlines how a training institute, as a provider of psycho-somatic therapy trainings, functions as both a consumer and generator of research. Issues explored include how somatic therapists have pioneered aspects of psychotherapy in advance of corroborating research findings; how findings are engaged critically in light of clinical experience; and how findings beyond psychotherapy in cognate fields such as neuroscience, developmental studies, multicultural, and spiritual arenas are necessarily integrated into an adequate research agenda. "Science" in this context refers to principles from the sciences of complex adaptive systems (CAS) and the philosophy of science of what it means to be human. "Research" refers to experimental methods for confirming or questioning scientific/clinical assertions

Keywords: psychotherapy research, somatic psychotherapy, Hakomi Therapy, AQAL Integral Theory

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Introduction

Somatic psychotherapy today encounters issues of widespread applicability due to the current emphasis on evidence-based practice and research. Some practitioners and some agencies simply will not consider using or training in body-inclusive methods unless "you show me the research." And by research they mean double-blind studies such as those used with pharmaceuticals. In this article a number of research issues are referenced and woven into a position that questions the unquestionable authority of facile remarks about research that serve to denigrate somatic psychotherapy methodologies. This denigration is hurtful not only to the somatic field, but also to those who could benefit from it. For instance, the author's personal experience with the Veteran's Administration in the United States revealed that it has not yet incorporated the crucial somatic elements of working with trauma that have been pioneered by Van der Kolk (1994, 2003), Ogden (Ogden, Minton, & Pain, 2006), Rothschild (2000), and others. Deeming these methods not yet empirically validated is a serious detriment for veterans experiencing PTSD who often feel forced to seek effective help outside the VA system, which means paying out of pocket for services. Offering a hopefully more nuanced account of research issues does not mean to call into question the overall

importance of research in the somatic field or the field's willingness to engage in research projects when the necessary conditions are present.

While this article addresses somatic psychotherapy, science, and research in general, I am most familiar with Hakomi Therapy, and therefore use it as a particular example of a body-inclusive modality. Hakomi has integrated much from gestalt, psychomotor movement, bioenergetics, focusing, psychodrama, and more, plus more recent integrations from internal family systems, accelerated experiential dynamic psychotherapy, recent attachment theory, interpersonal neurobiology, and more. Parallel thinking and articles might be done, focusing on many other modalities.

Science and Research

Historical Discontent

Hakomi, along with many other somatic modalities, was born in the 1970s in a period of relative discontent and dissatisfaction with the psychological theory and research of the time (Johanson, 2012). The efficacy of psychotherapy was still debatable. Ron Kurtz, the founder of Hakomi Therapy, generated excitement in those who gathered around him in the 1970s by approaching psychotherapy through theories and methods other than those used by the standard, well-known schools of psychology. Rather, he evaluated and incorporated various therapeutic modalities and sub-processes through the lens of his background in the sciences of complexity and non-linear organic systems, as these informed what it meant to be human. Thus, those involved with Hakomi have had a long-standing, continuous interest in science and the philosophy of science, broadly conceived (Johanson, 2009b, 2009c).

This unique background foundation in non-linear systems has served the Hakomi Institute well in its primary functioning as a training institute as opposed to a research institute. Hakomi of Europe, headquartered in Germany, led the way in getting Hakomi approved as a scientifically validated modality within the European Association for Psychotherapy in the European Union. As such, the Hakomi Institute is an approved psychotherapy-training provider in the European Union. Credits in doctoral programs for studying Hakomi have been obtained through a number of educational institutions worldwide. Likewise, the Hakomi curriculum was approved as an official national training for psychotherapists in New Zealand through the Eastern Institute of Technology in Napier. Subsequently, chapters on Hakomi Therapy have been included in standard textbooks on theories of counseling and psychotherapy (Roy, 2007), as well as investigated in various theses and dissertations (Benz, 1981; Kaplan, 2005; Myllerup, 2000, Rosen, 1983; Schanzer, 1990; Smith, 1996), and other books (Caldwell, 1997; Johanson & Taylor, 1988; Staunton, 2002), and articles.

Critical Consumers of Research: The Standard of a Respectable Minority

Research in general is a broad topic with numerous aspects. Somatic psychotherapy modalities that sponsor training institutes are consumers of research that have striven for an engaged and constructive, yet critical, relationship with psychotherapeutic and other research that remains in tension with its clinical experience. As an example, Hakomi faculty and practitioners have not been willing to wait for positivistic scientific approval of what seemed clearly therapeutically helpful, though they do track a wide range of scientific studies for confirmation or disconfirmation as they arise. For instance, Kurtz realized in the early 1970s the potency of mindfulness in helping clients become aware of and transform the way they organized their experiences, something central to depth-psychotherapies (Shedler, 2010, p. 100; Stolorow, Brandchaft, & Atwood, 1987). The effectiveness of this discovery has been explored and deepened ever since. Most other therapists who were interested in the mindfulness-therapy interface would not allow themselves to speak of it in professional settings until the early 1990s (Siegel, R., 2010). Kabat-Zinn began publishing about the use of mindfulness for working with pain in the mid-1980s (Kabat-Zinn, Lipworth, & Burney, 1985). Linehan (1993) published on the use of mindfulness in treating borderline personality disorders in the early 1990s. Varela et al. (1991) used mindfulness to begin moving cognitive science into the realm of embodied neurophenomenology (Colombetti, 2013; Thompson, 2007). Today, there is an ever-growing wealth of studies related to mindfulness and psychotherapy (Johanson, 2006a, 2009a). There is now much emerging knowledge from interpersonal neurobiology about the underlying mechanisms of mindfulness (Hanson, 2009; Siegel, D., 2007, 2010; Simpkins & Simpkins, 2010). Pesso (1973) notes that somatic psychotherapy, especially psychomotor, has always had an element of mindfulness. The example of mindfulness illustrates that experimental psychotherapy research does not generally produce new knowledge so much as evaluate hypotheses generated in clinical practice (Gendlin, 1986; Goldfried, 2009). It is also an example of when the somatic community and Hakomi have maintained "the standard of a respectable minority . . . out of concern that the standard of common practice was insensitive to emerging but not yet popular treatments", a standard that "recognized that the healthcare fields do not always have a consensual view of what is effective" (Beutler, 2009, p. 308).

The Personhood of the Therapist

This stance of a respectable minority has also played out in the caution of the somatic psychology field toward the supposed gold standard of randomized clinical trials (RCTs), which separate "the person of the therapist from the acts of psychotherapy" (Beutler, 2009, p. 311). Somatic psychotherapy trainings routinely balance concentration on the being or personhood of the therapist with the doing aspects of method and technique, as it has always been obvious to training faculty and supervisors that it is the characterological limitations of therapists that restrict their effectiveness in utilizing the processes being taught. This position is congruent with much research that has built on the investigation of common factors and underlined the importance of the therapeutic relationship (Ablon & Jones, 2002; Beutler, et al., 2003; Beutler et al., 2004; Castonguay & Beutler, 2006; Duncan & Miller, 2000; Horvath & Bedi, 2002; Horvath & Symonds, 1991; Mahoney, 1991; Norcross, 2002, 2005; Orlinsky, Ronnestad, & Willutzki, 2004; Safran & Muran, 2000; Sexton & Whiston, 1991; Shedler, 2010; Tombs, 2001; Vocisano et al., 2004; Wampold, 2001; Whiston & Coker, 2000).

Factors that Comprise Psychotherapy

Along this line, somatic psychotherapy that deals with characterological change agrees with those who argue the need to "revise our definition of 'research-informed psychotherapy practice' (RIP) so that it addresses those factors that actually comprise psychotherapy" (Beutler, 2009, p. 302). For instance, the Hakomi unity principle agrees that variables relating to "therapist and patient personalities, interpersonal values, therapist and patient gender, social skills, and attachment levels and the like [that] are not always capable of being randomly assigned" must not be ruled out in RCTs (Beutler, 2009, p. 310). The same applies to cross-cultural issues (Johanson, 1992; Paniagua & Yamada, 2013). And, as Gendlin (1986) has pointed out, it is better not to isolate chemical from psychological from social factors, but to

control for all three and test them together. "They are already always together. . . . Everyone thinks, feels, dreams and imagines; has a body; has a family; acts in situations; and interacts with others" (Gendlin, 1986, p. 135). Likewise, "the practice of therapy often involves more complex clinical cases" with numerous co-morbid conditions than are dealt with in much of academic research (Goldfried, 2009, p. 26). Though the DSM is purposefully a-theoretical, somatic psychotherapy, along with others (Blatt & Zuroff, 2005), continues to see the connections in character issues related to Axis II that affect many Axis I conditions, and thus, the value of teaching characterology, though in a non-pathologizing way.

Beyond Acute Symptom Alleviation

As psychodynamic depth-psychotherapies, it is significant to somatic psychotherapy practitioners that "researchers . . . have yet to conduct compelling outcome studies that assess changes in inner capacities and resources" (Shedler, 2010, p. 105), because

> the goals of psychodynamic therapy include, but extend beyond, alleviation of acute symptoms. Psychological health is not merely the absence of symptoms; it is the positive presence of inner capacities and resources that allow people to live life with a greater sense of freedom and possibility. Symptom-oriented outcome measures commonly used in outcome studies . . . do not attempt to assess such inner capacities (Shedler, 2010, p. 105).

The development of such tools as the Shedler-Westen Assessment Procedure (SWAP) (Shedler & Westen, 2007) that assesses "inner capacities and resources that psychotherapy may develop" (Shedler, 2010, p. 105) in support of healthy functioning, is important to Hakomi. A main goal of the method is to mobilize clients' capacities to employ mindful or compassionate awareness (Eisman, 2006) with aspects of themselves that might be evoked throughout a lifetime, beyond formal therapy. This kind of research could help confirm that it is intra-psychic changes in the organization of a client's experience, a central concern of Hakomi (Johanson, 2006a), that "account for long-term treatment benefits" (Shedler, 2010, p. 103). A change mediated through the neuroplasticity of the brain alters the flow of energy and information and "activates neuronal firing that is integrative and produces the conditions to promote the growth of integrative fibers in the nervous system" (Siegel, 2009, p. 166), the physiological mechanism of effective psychotherapy.

Clinician/Researcher Interface

Many people in the broader field of psychotherapy are aware of the "long standing strain in the alliance between clinicians and researchers" (Goldfried, 2009, p. 25). For one, evidence-based treatments don't work as well in actual practice settings as they do in the lab partly because perfectly and narrowly diagnosed clients do not walk through the treatment door. Furthermore, it does matter who uses a treatment protocol and in what way. Others note ". . . the chasm that exists between science and practice . . . [along with] how weak the evidence is for certain widely held beliefs about the nature of empirically supported treatments (ESTs)" (Beutler, 2009, p. 301; Goldfried, 2009, p. 26). For instance, it is not true that "psychotherapy would be more effective if everyone practiced an 'empirically supported treatment' . . . [or that] cognitive and cognitive-behavioral therapies are more effective than relational and insight-oriented forms of psychotherapy" (Beutler, 2009, p. 303) (cf. also Duncan & Miller, 2006; Elkin et al., 1989; Kazdin, 2008; Schulte et al., 1992; Shedler, 2010; Wampold, 2001; Wampold et al., 1997).

Likewise, it is now clear that "most manual-driven therapies are equivalently effective

and not substantially different from most rationally derived therapies" (Beutler, 2009, p. 310). Actually, the effects of cognitive behavioral interventions tend to fade and require relapse prevention strategies (de Maat et al., 2006; Gloaguen et al.,1998; Westin, Novotmy, & Thompson-Brenner, 2004).

Though it is not yet common knowledge in all academic or therapeutic quarters, empirical evidence plainly supports the efficacy of psychodynamic therapy, a characteristic of Hakomi, Bioenergetics (Lowen, 1975), Core Energetics (Pierrakos, 1987), and other somatic approaches to characterological transformation (Ablon & Jones, 1998; Bateman & Fonagy, 2008; Blatt & Auerbach, 2003; Bucci, 2001; Clarkin, Levy, Lenzenweger, & Kernberg, 2007; Fonagy et al., 2002; Jones & Pulos, 1993; Leichsenring, 2005; Leichsenrign & Leibing, 2003; Leichsenrign & Rabung, 2008; Leichsenrign, Rabung, & Leibing, 2004; Milrod et al., 2007; Shedler, 2010; Szecsoedy, 2008; Westen, 1998).

Norcross, Beutler, & Levant (2005) note other unexamined assumptions and limitations of research. There is certainly a social construction aspect to validity studies (Kvale, 1995). Linford & Arden (2009) have called into question what they term the Pax Medica of the current three-part standard of therapeutic practice that is comprised of strict DSM categories, evidence-based treatments (Blatt & Zuroff, 2005; Duncan & Miller, 2006; Elkin et al., 1989; Kazdin, 2008), and the use of antidepressants (Greenberg, 2010; Kirsch, 2010; Meyer et al., 2001; Turner et al., 2008; Wakefield & Horwitz, 2007).

A Complimentary Model

Based on its defining principles (Johanson, 2009b; Kurtz, 1990), Hakomi practitioners recognize the interrelatedness of all things and generally think that psychological science would do well to conceptualize research subjects with a metaphor, something like the rhizome suggested by Delueze and Guattari (1987): "A rhizome has no beginning or end; it is always in the middle between things, interbeing" (p. 25). It embodies an "acentered multiplicity" (p. 17) that is multiply derived or over-determined, which displays nonlinear emergent properties. Thus, there can be "no dictatorial conception of the unconscious" (p. 17). While hardly anyone will disagree that a human being is a non-linear system with the possibility of emergent properties that defy easy determinisms, almost all psychotherapy research defaults to a linear setting (Johanson, 2009b, 2009c; Marks-Tarlow, 2011; Thelen & Smith, 2002), which thus imposes constraints and limitations that tend to throw away unexpected results.

The rhizome metaphor would lend itself to adopting Kurtz's preference for working with Popper and Eccles' (1981) conception of unconscious behavioral determinants as "dispositions." We are not absolutely determined, but rather disposed in various directions by many factors such as genes, biochemistry, interpersonal relationships, cultural, and social forces. Since everything is interconnected, each variable will produce a disposition in relation to the others so no one item can remain independent. This understanding fosters a healthy degree of humility in psychological research that allows for a pluralistic conception of psychology and a number of types of investigation, which contemporary theorists also call for (Held, Richardson, Slife, & Teo, 2010; Teo, 2009).

A Model Embracing Awareness and Complexity

Certainly, according to postmodern principles, there is no question that all psychological research and methodologies reflect underlying philosophies and values (Bishop, 2007; Johanson, 1979-80; Polkinghorne, 1983; Spackman & Williams, 2001) of which one should be as conscious and explicit as possible (Romanyshyn, 2007, 2010). For instance, the pre-

WWII period valued the importance of the Freudian differentiated autonomous self as opposed to the self-in-relation concept of post-war feminist therapists (Gilligan, 1982; Jordan, et al., 1991). Likewise, Ahammed and Cherian, (2013) and others criticize Western psychological research for not being in relation to expanded states of consciousness commonly valued in the East. Sundararajan, Misra, and Marsella (2013) contrast the Western grand atomic self that considers mental diseases as entities considering culture only an add-on to the self, with multicultural views of a relational or contextual self that affirms "all mental disorders are culture-bound disorders since no disorder can escape cultural encoding, shaping, and presentation" (p.75).

> Translated into research methodology, the [Western] particle/atomic perspective favors a descriptive model that generates numerous objective lists in psychology--behaviors, personality traits, social cognitions, and so on. By contrast the [Multicultural] wave perspective favors the holistic, explanatory models that capitalize on hermeneutics--interpretations and narratives of emergent phenomena such as meaning and subjective experiences (p. 74).

An Integral Model

Hakomi's unity principle, for example, fits most closely with Wilber's (1995, 2000, 2006) AQAL (all quadrants, all levels, all lines) Integral Model of human functioning. Here, the quadrants are derived from acknowledging both the individual and communal aspects of being human, combined with both the objective-outer-monological and the subjective-inner-dialogical aspects. The resultant quadrants represent the inner aspects of individual consciousness and cultural values as well as the outer aspects of social structures and individual behavior and biochemistry, in a non-reductionistic mutual interplay where each quadrant has a science, methodology, and validity appropriate to its field. A danger of research from this integral perspective is of over-emphasizing variables from one quadrant while ignoring those from the others, constricting the contextual field and relevance of the research.

This integral, holonic (Koestler, 1967) conception of humanity certainly makes room for the use of qualitative research stemming from phenomenological, existential, hermeneutical perspectives (DeAngelis, 2010; Giorgi & Giorgi, 2003; Halling, & Nill, 1995; Michell, 2003; Moustakas, 1990; Packer & Addison, 1989; Wertz, 2005; Wiggins, 2009). It honors and requires quantitative studies as well. It celebrates developments in neurobiology that demonstrate that mind (inner aspect) and brain (outer aspect) inform each other (Kandal, 2007; Porges, 2011; Schacter, 1992, 1996; Siegel, 1999, 2006, 2007).

The somatic psychotherapy community generally supports the use of mixed methods research, which in its combination offers the broadest view of a subject (Creswell & Plano Clark, 2007). Wiggins (2011) writes, however, that there still exists a dilemma in the use of mixed methods in that every use of the mix tends to come from an underlying positivist or interpretivist worldview that evaluates or subsumes the methods in accord with its privileged viewpoint. Mruk (2010) offers a research approach to an integrated description that carefully conserves overall holistic humanistic concerns and principles, but incorporates traditional positivistic values related to validity, prediction, measurement, control, and real world utility. The APA Presidential Task Force on Evidence-Based Practice (2006), on the other hand, wanted to endorse "the evidentiary value of a diversity of research methods" (Wiggins, 2011, p. 55). However, in an unacknowledged way, "as Wendt and Slife (2007) observed, the task force proposal places qualitative methods on the bottom of a hierarchy of research methods, ranked according to their rigor and value within a positivistic worldview" (Wiggins, 2011, p. 55).

The research paradigm wars (Gage, 1989), and dilemmas (Wiggins, 2011) can be transcended by the adoption of Wilber's AQAL model, which not only honors but also invites the "otherness" of methods appropriate to each quadrant. A framework that accounts for, welcomes, and utilizes the most research from the most places is more inclusive than one that does so to a lesser degree. It is not an arbitrary power move to say this, any more than it is to assert that a molecule has a more inclusive embrace than an atom, or that this paragraph has more significance than a single letter, though atoms and letters are more foundational as building blocks (Ingersoll & Zeitler, 2010; Wilber, 1995). Those espousing the AQAL framework would, however, criticize approaches with a limited viewpoint and methodology such as that of Baker, McFall, and Shoham (2010), who are seen as imperialistic or reductionistic in making their partial perspective more than what it is.

Encouraging Developments

With all the above cautions noted, the overall thrust of psychotherapy research in the last thirty years, in conjunction with that of cognate disciplines such as interpersonal neurobiology, trauma, and developmental studies, has been quite substantial and encouraging. It is an exciting time in psychology and psychotherapy. Research now confirms that psychotherapy is actually effective (Seligman, 1995). The Dodo Bird conclusion from comparing therapies that "all have won and everyone must have prizes" has likewise induced some helpful humility in the field, motivating schools to learn from each other, including the delineation of common factors (Bateman & Fonagy, 2008; Beutler et al., 2003; Bohart, 2000; Bucci, 2001; Castonguay, 1993; Frank, 1986; Lambert & Ogles, 2004; Lipsey & Wilson, 1993; Luborsky, Singer, & Luborsky, 1975; Mahoney, 1991; Orlinsky, Ronnestad, & Willutzki, 2004; Sexton & Whiston, 1991; Smith & Glass, 1977; Smith, Glass, & Miller, 1980; Stevens, Hynan, & Allen, 2000; Stiles, Shapiro, & Elliot, 1986; VandenBos & Pino, 1980; Wampold et al., 2002; Wampold et al., 1997).

Cautions

At the same time, Lilienfeld (2007), and Cummings and Donohue (2008) have noted the problems of simply following charismatic leaders in the field who circumvent honest dialogue with the research tradition, as some in the somatic community have. As Neukrug argues, though it is necessarily true that "all research is biased . . . that does not mean that research is not important" (2007, p. 384). And, all research that results in actual data is good, even though the theory that drove the experiment might not hold up (Johanson, 1988). The postmodern quest to know everything contextually in relation to everything else remains, and requires that we honor all the pieces of the puzzle available to us (Wilber, 1995).

Levels of Experiencing and More

One of the common factors of therapeutic effectiveness delineated by Castonguay et al., (1996) relates to levels of experiencing. Of the seven levels the study explores, somatic modalities operate routinely and preferably at the highest levels of gaining "awareness of previously implicit feelings and meanings . . . [and] an ongoing process of in-depth self-understanding" (p. 499). It has been gratifying that many stock and trade elements of somatic psychotherapies from their post-1960s beginnings have found mainline psychological support through ongoing research. For instance, Hayes (2004) notes that the cognitive-behavioral therapy tradition

> . . . has maintained its core commitments to science, theory, and good practice. In

> the last 10 years, a set of new behavior therapies has emerged that emphasizes issues that were traditionally less emphasized or even off limits for behavioral and cognitive therapists, including mindfulness, acceptance, the therapeutic relationship, values, spirituality, meditation, focusing on the present moment, emotional deepening, and similar topics. (Hayes, Follette, & Linehan, 2004, p. xiii)

Compassion and the Positive

Another gratifying development in psychodynamic work, through the influence of attachment, developmental, and psychotherapy efficacy studies, is research supporting the use of compassion and positive affects in therapy (Baumeister & Leary, 1995; Beebe & Lachmann, 2002; Bridges, 2006, Davidson & Harrington, 2002; Decety & Jackson, 2004; Fehr, Sprecher, & Underwood, 2009; Fosha, 2000, 2004, 2009c; Fredrickson, 2001; Fredrickson & Losada, 2005; Germer, 2009; Gilbert, 2005, 2010; Greenberg & Paivio, 1997; Greenberg, Riche, & Elliott, 1993; Ji-Woong et al., 2009; Johnson, 2009; Keltner & Haidt, 1999; Laithwaite et al., 2009; Lamagna & Gleiser, 2007; Lewis, Amini, & Lannon, 2000; Panksepp, 2001; Paivio & Laurent, 2001; Prenn, 2009; Schore, 2001; Shiota et al., 2004; Trevarthen, 2001; Tronick, 1998; Tugade & Frederickson, 2004). This is something Kurtz (1990) affirmed from the beginning, though he knew it was not the mainline model of "professional demeanor" (Kurtz, 2008, p. 15) at the time. He was often heard in trainings to say, "Find something in the client you love."

An Impulse Toward Growth

Something occurs in therapy that seems beyond the control of therapist and/or client. Growth can happen in the face of ignorance, stumbling, and fumbling by therapist and client alike. Growth may not happen despite the most highly trained clinician employing the most state of the art techniques. Peck (1978) was so impressed that growth happens at all — in the face of so many obstacles working against it — that he posited some spiritual force called grace to account for it in his best seller The Road Less Traveled. In Hakomi, Kurtz (1990) often referred to the concept of "negentropy" as expounded by Bateson (1979), Prigogine and Stengers (1984), and Wilber (1995), the notion that there is a force in life that moves to build wholes out of parts, as well as the more well-known second law of thermodynamics that posits the opposite. By any name ("transformance" for Fosha, 2000; "the life-forward direction" for Gendlin, 1996), there is an organic impulse to heal, which can be experienced phenomenologically, and that moves toward increased complexity and wholeness. Somatic therapists (Caldwell, 1996) always count on this organic impulse, which has received increasing research support in recent years (Eigen, 1996; Emde, 1988; Fosha, 2006, 2008, 2009a, b; Ghent, 1999, 2002).

Larger Self-States

There are also core aspects of mindfulness or consciousness — inclusive of passive awareness and active compassion — that somatic therapists working with awareness assume are essentially present in all clients. These potentials are there regardless of the person's object-relations history as it shows up on the ego level of past conditioning. Some refer to these essential qualities as comprising the Self, core self, heart self, ontological self, and so on. The concept of a larger self, new to Western psychology (Ahammed & Cherian, 2013; Schmidt, 1994), has likewise received research support since the 1970s (Almaas, 1988; Fosha, 2005; Kershaw & Wade, 2011; Mones & Schwartz, 2007; Panksepp & Northoff, 2008; Russell & Fosha, 2008; Schwartz, 1995). Within the Hakomi community, Eisman (2006) has led the way by developing a healing approach called the re-creation of the self (RCS) that centers on resourcing clients as fast as possible in the non-egocentric trans-historical aspects of this larger self state.

Resourcing

The emphasis on resourcing through larger self-states is congruent with the more general emphasis on resourcing in somatic modalities by helping clients be in touch with their strengths, bodily energies, hopes, positive images, memories, and so forth (Caldwell, 1996). Much recent research supports this emphasis (Gassman & Grawe, 2006). For trauma therapists who work with lower brain activation, multiple forms of resourcing are absolutely necessary (Ogden, Minton, & Pain, 2006). Somatic psychotherapies generally begin with fostering qualities of safety, curiosity, and present moment experiencing, which is a way of resourcing clients to successfully explore inner material (Fogel, 2009). Humor — with which Kurtz was so brilliant — can provide a hypnotic affirmation of faith communicating to clients that they have what it takes to deal with whatever is afflicting them (Sultanoff, 2013). Working through barriers to transformation and the introjection of positive "missing experiences" is a way of both unburdening hurtful experiences and expanding a client's toleration of positive experiences (Robbins, 2008). Encouraging clients to move toward the future with hope by integrating more positive experiences into their lives while dealing mindfully with whatever barriers arise stimulates the immune system and a more grateful, energized way of meeting life (Johanson, 2010; LeShan, 1989).

Appropriate Trainees

Although most somatic trainings are marketed primarily to licensed mental health professionals as continuing education opportunities, the central importance of relationship, self-qualities, compassion, and awareness to the practice of psychotherapy has led many faculties to also accept others into the trainings who are assessed as able to benefit from the teaching. An array of body workers, naturopaths, lawyers, teachers, artists, nurses, medical doctors, and others have taken trainings, either to learn methods they can incorporate into their work, or as a way of tasting the field of psychotherapy before committing to various graduate programs. Setting aside the legal questions that are different in various countries, is it ethical to train people in therapeutic techniques who are not licensed? What does the research have to say about this?

As it turns out, research into commonly held assumptions about what makes better psychotherapists, enshrined in requirements for licensure and membership in clinical associations, are not faring well in recent research. Surely, getting advanced degrees and licensure enhances our effectiveness. No, not really. Nyman, Nafzier, & Smith (2010) established that there was no discernible difference in outcome if the therapy was done by a licensed doctoral level psychologist, a pre-doctoral intern, or a practicum student. How about professional training, discipline, and experience? They certainly sound logical, but no, they don't hold up either (Beutler, et. al., 2004). Using the right method or the latest evidence-based treatment should help. While we continually keep trying to find the key, any single one has yet to be found, though many seem to work in their own way (Duncan, Wampold, & Hubble, 2010). Plus, no studies support increased effectiveness through continuing education, which may seem disappointing and hard to believe. What about therapists working on themselves as their own best instrument in therapy? There are wonderful subjective benefits reported

here, but they do not show up in terms of affecting effectiveness (Geller, Norcross, & Orlinksky, 2005). The upshot of this research does not support the necessity of state licensure boards so much as it does registries of psychotherapists that list training and ethical allegiances, and then respect a client's ability to search and find practitioners who provide the help they are seeking.

Collaboration

One bright spot in efficacy outcome studies is that soliciting and responding appropriately to client feedback does improve the outcome for the client and the development of the therapist (Anker, Duncan, & Sparks, 2009; Duncan, 2010; Duncan, Solovey, & Rusk, 1992). This research finding is fully congruent with training in numerous somatic methods. The organicity principle in Hakomi states that when all the parts are connected within the whole, the system is self-organizing, self-directing, and self-correcting. This translates into therapists tracking and contacting a client's felt present experience in such a way that the therapist helps the person safely mine the wisdom of his or her own experience in a continuously collaborative way. This fine-tuned collaboration in turn provides a profound safeguard against either licensed or un-licensed trainees unwittingly committing forms of violence on the client and/or inducing appropriate resistance. Other aspects of somatic psychology trainings could be elucidated that fit with research findings on how psychotherapists develop and grow (Orlinsky & Roennestad, 2005).

More Encouraging Developments

In contrast to the state of psychology in the 1960s, there is now serious and sustained research dedicated to cross cultural and social issues (Augsburger, 1986; Foster, Moskowitz, & Javier, 1996; Helms & Cook, 1999; Keita & Hurrell, 1994; Marsella, 1998; Marsella, 2009; Marsella et al., 1994; Marsella et al., 2008; McGoldrick, Giordano, & Pearce, 1996; Nadar, Dubrow, & Stamm, 1999; Paniagua & Yamada, 2013; Pinderhughes, 1989; Ponterotto et al., 2010; Sue & Sue, 2010; Vasquez, 2012; Wessells, 1999).

Likewise, numerous somatic schools have often been open to the spiritual dimension of clients as an important aspect of their being (despite not representing themselves as spiritual paths as such). This significant facet of many clients' lives (Eisner, 2009; Johanson, 1999; Mayo, 2009; Sperry, 2010; Torrance, 1994), routinely ignored or pathologized in the twentieth century (LeShan, 1990), is now being researched by such journals as the American Psychological Association's Division 36 *Psychology of Religion and Spirituality* and the *Journal of Spirituality in Mental Health* from Routledge Press, textbooks such as Miller (2003), numerous APA titles, and myriad contributions of others.

Somatic Sponsored Research

Somatic modalities, as opposed to academic schools with somatic psychotherapy programs, have encouraged and pursued research wherever possible within their context as training institutes. Through the leadership of the Hakomi Institute of Europe, the first major empirical research was done demonstrating the efficacy of body-psychotherapy methods in outpatient settings. This multi-year, multi-center investigation was done in Germany and Switzerland, and involved both clinical practitioners and university professors (Koemeda-Lutz et al., 2008). In the United States, Kaplan and Schwartz (2005) provided a methodologically rigorous study of the results of working with two clients within a twelve-session protocol.

Further research into body-inclusive psychotherapy was given a major impetus when Halko Weiss, director of the Hakomi Institute of Europe, joined with his colleague Gustl Marlock to edit the Handbuch der Koeperpsychotherapie, a thousand-page handbook on body psychotherapy published by Schattauer, a highly respected medical publisher in Germany. This well-referenced and positively reviewed work has contributions from 82 international somatic psychotherapy experts. Translated into English, it will likewise further the field in many countries and give impetus to the growing literature that addresses somatic issues (Aron & Anderson, 1998; Boadella, 1997; Field, 1989; Griffith & Griffith, 1994; Halling & Goldfarb, 1991; Heller, 2012; Kepner, 1993; Leder, 1984, 1990; Matthew, 1998; Ogden, Minton, & Pain, 2006; Romanyshyn, 1992; Shaw, 2003, 2004; Stam, 1998; van der Kolk, 1994).

The majority of clinical research by body-inclusive therapists has been dedicated to what Gendlin (1986, p. 133) has termed "playing in the laboratory". This is part of the trend in psychotherapy research toward identifying and evaluating small sub-processes of therapeutic interactions, as opposed to evaluating entire therapies in relation to each other (Johanson, 1986). Playing in the lab involves creatively and curiously exploring a sub-process with the rapid feedback in a clinical encounter that can confirm or disconfirm a hunch, or open up new trailheads. It eventually leads to promising hypotheses that are worthy of the more extensive time, money, and energy that goes into formal research.

The main laboratory settings for somatic psychotherapists are private practice, public and private health services clinics, and comprehensive psycho-somatic therapy trainings. Here, Gendlin's (1986) suggestion is carried out, that there be a central databank of successful cases for examination. Ron Kurtz, Alexander Lowen, John Pierrakos and others have left hundreds of videotapes demonstrating their work. Some training institutes ask those who have successfully shown enough competency in the method to become certified to place copies of their certification tapes in a central office archive. These case examples are available for the psychotherapy process, Q-sort, PQS of Jones (2000), and other research uses outlined by Goldfried and Wolfe (1996), Jones and Pulos (1993), Kazdin (2007), Nathan and Gorman (2002), and others. There are a number of research studies the somatic community would like to engage with when possible in terms of time, energy, funding, and appropriate, resourced partners.

However, on behalf of the many right-brained practitioners drawn to the experiential power of somatic methods, it must be said there is much sympathy for Shedler, who asserts:

> Many of the psychotherapy outcome studies . . . are clearly not written for practitioners . . .[but] for other psychotherapy researchers. . . . I am unsure how the average knowledgeable clinical practitioner could navigate the thicket of specialized statistical methods, clinically unrepresentative samples, investigator allegiance effects, inconsistent methods of reporting results, and inconsistent findings across multiple outcome variables of uncertain clinical relevance. . . . Psychotherapy research needs to be more consumer relevant (Westen, Novotny & Thompson-Brenner, 2005). (2010, p. 107)

Final Word

Today, as suggested above, psychology and psychotherapy comprise exciting and promising fields, which have grown considerably since somatic psychotherapy's beginnings in the 1960s (Heller, 2012). Part of the excitement is the responsibly eclectic expansion of concern to include contributions from developmental studies, interpersonal neurobiology,

trauma, and the body (Levine, 1997; Ogden, Minton, & Pain, 2006; Rothschild, 2000; van der Kolk, 1994, 2003), multi-cultural values, social structures, and more. All this is being done with a view to better integrate theory and clinical practice while making applications to coaching, teaching, human relationships, group, corporate situations, and more. Somatic psychotherapies have a specific and unique contribution to make to the training of healers in today's world. This contribution that discriminately integrates so many scientific findings in clinical practice and teaching should not be ignored because of a limited conception of research in relation to these integrations as a whole, nor should it hold back somatic approaches from seeking greater exploration through research where possible. For a longer view of the history, concepts, and methods of body-inclusive psychotherapy in general, see Barratt (2012) and Heller (2012).

With all that has been said here (and the more that could be said) about somatic psychotherapy engaging the ambiguity of the promises and perils of psychotherapy research and beyond, it must be noted that the governmental and corporate entities that control third-party payments still look with tunnel vision at hard experimental research yielding quantitative results. It has been hard for psychotherapy in general, let alone somatic psychotherapy (Barratt, 2012; May, 2005; Young, 2010), to meet such requirements in a manner similar to double-blind psychotropic drug research. Given the myriad issues suggested above, more philosophical perspectives that could be brought to bear (Fulford et al., 2013), political-economic interests, and the sometimes overwhelming monetary requirements involved, somatic psychotherapy schools and modality institutes will not likely be producing the requisite research soon, though the community remains open to finding university, government, or corporate partners who can facilitate such substantial research efforts.

Though we can point to over 2,500 research studies on the efficacy of mindfulness in therapy alone, plus so much other research we draw on from interpersonal neurobiology and developmental studies, people in power will still ask, "Where are the studies on Hakomi per se?" This means that prospective Hakomi, as well as other somatic psychotherapy, students will have to make considered choices about training in methods that are subjectively meaningful and effective for clients and therapists, but carry objective costs in terms of finances and official standing beyond private practice settings —another source of ambiguity.

BIOGRAPHY

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Somatic Colloquium: Embodied Relating Introduction

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Big bodies interest me — by which I don't mean heavy-built people, but big bodies – families, organisations, communities. The body of our community as body psychotherapists has a painful history of ostracising and marginalising. It often had to fight for its right to exist alongside the more mainstream therapeutic modalities. Reich and the first generation of his students had to struggle to be acknowledged as legitimate theoreticians and clinicians, and we are fortunate to be living in a different era. Most psychoanalytic journals are not only addressing the body in psychotherapy, but also relating to somatic methodologies of working with the body in therapy. Looking at the body psychotherapeutic community I am left wondering about the body that we are; what kind of body do we have? Sadly, it feels that we are oftentimes fragmented and isolated — that even within body-psychotherapy there exists a lot of segregation, dissociation, and primarily, lack of rigorous interdisciplinary dialogue.

We at the IBPJ wanted to help us embody our communal body by facilitating interdisciplinary discussions through a platform for clinicians from different modalities to share their thoughts and feelings about themes that concern us all.

This colloquium is the first dialogue in what we hope to be many. We have asked Nick Totton to write about embodied relating, the connection between being bodies and being in relationships, from his own theoretical and clinical stance, Embodied Relational Therapy (ERT). Following Totton's lucid foundation of his ideas and understanding, we have asked four leading figures in the field of body psychotherapy to each write a responding paper, dialoguing with Totton's. Finally, Totton has shortly commented about those responses.

The four respondents are David Boadella, founder of Biosynthesis; Stanley Keleman, pioneer of Formative Psychology; Will Davis, who created Functional Analysis; and Akira Ikemi, one of the most senior clinicians in Focusing Oriented Psychotherapy today. We are delighted and proud that such prominent members of our community were willing to partake in this project and are certain that our readers will appreciate the variety and conviction, the similarities and differentness. We hope that this project will continue and are engaged in gathering material (and writers) for further themes around which to dialogue.

We hope that you enjoy the richness of this unravelling body and, as always, invite feedback, questions, and comments.

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Embodied Relating: The Ground of Psychotherapy

Nick Totton, MA

Abstract

This paper argues and tries to demonstrate that embodiment cannot simply be bolted onto traditional concepts of transference, countertransference, and projection, or vice versa, but that a fully embodied therapy must be reconceived from the ground up. It offers an embodied account of relational patterns; a theoretical context for this account, which draws on theories of embodied cognition and on the work of Maurice Merleau-Ponty; and, following out of these two themes, an argument for thinking of therapy as play. There is also a note on embodied social and cultural processes. The conclusion is that an embodied therapy throws into question the separation between world and perceiving subject, as well as between one subject and another.

Keywords: embodiment, phenomenology, embodied cognition, embodied relationship

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> Why did psychoanalysis develop as a "one-person psychology", i.e. as having a disproportionately large interest in the intra-psychic, at the expense of the inter-psychic? Why was the therapeutic relationship conceived of as primarily a manifestation of the illness (the "neurosis") of the patient? Why was a sharp cleavage established between talking and acting, and between verbal and non-verbal, and why was the word, the symbolic, given such a remarkably elevated and protected status? And, in the same vein, why were most movement-related therapies split off from the talking therapies for so long, and initially assigned mainly to handicapped or autistic patients as second-class treatments? These questions are all interrelated.
>
> Daniel Stern (2010, p. 119)

Introduction

This paper is intended as a contribution to a collective project which has been underway for some years now: the project of developing *a contemporary theory of body psychotherapy*, which dialogues with other contemporary thinking and research, but at the same time asserts its unique viewpoint through conscious, critical ownership of body psychotherapy's historical positions — a theory which above all is founded in lived experience. Many practitioners are involved in this effort; for me personally, the most valuable work has come from a group of UK practitioners including Shoshi Asheri, Roz Carroll, Asaf Rolef Ben-Shahar and Michael Soth; from assimilating the work of certain neuroscientists, notably Stephen Porges, and relational psychoanalysts, notably Daniel Stern and the Boston Change Process Study Group; and also from the phenomenology of Maurice Merleau-Ponty.

What follows will be primarily a piece of theory, with only a little clinical anecdote to enliven it. I hope that readers will be able to connect it to their own clinical experience. Where it perhaps

breaks new ground is in more or less dropping body psychotherapy's long-standing effort to learn from verbal psychotherapy. I suggest that we have learnt enough — in some cases, rather too much — and that we might now usefully focus on *teaching*, by which I mean teaching verbal therapists that embodiment is central to what they, as well as we, are trying to do. I hope that among other uses this is a paper that body psychotherapists, especially relationally oriented ones, can pass on to their sceptical or uninformed verbal colleagues, and that they can also use to strengthen their grounding in the core positions of body psychotherapy.

I am of course not the first person to write about this, and more is being written all the time. However, it seems to me that much of this writing does not have enough commitment to the extraordinarily radical results of taking embodiment really seriously. It reminds me somewhat of negotiations around emancipating some segment of the population — women, say, or blacks. For a considerable time the hegemonic group often still somehow believes that it can maintain a veto and keep ultimate control of how the newly emancipated group will behave. It is only when the privileging — though not the contribution — of the rational and the verbal is wholly surrendered that embodied relationship can be integrated. I am quite aware of the irony of the fact that I am making this claim in a rational and verbal style.

In what follows, I will address three primary themes: an embodied account of relational patterns; a theoretical context for this account; and an argument, which follows from the previous two themes, for thinking of therapy as *play*. In the course of all this, I hope to shed some light on the questions posed by Daniel Stern in the epigraph to this paper. I will also add a note on the embodied relating of more-than-two, i.e. embodied social and cultural processes.

The Embodiment Matrix

> I am not in front of my body, I am in it or rather I am it... If we can still speak of interpretation in relation to the perception of one's own body, we shall have to say that it interprets itself.
>
> (Merleau-Ponty, 1962, p. 150)

The embodied therapeutic relationship is frequently treated as an interesting and somewhat exotic optional extra, relatively marginal to the core themes of verbal therapy — an additional channel through which practitioners — perhaps only unusually sensitive ones, with all the ambiguous implications of 'sensitive' — can gain information about their clients' psychological processes. Correspondingly, within body psychotherapy concepts like transference-countertransference and projection have been adopted and adapted from verbal therapy, and bolted on, often crudely, to our embodied practice.

I will argue that we should think the other way around and recognise embodiment as the matrix of human relating. Our current theory of the therapeutic relationship needs to be remade from the ground up as a fully embodied account — not just of body psychotherapy, but of *all* psychotherapy. 'Embodied countertransference', for example, is not a special sub-category of a wider phenomenon; it is the thing itself. We might more usefully call countertransference which is *not* experienced in the practitioner's body 'disembodied countertransference', and ask why and how it has become dissociated.

> Here is a superbly vivid description of an embodied counter-transference, from Susie Orbach:
>
> For my part, I began to feel rather tiny. Like Alice...I felt myself grow down and grow in as though I were a miniature. Doreen appeared as a blow-up doll or, perhaps I should more accurately say, an overblown, overgrown, blown-up pretend woman figure such as are sold

> for sexual purposes on the internet. My diminution was not altogether unpleasant. I went back and forth between feeling teetered over as though I was this little thing underneath her, and then sensing my lungs expand to take a metaphorical hearty breath as they were poised to shoot forward to prick and deflate her. She was at once substantial and puffed out, carrying too much water to let her feet sit comfortably in her dainty shoes, and yet almost menacingly large and solid. (Orbach, 2003, p. 4)

We need no context to grasp the *mutuality* of the experience: something is happening both to the therapist and to the client. Or one could start to distance oneself from this by re-centring in the therapist's subjectivity, by saying that "something is happening to the therapist's perception of herself and her perception of the client". And this distancing does perhaps begin to occur as Orbach interprets her experience:

> My body countertransference with Doreen was a visceral rendition of her early experience of bodies around her being too large and yet not sufficiently robust or stable for her to find or develop a body herself from. She *did* feel them teetering over her. She couldn't get them to be in focus, and the volatility of the body size I experienced in the countertransference was a version of the search for a body for herself that could moor itself by finding a place in the physical storm that surrounded her. (2003, p. 4)

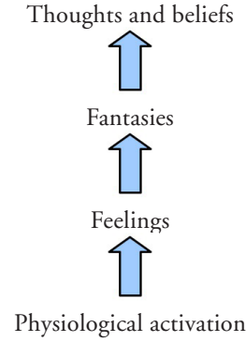
"A visceral rendition", "a version" — phrases like these are surely attempts at withdrawal from the "physical storm" in which Orbach was caught up — positioning it as a record or transcription of *something else*, of an experience which was *not* the practitioner's. Embodied countertransference is a micro-enactment, in which the therapist is helplessly acted-upon by the client's presence; and as with full-blown enactments, it is neither possible nor desirable to dissociate oneself, in any sense of the phrase, from the intersubjective nexus (Soth, 2005, pp. 49-50). As Orbach makes exquisitely clear, her helplessness was a direct function of Doreen's; it was *necessary* for her to experience it in order to come into relationship with her client. It's similar to what James Hillman (1979) says about dreams: that when we *interpret* them "we wrong the dream, we wrong the soul", because "dreams are the primary givens" (Hillman, 1979, pp. 2, 4). The embodied therapeutic relationship is also a primary given, part of the body's dream; to interpret it can often be to deny it.

My suggestion, then, is that therapists experience a natural and inevitable desire to extricate themselves from most forms of embodied countertransference (sexual desire is sometimes an exception). It can make one feel uncomfortably out of control, and hence both vulnerable and irresponsible. This natural defensive reaction leads in many cases, though not in Orbach's account, to the preconscious erasure of the most embodied aspects of therapeutic relationship, the abstraction and intellectualisation of these visceral experiences. This allows the therapist to stay apparently in command of the situation, but, just as when we resist full enactments, it limits the potential for transformative relational experience. 'Embodied countertransference' is nothing but a special case of embodied relating; if we refuse one, then we at least partially refuse the other and thus weaken our capacity to connect deeply with our clients.

The Up-Hierarchy

> The ground of the psyche is the affective mode in its most expansive form as feeling, which is the root and fundament of all the other modes and contains them in tacit or latent form. (Heron, 1992, p. 20)

To understand embodied relating, we need to be clear about what we mean by 'embodiment'. As a counterweight to the usual top-down way of perceiving mind-body relations, I want to use John Heron's 'up-hierarchy', in which the lower elements sequentially shape and determine the upper ones. Heron's basic up-hierarchy consists of what he sees as the four fundamental modes of human experience: from the bottom, Affective → Imaginal → Conceptual → Practical. I have adapted this by selecting a different set of moments out of the continuum, starting with the level of our physiology, which most psychologically-oriented systems, including Heron's, leave out of the picture entirely or treat as a separate substrate.



These four levels represent moments in what is really a smooth and continuous shift from what is called the 'physical' to what is called the 'psychological'. Each of these levels, like the many other intermediate levels which could in principle be distinguished, expresses emergent properties of the one below. As Heron says, "In an up-hierarchy it is not a matter of the higher controlling and ruling the lower, as in a down-hierarchy, but of the higher branching and flowering out of, and bearing the fruit of, the lower" (1992, p. 20). Hence there is no sense in which the upper levels of the up-hierarchy are "better" than the lower ones.

The up-hierarchy I have illustrated, however, is plainly over-simplified; many levels in many dimensions, and many interpenetrating hierarchies, would be required to come anywhere near an adequate depiction. For example, although in one sense culture clearly emerges from and depends on embodiment — there could be no culture without bodies, while the opposite is not the case (Wilden, 1987, pp. 73ff) — it is undeniable that embodiment in turn is socially constructed (Haraway, 1991; Grosz, 1994; Evans, 2002), emerging from and depending on culture. This exemplifies what is a frequent feature of ecological and other cybernetic systems, and what Gregory Bateson (e.g. 1971) calls 'circular causality': a continuous feedback loop rather than a unidirectional arrow.

So 'embodiment' has two important senses. On the one hand it refers to the *state* of being a self-aware organism, something which all living human beings share, corporeality. On the other hand, it refers to the meta-level *process* of knowing and experiencing that one is this organism, and that there really is no separate psychological realm divorced from the body (though there sometimes seems to be), and equally no separate bodily realm divorced from the psyche. This is a process in which we are all involved, but which is realised to different degrees in different people at different times, due in part to conditioning by social and cultural context, which will be to varying degrees "body-friendly". For everyone, there are

moments of exaltation or suffering when one *knows* oneself to be unified bodymindspirit, and moments of alienation or dissociation when these aspects of experience seem to peel apart and even to attack each other.

Embodied knowing

> Our body is not just the executant of the goals we frame or just the locus of the causal factors which shape our representations. Our understanding itself is embodied. That is, our bodily know-how and the way we act and move can encode components of our understanding of self and world. (Taylor, 1995, p. 170)

Embodiment in this second sense can be understood as (aspiration toward) a full and practical awareness of the whole up-hierarchy from physiology through feelings and fantasies to thoughts. This entails what Varela, Thompson and Rosch (1991) call *enaction*, a coinage from the phrase 'embodied action':

> We…call into question the assumption…that cognition consists of the representation of a world that is independent of our perceptual and cognitive capacities by a cognitive system that exists independent of the world. We outline instead a view of cognition as *embodied action*… (1991, p. xx)

This viewpoint is very much indebted to the work of Merleau-Ponty (1962, 1964, 1968) and other phenomenologists, as well as to the Madhayamika school of Buddhism (Varela, Thompson & Roche, 1991, pp. 217-35). A whole range of approaches, many of them much more mainstream in their picture of reality, converge on the same position. The ensemble of such approaches is known as 'embodied cognitive science' (Wilson & Foglia, 2011); what they share is a belief that cognition is integrally bound up with the embodied nature of being, and a rejection of the traditional view that the body is peripheral to mental processes.

Among the many strands which make up embodied cognitive science are research and theoretical work around mirror neurons (Oberman and Ramachandran, 2007; Rizzolatti and Craighero, 2004); artificial intelligence and robotics (Clark, 1997); ecological perception (Gibson, 1979; Sewall, 1999); and dynamic systems as applied to human development (Thielen & Smith, 1994). All of this material considerably enriches body psychotherapy's conception of embodiment. Much of it also addresses embodied cognition of other people, which enables, and in some ways actually *constitutes,* embodied relating.

The Felt Sense of the Other

> It is through my body that I understand other people.
>
> (Merleau-Ponty, 1962, pp. 184-5)

> The felt sense is an interaction with the presence of the other.
>
> (Ikemi, 2005, p. 286)

Embodied relating, then, is a specialised area of embodied cognition which involves what we might, drawing on Gendlin (e.g. 1998), call 'the felt sense of the other'. I thought briefly that I had coined this expression, but it turns out to be used by several people, in particular Akira Ikemi (2005; 2013) who works at the meeting point of person-centred therapy and Focusing. What especially appeals to me about the phrase is its double-sidedness: it names both *my* felt sense *of the other person*, and *the other's* felt sense *of me* — both central to the

transference matrix, where transference and counter-transference are woven out of the same substance, braided together in a trans-causal process of mutual co-arising (Totton, 2011; Varela et al., 1991). As Merleau-Ponty says, "Every perception doubled with a counter-perception…is an act with two faces, one no longer knows who speaks and who listens" (Merleau-Ponty 1968, pp. 264-5).

This sentence seems to me to encapsulate and give a context for the whole elaborate therapeutic apparatus of identifications, introjections, projections, transferences and counter-transferences, and so on. The medium in which all these transactions circulate is what Merleau-Ponty calls 'flesh'.

> The Flesh is the mysterious tissue or matrix that underlies and gives rise to both the perceiver and the perceived as interdependent aspects of its own spontaneous activity. It is the reciprocal presence of the sentient in the sensible and of the sensible in the sentient, a mystery of which we have always, at least tacitly, been aware since we have never been able to affirm one of the phenomena, the perceivable world or the perceiving self, without implicitly affirming the existence of the other. (Abram, 1997, p. 66)

Merleau-Ponty discovers this reciprocity in the whole of reality (and this has been usefully applied to ecopsychology: Abram, 1997; Cataldi & Hamrick, 2007). He also finds it specifically in human relating, where he names it *intercorporeality* (Merleau-Ponty, 1964, p. 19; 1968, p. 143), a fleshly intersubjectivity, and also wrote of 'carnal intersubjectivity' (1968, p. 173). Through embodiment, we are immediately and inherently linked in shared understanding; no one can touch the other without *being* touched. "Subjects are joined by their belongingness to a common world. Furthermore...they 'open' onto each other" (Crossley, 1995, p. 57). Embodiment, or flesh, is the matrix for human relationship; and psychotherapy is perhaps the place where this can be brought most clearly into awareness.

A point that emerges strongly out of work on embodied cognition is the important role of implicit knowledge in human learning. For every repeated activity from riding a bicycle to forming a relationship, humans rely on preconscious or unconscious patterns of activation and behaviour which are developed when the activity was first learned (Thielen and Smith, 1994). As sports instructors know very well, it is extremely hard to affect these implicit procedural habits, which have to be brought into awareness before they can be changed (Straub & Williams, 1984).

Some of the deepest embodied, implicit patterns we hold seem to be those around relating (Boston Change Process Study Group, 2008). Following Juhane (2003, ch. 9), I have chosen to call such patterns 'engrams', a longstanding neurological term for the physical unit of memory, which was never pinpointed in neural structures and is now conceived as holographic. The term 'engram' literally means something *inscribed within*. Embodied relational engrams, then, are formed in our earliest relationships; and we use them, for better or worse, as blueprints in each attempt to negotiate new encounters. As Allison Priestman and I have written:

> The embodied engrams which store our early experiences of relationship are enormously powerful in shaping our experience...and, equally, other people's experience of us: human bodies constantly respond to and become entrained with each other's relational engrams, and this process in a therapeutic context is traditionally described in the language of transference and projection. The therapist's countertransference is in large part an out-of-awareness reaction to the client's transference engram: joining in the physiological dance. (Totton & Priestman, 2012, p. 39)

I now want to take this a step further, and suggest that the transference and countertransference components cannot be separated out and linear causality allotted in such a straightforward way. We could equally say, as Jacques Lacan does in an early paper (1950), that it is the therapist's countertransference engram which elicits the client's transference. Each subject's engram is an 'exogram' for the other.

> …as soon as we acknowledge that other people may (in certain circumstances) form part of our external memory fields, with their own dynamic engrams potentially acting as exograms for us, it becomes clear that passive external words and images in no way exhaust the media in which cognition and remembering are situated and that materiality can have many different kinds of causal efficacy. (Sutton, 2008, p. 43)

Interrelating individuals are equal partners in the physiological dance referred to earlier: each forward movement of one dancer's limbs implies and elicits, gives meaning to and takes its meaning from, a backward movement of the other, and vice versa. Listen, they're playing our tune: the dance is a unique synthesis of the two partners' relational engrams, in which each constitutes an exogram for the other. Again we encounter circular causality, mutual co-arising.

Embodied Relating and Mutuality

> This move to situate subjectivity in the lived body jeopardizes dualistic metaphysics altogether. There remains no basis for preserving the mutual exclusivity of the categories subject and object, inner and outer, I and world.
>
> (Young, 1990, p. 161)

> The first epigraph to the previous section of this paper is part of a longer passage:
> Faced with an angry or threatening gesture, I have no need, in order to understand it, to recall the feelings which I myself experienced when I used these gestures on my own account… It is as if the other person's intentions inhabited my body and mine his… It is through my body that I understand other people. (Merleau-Ponty, 1962, pp. 184-5)

Merleau-Ponty is describing the sort of core human experience now generally framed within the concept of mirror neurons (which had, of course, not been identified when Merleau-Ponty was writing). However, it is important to realise that mirror neuron theory neither *defines* the experience it refers to, nor, really, *illuminates* it; most of its effect is simply to *underwrite* the lived experience, to licence belief in it. And that lived experience is not some sort of internal "simulation" of the other's action or expression, as it is often theorised (e.g. Gallese and Goldman, 1998; Oberman and Ramachandran, 2007), but *a direct and immediate knowing* (Gallagher, 2005, 2012; Lindblom, 2007).

Mirror neuron theory comes to life when incorporated into the wider field of embodied cognition. Paraphrasing Stephen Gallagher (2005), Jessica Lindblom writes:

> Mirror neurons and shared representations are not primarily the mediators of simulation but the *enactment* of direct intersubjective perception. [Gallagher] exemplifies this view in the imitation of facial expression, emphasizing that infants have no need to simulate the facial gesture internally, as an extra step, since through actually seeing it, they already simulate it on their own faces. This means, one's own body is already communicating with the other's body at unconscious and perceptual levels that are sufficient for intersubjective interaction to emerge. (Lindblom, 2007, p. 128)

Gallagher and Lindblom are referring to the well-established fact that infants — as soon as thirty five minutes after birth! — will spontaneously try to reproduce adult facial expressions (Meltzoff & Moore, 1995). There are two interwoven aspects to this: the infant *responds* to the adult in the act of *receiving* the adult's expressed emotion. The at-a-distance image of embodied mirroring is perhaps better conceived more tactilely, as an *intaglio print,* in which the convex and concave, "receiver" and "transmitter" faces of the same image match and coincide. With an intaglio print, an image is cut into a metal plate and then inked; a sheet of paper is pressed into the image with a roller, and this intimate contact produces an embossed image on the paper. An image (engram), which has been carved into one surface, now stands out from another surface.

This metaphor of an intaglio is vaguely inspired by, though quite distinct from, Jean Laplanche's concept of "embossed" and "hollowed out" transference (e.g. Laplanche, 1992, pp. 12-13.) It returns us to the Merleau-Ponty passage I quoted earlier: "Every perception doubled with a counter-perception…is an act with two faces, one no longer knows who speaks and who listens" (Merleau-Ponty, 1968, pp. 264-5). Merleau-Ponty constantly refers back to the experience of touching one's own body, and applies it equally to one's relationships with others and with the world. The example of infant imitation demonstrates most clearly how central embodied enaction is to an experience of relationship. Here is the hinge on which this whole paper turns: the image of embodied relating as "an act with two faces", a combined engram/exogram, an intaglio imprinting which fuses together the experience of two bodyminds.

The Obvious Question

If any of this is true, why are we not — as we appear not to be — transparent to each other? Why are we not of one flesh? Why is human life suffused with experiences of misunderstanding, of loneliness and isolation, and also with attempts to avoid close contact — what Freud (1908, p. 153) described as "the feeling of repulsion in us which is undoubtedly connected with the barriers that arise between each single ego and the others"? On one level this is an unanswerable question about the nature of human existence; on another, it is rather a question with only two answers, between which the only way to choose is by following one's own temperamental preference. These answers can be briefly summed up as "innate imperfection" and "contingent circumstances", with Freud for example preferring the former and Reich for example the latter (see Freud. 1930; Reich, 1945; for a speculative narrative of possible contingent circumstances, see Totton 2011, ch. 5).

Staying closer to the immediate situation, though, there is a lot to be said about how this alienation is *transmitted* through the generations. One can think of an infant experiencing the intaglio imprint of an adult's early wounding as it is held in the adult's character structure, and how the infant in turn struggles to survive and assimilate the invasion of this "foreign body" (Laplanche 1976; Totton, 2002), helplessly imprinted upon just as by a facial expression. As Martin Stanton summarises the thinking of Jean Laplanche:

> The first intake of messages from the other is neither naturally assimilated, nor greeted with projective elaboration, but experienced as an intrusion of the other. The affective processing of the inside of the body is therefore also primarily marked out as 'other' – the inner body is therefore an 'inner foreign body' *(corps etranger interne)*. (Stanton, 1997, p. 38)

Laplanche, like Freud, sees this as part of the human condition; I prefer to see it, like

Reich, as a product of social conditions — the messages of the other cannot be assimilated because they are messages about intolerable wounds. Either way, it is the condition we are born into by being born into embodied relating.

In his last book, *Forms of Vitality* (2010), Daniel Stern gives an excellent example of how relational engrams work:

> A mother and her 9-month old son were sitting side by side on the floor playing with a cardboard jigsaw puzzle.
> The boy picked up a piece of puzzle and brought it to his mouth.
> Hi mother said in a normal voice "No, it's not to eat, it's a leaf" (of the puzzle). She stopped his movement with her hand.
> The boy answered "Ugh." Then he tried again to get the piece to his mouth.
> She repeated, in a firmer voice this time, "No!"
> His response was "Uuggh!"
> She escalated even higher and said, "NO, IT'S NOT TO EAT!!!"
> He escalated even further, "UUGGHH!!"
> She then leaned forward toward him, lowered her eyebrows, and said in a flat voice with no melody and much vocal tension (as in anger), "DON'T YOU YELL AT YOUR MOTHER. I SAID NO!"
> He then over-escalated her, yet again, and said "UUUGGGHHH!!!"
> At this point she gave up and conceded the victory to him. She sat back, her face softened and broke into a slightly seductive smile. She said, with a melodic voice, "Does that taste good?"
> He then put the puzzle piece in his mouth.
> She then made him pay for his victory. With a disgusted wrinkling of her nose and a slightly contemptuous voice she said, "It's only cardboard, does that taste good?
>
> (Stern, 2010, pp. 146-7)

This interaction creates a relational engram which no amount of verbal therapy will be able to unearth. Stern suggests that

> [t]he whole scene...was a lesson in how to negotiate with a woman.… The infant… was already learning non-verbally about the negotiation of the authenticity of desire. He will spend the rest of his life expanding his knowledge of how to do this. In addition, it will come into play in the consulting room. (Stern, 2010, p. 148).

Stern also emphasises that embodied dynamic patterns, 'vitality forms', are central in constructing and maintaining this engram.

When as client we come to meet a therapist, we deploy an ensemble of embodied-relational engrams developed through previous interactions. It is against these engrams that we measure and test our interaction with the therapist to see where it best fits. We have an inbuilt preference for using an existing engram rather than developing a new one, because the latter process is emotionally and energetically expensive: it requires a melting-down and recasting of armouring, so to speak. (It is only if and when this melting-down takes place that the therapy can be transformative.) So locking our interaction into a familiar pattern is parsimonious, in some senses even skillful. As with all human activity, our first resource is pattern recognition.

The shortcoming of pattern recognition, of course, is that it opens the door to *mis*recognition. And because relationship is always *between* the entities relating, how we as therapist are approached influences our own experience of the situation, as we in turn

parsimoniously try to fit it into our ensemble of previously experienced situations. We often find ourselves giving embodied assurances that in fact we *are* like the client's mother, father, etc. What we as therapist try to do, therefore, is to surrender to this process of engram-matching *with awareness*. If we don't surrender to it, nothing useful happens, no information is gained; if we surrender totally and lose awareness, nothing useful happens either, no information is gained. Like the Fool in the Tarot pack, we dance precariously on an edge between these two attractors. We play.

Therapy as Play

> The resemblance between the process of therapy and the phenomenon of play is, in fact, profound.
>
> (Bateson, 1954, p. 191)

> Not only do the playing animals not quite mean what they are saying but, also, they are usually communicating about something which does not exist.
>
> (Bateson, 1954, p. 182)

The work of Stephen Porges (2011) on the Social Engagement System is increasingly well-known. Its relationship to body psychotherapy is similar to that of mirror neuron theory: it supports us in believing what we already know from direct experience, that our organisms have an inherent and skilful tendency towards forming relationships with others. Porges describes a complex interactive network of cranial nerves and functional systems that was originally devoted to absorbing oxygen from water, gradually developed in mammals into a system for absorbing food and comfort from the mother's breast, and then, in humans, brought together with visual, facial, and vocal interaction with a caretaker to become, in adults, a system for absorbing relational nourishment from a social context.

In terms of the up-hierarchy discussed earlier, Porges' work is largely concerned with the crucial transition from physiology to feeling. For the purposes of this paper, though, I am going to pick out one fairly tangential aspect of the work, concerned with the role of *play.* Porges (2011, p. 278) identifies five physiological states of activation, which can be thought of as species-wide (in fact, mammalian-wide) engrams, ancient scaffolds on which our personal engrams are constructed. Four of these states are: *social engagement* (the polyvagal system), *mobilization* (fight-flight), *immobilization* (freeze), *and immobilization without fear* (involved in various forms of intimacy). The fifth state is *play,* which Porges suggests is a combination of mobilization with social engagement.

All of these states are of enormous interest in relation to therapy, especially immobilization without fear; but I want to focus here on play, which Porges describes like this:

> Access to the social engagement system is critical in defining mobilization as play and not aggression. … A 'polyvagal' definition of play requires reciprocal interactions and a constant awareness of the actions of others. Play is different than fight-flight behaviors. Although fight-flight behaviors often require an awareness of others, they do not require reciprocal interactions and an ability to restrain mobilization. Play recruits another circuit [social engagement] that enables aggressive and defensive behaviors to be contained. (2011, p. 276)

Isn't this very relevant to the "as-if" character of psychotherapy, where — if there is relational work at play —both client and therapist need to experience deep positive and

negative feelings towards each other while inhibiting the sort of actions that would normally be implied by such deep feelings? Must not client and therapist alike hold some meta-perspective which reminds them, "I am not *really* loving or hating this person in front of me, though I *am* feeling *real* love or hate"?

We are brought back again to the work of Gregory Bateson, this time to his paper on play and fantasy (1954) which was a key document in the development of systemic family therapy. Bateson argued (1954, pp. 178-80) that play in humans and other mammals is a matter of meta-signals, which convey the message, "This is not what it seems". He relates this to a number of other human activities, including threat, deceit, dramatization, ritual, and psychotherapy. (Hopefully it is clear that I am not writing about Winnicottian play *in* therapy, but about the very different idea of therapy as play.)

Bateson's insight is extremely important but in its original form quite dry and abstract, in fact distinctly disembodied. When we combine it with Porges's description of the *embodied signalling* of play, it takes on a very different tone. Porges isn't talking about some sort of coded message flashing between the protagonists, but about a contagious state of physiological activation, transmitted through the flesh. We could think of this as a particular kind of *relaxation,* which translates further up the up-hierarchy as the "realization that signals are signals" rather than reality (Bateson, 1954, p. 178). This state of relaxation connects with the state of "immobilization without fear" also described by Porges (2011, pp. 178-9) and also essential to therapy. What else could keep us in our chairs for an hour?

Social Embodiment

> Social practices are the sedimentation of history at the level of the body. When I teach, when I write this article, when I run a race or teach one of my children how to ride a bicycle, my body is oriented in particular ways, conforming to or rejecting particular norms, responding to the constraints and restraints of those practices as they have evolved in interaction with other practices over time. Through its engagement in these practices, my body has taken on a history that is not of my making but is nevertheless part of my inheritance.
>
> (May, 2005, p. 524)

As mentioned above, many theorists of embodied cognition see human social interaction facilitated by the ability to *simulate* the experience of others, to use mirror neurons and other capacities to create an internal model of someone else's internal state (Rizzolatti & Craighero, 2004; Oberman & Ramachandran, 2007). Merleau-Ponty provides a less arms-length, more embodied conception of fleshly intersubjectivity, implying that "the body and its sensorimotor processes function as a social resonance mechanism" (Lindblom, 2007, p. 144). Hence, "embodiment is the underlying foundation for the individual and social mind rather than merely linking or bridging them from these two different perspectives" (Lindblom, 2007, p. 246).

However while embodiment is the ground of social relations it is also constructed *through* social relations. This is paradoxical from the viewpoint of formal Western logic, but such chains of mutual or circular causation are common from the perspective of ecological and other cybernetic systems, and are the foundation of Buddhist ontology (Macy, 1991, p. 1995). In fact it would seem as though the relaxed physiological state of

play described earlier, which allows one to distinguish the sign from the reality, the map from the territory, is a part of what can be reached through meditation, especially in the Zen tradition (Watts, 1969, 1973).

Returning to the theme of social embodiment, Shawn Gallagher (2013) has recently treated the concept of the 'extended mind' (Clark & Chalmers, 1998; previously one of Gregory Bateson's 1980 insights) as applying not only to the body and the physical world but also to the social world:

> Just as a notebook or a hand-held piece of technology may be viewed as affording a way to enhance or extend our mental possibilities, so our encounters with others, especially in the context of various institutional procedures and social practices may offer structures that support and extend our cognitive abilities. (Gallagher, 2013, p. 4)

In other words, people are continuously using each other and their environment as exograms, extensions of their minds. But since people are also being used in the same way by others, the concept of one's own mind, like one's own body, is thrown into question, exposed as to some degree illusory. Rather, there are collective projects flowing through and between us, expressing themselves in different ways at different moments in different bodyminds. "Mind" cannot be separated from "body". It is the knowing continuum of flesh that underlies and gives meaning to our social world. As has often been said, language would be an inadequate tool for communication if we didn't already know what each other mean.

> The linguist Edward Sapir says something similar about gesture:
> We respond to gestures with an extreme alertness and, one might almost say, in accordance with an elaborate and secret code that is written nowhere, known to none and understood by all.... Like everything else in human conduct, gesture roots in the reactive necessities of the organism, but the laws of gesture, the unwritten code of gestured messages and responses, is the anonymous work of an elaborate social tradition. (1949, p. 556)

Embodiment, as Sapir writes in the case of gesture, "roots in the reactive necessities of the organism", but what we conceive to be those necessities are themselves socially constructed. Embodied cognition enacts our world, but the world, including the social world, sets the conditions of embodied cognition. Embodiment (in the sense of consciously self-aware corporeality) is inherently languaged (Merleau-Ponty, 1968, p. 155), but language, equally, is inherently embodied — "discourse itself is a fleshy process.... It is produced through the work of the body" (Crossley, 1995, pp. 50-51). Time to turn "but" into "and", and acknowledge that cutting the circle of causation at any point, privileging either disembodied language and society or the unlanguaged, unsocialised organism, is fundamentally unhelpful and untrue to human experience.

What is constructed as embodied subjectivity combines traumatic and non-traumatic elements, often in the same engram, and inherited through generations as well as newly minted (Totton, 2009, 2010). Both trauma and nurture are what one *takes in* from the world into which one comes. They are the stuff out of which one is made, out of which one makes one's self. But unless the self that is constructed is an open system, open in both directions to the world and to others, it is both illusory and deadly. In the play of therapy, it is sometimes possible to expose and explore deadly defences against openness without destructive effect; but only when the therapist is prepared to join in the serious game.

Conclusion

> Mental models and neural networks can be reshaped by doing something differently, imagining it differently, seeing another doing it, or by hearing about it in words. The walls separating different modes of experiencing are starting to come down as we realize that it all has to pass by way of imagined movement.
>
> (Stern, 2010, p. 135)

In describing embodied relating as the ground of psychotherapy, I am not saying that it is the whole of psychotherapy. I am intending a fairly precise claim: that it is the surface on which therapy stands (or falls), the soil in which everything grows (or fails to grow). And like the ground, embodied relating can easily be forgotten or ignored, as we hurl great skyscrapers of theory into the stratosphere.

Like soil, embodied relating is a medium: the flesh as it manifests in human relationship. It is the medium through which infants assimilate both nurture and trauma; the medium through which patterns of creativity and defence are reproduced in the therapy room; and the medium through which, potentially, change can be generated and stuck patterns released. It is becoming clearer and clearer that, as Daniel Stern indicates in the epigraph to this section, both stuckness and change are fundamentally cross-modal (Stern, 1985, 2010) — a pattern, which can be expressed in many different channels, but always with the same underlying dynamic structure or "form of vitality". The central role of dynamic structure supports the sense of many researchers that motor imagery is the crucial element that actualises new learning:

> There is a growing notion that therapeutic change cannot happen if there is not a 'real' or imagined action at the local level.… Changes in 'implicit relational knowing' occur only when one 'does', i.e., enacts an aspect of the relationship in a new way. It need not be reflected upon and verbalized. (Stern, 2010, pp. 134-5)

This is not to say that actual bodily movement is required (though it certainly doesn't hinder); here Stern is talking about motor *imagery,* forming new neural circuits which can be elicited in many ways including through talking. However, it does suggest reasons — as I hope this whole paper has done — for considering changing theoretical and clinical priorities, and thinking and working from the embodied-relational ground up. How this would work from a detailed clinical point of view, though, is a subject for another paper.

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BIOGRAPHY

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Response to Nick Totton's Embodied Relating, The Ground of Psychotherapy

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Nick Totton has given us an admirable view of the embodied relationship in body psychotherapy. It advances our understanding of what Wilhelm Reich called 'vegetative identification', and enriches the concepts of somatic transference. Totton draws on deep roots in phenomenological philosophy (Merleau-Ponty) to broaden the basis of his view. He deepens the reader's interest by introducing concepts such as 'engrams' and 'intaglios' to widen the understanding of what Daniel Stern (2010) calls "vitality forms". Totton links embodied relating, naturally, to mirror neurons. These exist not only in the motoric part of the brain, but also in the higher limbic system, which supports empathy in contact. To his view of mirror neurons could be added the recent research, by Tognioli and others (2007). on "anti mirror neurons". In any relationship, the balance between mirroring and anti-mirroring is the balance between "you" and "I". This is essential in order to avoid the extremes of over-caring (where one loses oneself in the other) or egocentricity (where one loses the other by retreating too much into oneself).

Totton draws on Gregory Bateson to emphasise important resemblances between therapy and play. Play is a creative sharing between individuals, in which resources can be activated and the vitality affect of two or more people can be shared. There are play centres in the brain which have become dysfunctional in many neurotic states, most strongly in depression. Totton links the theme of therapy as play with the social engagement theory of Steven Porges.

Porges is a brilliant neurologist whose work should be fundamental for all body psychotherapists. He discovered a third branch of the vegetative nervous system, the so-called 'ventral vagal', which mediates between the extremes of sympathetic stress and parasympathetic resignation. The ventral vagal system involves neurons in the brain stem which have three main connections:

- to the lungs and the heart, leading to more centred breathing and heart rhythms;
- to the face and voice muscles, leading to more contact and empathic dialogue;
- and to the muscle spindles of the major muscles of the body, leading to more balanced muscle tone.

Totton's paper quotes a wide range of other valuable sources. Establishing the right frame for emotional contact is essential for all body psychotherapists, in particular when dealing with highly charged emotional energy states, in order to avoid re-traumatisation. Nic Waal (personal communication), Reich's Norwegian colleague pointed this out half a century ago. Stanley Keleman and I have continually emphasised this for many years (in a series of papers published in *Energy and Character*. This background is described in detail in Boadella, 2014). This is another reason why Totton's emphasis on clear contact as the basis of embodied relating is of fundamental importance.

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BIOGRAPHY

David Boadella was trained in vegetotherapy in the early nineteen fifties, and began work as an individual therapist in 1957. After thirteen years of practice he founded *Energy and Character, the Journal of Biosynthesis*, in 1970.
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Embodying
Response to Nick Totton's Embodied Relating, The Ground of Psychotherapy

Stanley Keleman

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Introduction

The human situation is such that our inherited patterns of action for satisfying needs or resolving conflicts do not match the modern situations in which we live. The notion of being natural as a guide for how to behave is passé. The human cortex's ability to respond to and imagine situations as well as to invent times of action and duration goes beyond the responses of the brainstem and limbic system.

The cortex uses voluntary muscular effort to influence so many levels of the organism's expressions. This ability creates tools and new relationships that alter how the body relates to itself and others. The human cortex and its muscular organs have invented many skills that have redefined how we use our body at work, in sexuality and love relationships, as well as in society.

Since the human enterprise has made great progress in preventing unnatural deaths and extending longevity, all stages of the human organism's cycle of shapes — childhood, adolescence, early adulthood, full-grown adult, and the maturing and older adult somatic shapes — have come more and more under the influence of the cortex and voluntary muscular effort to be developmental and learning dynamics.

The human ability to make transitions in its age-shapes, as well as a result of personal and social demands, produces stress that can be found in the organism's underforming of a specific set of preserved behavioral patterns. This can create anxiety and doubt as to how to behave, and an over-reliance on instinctual responses to carry one through. Being confronted by somatic-emotional-cognitive transitions from one stage of instinctual existence to another — or through important situations like personal relationships — without the experience of outside guidance can create cortical, emotional, and muscular pain. With the evolution to voluntary muscular-cortical effot, one no longer needs to rely on the instinctual, that is involuntary, management of patterns of inherited responses. This change from involuntary regulation to voluntary muscular-cortical effort for managing behavior and introducing voluntary forming behaviors, makes vivid the formative dynamic of the human being.

Embodying

In Nick Totton's article about *Embodied Relating,* Totton talks about the need to reconceive embodiment from the view of relational patterns and embodied cognition. Totton also speaks about the relational aspects of embodiment, without grasping the notion that these relationships are somatic patterns of behaving that cue responses between infants and adults. Formative Psychology® has pointed out how somatic postures and emotional attitudes are a co-bodying relationship process, and how body postures affect how one experiences and knows another, oneself, and the relationship (Keleman, 1985; 1987). Totton uses and refers often to engrams without identifying these as synaptic neural-muscular re-embodied maps and thus a somatic process of a particular kind of relationship between the muscular and neural body (Koob, 2009).

I think that being bodied is not only a relationship of the organism to the world but of the organism with itself. The human, like all animals, adapts its structure to the world it finds itself in. A developmental response that emerged was to change the world through domesticating animals, building shelters, cultivating plants, and rearing children. These practiced voluntary acts bring about anatomic behavioral changes, from influencing reflex acts to differentiating them, through the reorganizing, rehearsing, planning, and voluntarily applying that brought about the new behavior. This voluntarily developed behavior forms culture, civil codes of practiced muscular behavior that results in embodying new anatomic realties. It is a process of voluntary muscular effort to preserve and differentiate new expressions and transmit them, and is the relationship that constitutes an embodied life and the development of values and meanings which enrich human existence.

The evolution of the body through the voluntary motor acts governed by the cortex develops an organismic interior relationship of the body with itself and with others (Sheets-Johnstone, 1990). The voluntary muscular effort forms new motor patterns from inherited ones, by reassembling them, editing them, and applying them to create new anatomic relationships that result in a personal awareness of being an embodying process. This is an animate forming process of creating situations which extend our somatic presence over time.

Voluntary muscular efforts develop motor, muscular-neural-synaptic memories. The body that is able to grow from its voluntary muscular and cortical efforts begins to know itself as a personal formative agent of metamorphosis and morphogenesis, as an embodying agent of its life.

Sigmund Freud told us, "Anatomy is destiny" — but anatomy is more than destiny. It is also a behavior, a developing agent of expressions, experiencing, knowing, and understanding that is able to voluntarily influence relationships within itself and with the world of others. One is born bodied, but forming and embodying oneself through this process of voluntary forming is what creates a personal embodied life (Keleman, 2012). This orientation offers a way not only to address human dilemmas, but also to voluntarily change soma, to develop inherited possibilities and create educational and clinical tools. This is what it is to form personal and interpersonal relationships enriched by the values and meaning that are grounded in an experiential knowing of the embodying process and forming a personal embodied existence.

Totton is fond of Merleau Ponty, who deserves praise, but does not actually articulate that the organism is a primarily expressive architecture. Totton may not realize that he's implicitly saying that there is an unembodied realm influencing the bodied realm. Nina Bull (1951) has pointed out that feelings are feedback from uncompleted or delayed motor patterns.

The primary layer of the organism's structure is a pulsatory, cellular-molecular organization of behavioral interactions. These cellular chemical-electrical patterns are also organized structures that are neural maps and muscular expressive images, which include thought (Fields, 2009). All these acts — motor, muscular, cortical and neural — are anatomic behaviors, on a micro or macro, voluntary or involuntary level.

Forming and Living an Embodied Life

Experiencing and being aware of inherited soma do not by themselves constitute an embodied life. The body's forming process is at the heart of animate existence. The body lives a process of continuous morphogenesis, and its voluntary muscular effort organizes a personal somatic life

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field. This is the difference between a bodied life with body awareness and a personal embodied life awareness, which results largely from voluntary muscular efforts.

The bodied life is a life of morphogenesis that is the continual change of somatic shapes. Voluntary morphogenesis is how the organism learns how to use muscular effort to influence its inherited behavior, to repeat the effort to form memory structures of how it influenced its own behavior, and to recall its differentiated patterns over and over again to form new expressions. This creates a personal life field that has both subjective and social values and meaning.

Being embodied depends upon the organism's use of voluntary effort to generate experience and to form a memory of the body's relationship with itself. This remembering is an anatomic process, which is the ground of "I can do this; I can organize a personal behavior." Voluntary muscular effort helps form the personal somatic reality of an embodied life and makes new expressions so the organism is not a victim of its inherited responses.

Voluntary muscular effort facilitates excitatory patterns and gives them body by forming somatic memories. Voluntarily influencing inherited behavior is being able to voluntarily repeat the action of being bodily present when needed, that is, not to fall into old reflex patterns of response. Forming an embodied life and transmitting its stages of development furthers the human evolutionary dimension. It is a continuing education associated with the desire to form an autobiographical identity, a Formative rather than a causal identity.

Being embodied is a Formative process. For the organism it is imperative to develop voluntary motor acts to facilitate forming a personal somatic excitatory life field that rebodies its involuntary and voluntary experiences of changing somatic shapes. This demands that each person endeavor to develop, over time, fine motor skills for differentiating reflex motor patterns into new anatomic expressions of behavior and relationships. Voluntary muscular effort generates and develops the life field of one's somatic structures and alters the structures' excitatory, emotional, cognitive aliveness. Voluntary effort is not mental willpower. It is a muscular-neural effort that brings about an embodied way of experiencing anatomic morphogenesis, bestowing experiential awareness of past, present, and future anatomic-excitatory-structural possibilities and the values they are given.

Living an embodied life takes voluntary muscular effort to influence inherited somatic behavioral shapes, like reaching and approaching, withdrawing and retreating, and generating new motoric, feeling, and cognitive feedback. Voluntary muscular effort organizes memory structures that extend the permanence of personal formed acts, beyond the immediate situation and even the lifetime of the individual. Forming an embodied life helps the organism transcend its own field and be part of the larger evolutionary field of animate existence, making the organism an agent of its own destiny.

Conclusion

The body is a forming field, a process of metamorphoses and morphogenesis. This pulsatory process is an involuntary/voluntary excitatory tide, which organizes an anatomic architecture of behavioral expressions that in turn birth patterns of acting, which generate experiences of all sorts, and are remembered. Voluntary-muscular, and then cortical, effort generates relationships within the organism and constructs a personal embodied life.

That is the forming of an evolving embodying lifestyle. Voluntary muscular-cortical effort also involves influencing developing transitional shapes and emergency alarm patterns, which all too often exhibit excessive involuntary responses to the dilemmas of living.

We have to take responsibility to form our own lives, to give body to the experiences we generate, and to live a personal life of continual morphogenesis. Voluntary effort brings about self-empowerment. This ability forms new expressions and a narrative of influence that makes us

agents of our own personal life field of existing.

This paper offers a view linked to an evolutionary process of human experience, memories of previous and present forming shapes of behavior, and voluntary efforts which create behavior that is not genetically programmed.

BIOGRAPHY

Stanley Keleman is the director of the Center for Energetic Studies in Berkeley California where he teaches the Formative approach to human development. He is a somatic educator who has been researching and developing the Formative principles, an original method for influencing inherited behavior. He was awarded a PhD in Human Letters from Saybrook Graduate School in June of 2007. USABP awarded him a life time achievement award.
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The USA Body Psychotherapy Journal – Vol.6 No.1 – Dedicated to Stanley Keleman
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Response to Nick Totton's Embodied Relating: The Ground of Psychotherapy

Will Davis

Abstract

While agreeing with Totton's position on an embodied relationality in therapy, I have looked for clarification about some of the basic concepts to better understand the fused state of therapist/patient. This intertwined relationship is of particular interest to me because my position is that the role of the other is overemphasized in development and therapy.

Keywords: embodiment, self organizing, endo self, embodied relations

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Totton has written a good article. The embodied relational model is a growing theme in body psychotherapy and, as he points out, in other approaches as well. He takes a clear and strong position on a difficult theme. The therapist was originally considered to be "neutral" but over the last 100 years psychotherapy has gradually moved along a continuum towards more contact and interaction with the patient. How to do that and still maintain appropriate boundaries is a constant issue.

Theoretically, I am in the same camp as Totton. I agree with the underlying body/mind unity perspective. Concerning his argument for a "ground up" model basing the work first on physiology, I have also shown how this idea is growing even within robotics and computing design (Davis, 2012). I support his position that we should not simply "bolt on" ideas from verbal therapy but rather make the concepts not only our own, but an integral part of psychotherapy in general. In addition, his paper prompted me to reflect on my own point of view about self/other/us and, as any good piece will, it brings up questions.

A. Some general considerations

I do not take issue with the paper in general but with broader themes of using one's body to understand/know the other in a therapeutic relationship. The first theme is the need in general to clarify the many terms we use to describe various states of intersubjectivity and our individual responses to it. Of course it is beyond a short paper like Totton's to go into this and it is not his task; it is for all of us to do (and the focus of the 2014 EABP conference in Lisbon). For example, we use the terms embodied (counter)transference, somatic (counter)transference, resonance, vegetative identification, superimposition, intersubjectivity and empathy (a nice word in German – mitgefühl: to feel with). Mixed in with these terms are mirror neurons, primary identification, projective identification and Boadella's (Personal correspondence, September 2006) "real transference" which is similar to Reich's genuine transference (1976). An example of how confusing all this language is: …it is the therapist's countertransference engrams that

elicits the patient's transference." (Totton, p.5). I think a countertransference from the therapist will elicit a corresponding *countertransference* in the patient. I am also confused by the example from psychoanalyst Susie Orbach, although for Totton it is a "superbly vivid example of embodied countertransference" (p. 2). Was the patient transferring and Orbach had an embodied countertransference as suggested? Or was the patient simply being who she is – her "engrams" - indifferent to Orbach and Orbach had transference to the patient? Or is it projective identification: Orbach felt herself take a deep breath, blowing herself up as she had described the patient was? Was she identifying with the patient's power and enjoying it? Or was she unconsciously defending herself against a perceived attack.

I never understood the difference between projective identification and unconscious embodied countertransference which brings me to my second general theme: if we are going to work with the embodied relations within a unified body/mind state, we need to have some sort of criteria to delineate these different states. How do I know it is projective identification whereby I am unconsciously identifying with the projected feelings of the patient or the patient's transference is activating an unconscious, unresolved issue I have about myself? If the therapist is clear he will know it is projective identification. If he is acting out of his unconscious unacknowledged problem, he will *believe* it is the patient. Working with a patient I was hurt and became angry when she (maybe) suggested that I wasn't as "spiritual" as she was: "…oh, but I know you are not interested in that sort of thing." I had a (too) strong, immediate urge to take her into the next room to show her all my "spiritual" books on the shelf. I felt the anger in the body and I had the clear "I will show you" thought both at the same time. (At least I was a unified body/mind in my neurosis!) But it was clearly an overreaction on my part due to issues about being seen and appreciated. She was a highly successful business woman and could be seen as competitive so I had an embodied countertransference against her transference. Or did I? Maybe it meant nothing to her – it was all my imagination – in which case, my response was embodied transference. What are the criteria to know that any of the various terms listed above are actually happening?

I have taken the terminology of transmitter and receiver from German body psychotherapist Theresia Mestmäcker (Personal correspondence, at L' Academie de Sinsans, 2002) to deal with all these terms we use. We need to consider the quality, the clarity of any transmission and any reception as much as the content. What we transmit is not always what is received. All communications are filtered through our "engrams" and it is painfully clear that many of these are *not* clear. Are we empathic, resonating, embodied, or symbiotic, borderless, invasive? I remember in a congress presentation the first time I heard a therapist say he uses his body in the therapy to understand the patient. Immediately I was thinking and feeling, "I do not want *my* therapy based on *that* body!" It didn't seem to me to be a very clear receiver. In doing group supervisions, especially when using photos of patients, it is fascinating what the different supervisees respond to and in what manner. Sometimes it seems like three different patients are being presented simultaneously.

B. Connective tissue as "the flesh"

Totton uses the words "flesh" and matrix to discuss our embodied response to the other. I do think information is being transmitted unconsciously, below the verbal level and it is received in the body. I have written (Davis, 2012) elsewhere about Alan Schore's (1999) views on body-based, non-verbal communication.

> Concerning projective identification, there must be a "psycho-biological holding" by the therapist of the dangerous, projected, "nonverbal emotions" of the patient whereby the patient can vicariously explore and experience these emotions within a safe context. The therapist must "hold" and "metabolize" these emotions for the patient within her own *body* so that the patient can take them back again as his own. Havens and Larson (in Schore, 1999) comment, 'Perhaps the most striking evidence of successful empathy is the occurrence in our bodies of sensations that the patient has described in his or hers.' and that psychotherapeutic resonance is expressed in 'specific sensations and/or feelings kinesthetically perceived by the therapist.' (Havens & Larson as cited in Schore, 1999, p.10). This is more than an embodied self. This is embodied psychotherapy (Davis, 2012, p.5,).

Of course, it is of importance how little distortion the information goes through as it is being transmitted and received, but I am convinced that the physical reality of this "flesh" or matrix is in the connective tissue. In *Energy Medicine: The Scientific Basis,* Oschman (2000) refers to the networking of the connective tissue and calls it the matrix whereby information is passed throughout the whole body *instantaneously* outside the enteric, the vegetative and the central nervous system. (See my reaction to a perceived attack on my spirituality) Oschman is especially good at describing the energetic qualities of connective tissue. Connective tissue is a semi-conductor – between an insulator and a conductor - and all the biological energies pass through it: bio-magnetism, bio-acoustic, bio-luminescence, bio-chemical, bio-electric as well as all secretions. These energies are information, instructions for the body/mind. This is of importance if, according to Jantsch (p. 35) energy systems manifest themselves in the organization of material processes and structures.

> Connective tissue is a semi-conducting communication network. It conveys bio-electric signals between every part of the body and every other part...bio-electric, bio-magnetic, bio-chemical and bio-acoustic signals moving through collagen fibers, ground substance and associated layers of water molecules. (Larson, 1990 p. 253)

The condition of the connective tissue determines the quality of the transmission and receptions: hypo-hydrated and hyper-hydrated. A slight reduction in hydration of the tissue caused by chronic stress, which for body psychotherapists is character armor, will result in a radical reduction and distortion of transmissions and receptions. A 10-20% decrease in hydration slows protons by 5000 fold. When wet, a photon moves along a collagen protein at 1 tenth of a millionth of a second. When dehydrated, the same distance takes 1 million seconds. Electrons are affected by hydration, too (Oschman, 1997). Communication and *mis*-communication travel through the "flesh" of connective tissue.

C. On Engrams and Embodied Relating

I need clarification on embodied relational engrams. If an engram is, from a neurological point of view, "the physical unit of memory", "something inscribed within" (Totton, p. 5), it seems to imply that engrams arise from outside influences, i.e. relationship. Yet, when referring to mirror neurons, and I appreciate the nuanced distinction Totton makes here, he seems to be implying the opposite: "…it is not some sort of 'internal' stimulation' of the other's action

or expression…but a direct and immediate knowing". And, mirror neurons, "…*underwrite* the lived experience." (Totton, p.5). My need for clarification is woven through the discussion on engrams: Porges's engram is an "ancient scaffolding" on which we build" (Totton, p.8). Yet, Totton refers to engrams as being cultural/social. If I understand correctly, and there is no reason to believe I do, it seems Totton is using engrams as both innate, pre-existing patterns, archetypes, gestalts or programming and, at the same time, as learned cultural experiences through interaction with others.

Totton discusses this using the infant's face recognition ability. We are impressed by how early an infant recognizes a face. Kendal (2012) reports "that from birth onward, infants are much more likely to look at faces than any other object" (p. 288), and goes on to describe the neurology of face recognition. Kendal points out that the infant is better wired to differentiate hands – position, with or without fingers - than faces. "The cells that responded to faces were not selective for any unique face, but for the general category of faces. This suggested "…that a particular face, a particular grandmother, is represented by a small, specialized collection of nerve cells – an ensemble of grandmother cells, or proto-grandmother cells." (ibid., p.291) Furthermore it has been shown that even wasps and bees are capable of face recognition (Tibbetts & Dyer, 2013).

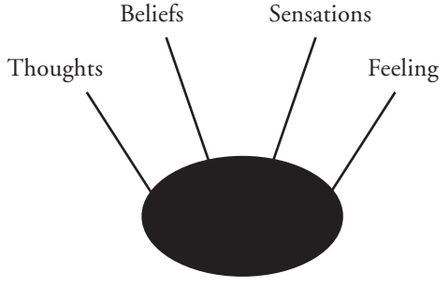
I refer to this research to point out that face recognition seems to exist independently of relationship and that relationship is built on this innate ability. The issue to me is, are we over-interpreting when we talk about infants imitating, receiving and responding to the other? Babies make faces when they are unaware that someone is looking at them. They seem to be responding to their own experiences of themselves and may be doing this when it appears to the outside observer that the infant is in relationship with the other. It is similar to Totton's reference to Bateson's (p.7) comment about how we anthropomorphize animals, or what the psychoanalyst Loewald (in Mitchell, 2000) would call imposing a secondary process view on the primary process, or Maturana and Varela's (1998) "operational closure". (p. 135)

This point is of particular interest to me. In a recently published paper I postulate an "endo self" which exists before relationship (Davis, 2014). The formulation of an *a priori* sense of self changes the dynamics of embodied relations. Is the infant "reproducing" the adult's expression whereby the object is the center of this relational dynamic, or is the infant experiencing itself in relationship? Is it an imitation as a learning process or is it the excitation of a pre-existent state or facility and the infant is experiencing the satisfaction of a completed gestalt and is subject oriented. Ryan (1991) speaks to this: "The pleasure in mastery, in effectance, …in experiencing action merely for its own sake is, as Piaget once called it, a basic fact of psychic life" (p. 209).I fear too many conclusions are being drawn and interpretations made about what is happening within the baby with the little knowledge we have of that state.

This brings us back to embodied relating themes: fusing, interacting endo and exograms, and circular causality. I need more clarity about this very important dynamic and the roles of self/other, social/cultural, and me/you/us specifically, because it will help me with my own formulation of an endo self. Do two different individuals become one in the embodied relational state? Is my unified body/mind/spirit, "me", fusing with another's, "you", and creating a *new* system, an emergence, an "us" whereby the "me" and the "you" are gone? Is this Reich's superimposition? Totton seems to be saying there is no subject/object: "Here is the hinge on which this paper

turns; the image of embodied relating as 'an act with two faces', a combined engram/exogram, an intaglio imprinting which fuses together the experience of the two body/minds (Totton, p. 6). Yet, he quotes Merleau-Ponty: "It is *as if* the other's intentions inhabit my body and mine his…It is through *my* body that I understand the other people" (p. 5 italics mine). Merleau-Ponty (Pagis, 2009) is a phenomenologist who, as far as I understand, emphasizes the *individual* experience (p.267). If that is so, then isn't it still two individuals experiencing the other within their separate individualities? If not, who is doing the experiencing? In the opposite direction from embodied relating, this is where I have always had trouble with transcendental psychology. If I transcend myself, who is left to have the new selfless experience?

My same confusion continues through his presentation of an up-hierarchy. Yes, unified body/mind, and yes to: "There is no psychological realm divorced from the body" (p. 3), and even though hierarchical, there is no judgment of "better". But can a body exist without a mind, a sense of self, of existence? I prefer the ice, steam, water analogy I offered at the EABP Congress in Vienna (2012). The three of them seem to be quite different and separate. Yet we know that they are the same on the molecular level. It is only different energy states that make the differentiation to us; they are differentiated but indivisible. I would formulate Totton's hierarchy of physiological to feelings to fantasies to thoughts and beliefs as all emerging simultaneously from the same source. The diagram below attempts to represent a simultaneous emergence.



Physiology

Instead of a hierarchy that implies a building up of a structure, I prefer the modeling of development more in terms of what Jantsch (1979) calls unfolding.

> Unfolding is not the same as building up. The latter emphasizes structure and describes the emergence of hierarchal levels by the joining of systems 'from the bottom up'. Unfolding, in contrast, implies the interweaving of processes which lead simultaneously phenomena of structuration at different hierarchical levels. Complexity emerges from the interpenetration of processes of differentiation and integration, processes running from 'the top down' and from the 'bottom up' at the same time and which shapes the hierarchal levels from both sides. (p. 75)

Besides it being a good developmental model for the infant, I think this description fits well with Totton's "act with two faces" …the fusing of two body minds as a co-evolutionary process in the therapeutic encounter.

D. Conclusion

I think this is an important paper and clearly written despite my questioning. I bring up these points because Totton's paper has stimulated me to think more deeply about my own position on the critical themes he writes about. I am grateful for the invitation to participate in this discussion.

BIOGRAPHY

Will Davis (1943) is an American with 40 years experience in psychotherapy. He has a psychology degree and was trained in Encounter Groups, Gestalt Therapy, Radix and in various alternative healing methods. He conducts body psychotherapy training workshops in Europe. Will developed the body-oriented psychotherapy, Functional Analysis, and is considered one of the major researchers in the fields of the functioning of the instroke and of the plasmatic basis of early disturbances. He is on the International Advisory Boards of the *Journal of Energy and Character* and the *International Journal of Body Psychotherapy.* He is a member of the Scientific Committee of the Italian Society of Psychologists and Psychiatrists and the European Association of Body Psychotherapy. He lives with his wife in the south of France.
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Responsive Combodying, Novelty, and Therapy
Response to Nick Totton's Embodied Relating, The Ground of Psychotherapy

Akira Ikemi, PhD

Abstract

In this paper, written as a response to Nick Totten's article "Embodied Relating: The Ground of Psychotherapy", the author first presents his recent view on embodiment. The term *responsive combodying* is used to express the three perspectives comprising his view. From this standpoint, reflexive awareness about the pre-reflexive living forward of the body is articulated. The implicit and the unconscious are contrasted on the grounds of their respective temporalities. While the unconscious points to the past, combodying pre-reflexively points to the not-yet, to novel ways of relating and living. In psychotherapy, novel ways of living forward change both the client's and therapist's existence.

Keywords: combodying, the implicit, reflexive awareness, Focusing

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Introduction

Nick Totton has written an engaging paper entitled "Embodied Relating: The Ground of Psychotherapy" in this journal. In the second to last line of his article, he hopes his paper has provided reasons for "considering changing theoretical and clinical priorities, and thinking and working from the embodied-relational ground up".

"Yes, let's do that!" was my reaction to this line as I finished reading his paper. I too, share this enthusiasm for letting the body speak for and from itself, rather than imposing and framing concepts upon it. Totton writes, "I am quite aware of the irony of the fact that I am making this claim in a rational and verbal style." I wonder if it would really be an "irony". I am cautious about imposing verbal and rational concepts on the body, for I appreciate the body as interacting in language, before language, after language, and in wider ways than language.

There are many points of convergence between Totton's article and my views. I was delighted to read the following sentence about 'the felt sense of the other'. "I thought briefly that I had coined this expression, but it turns out to be used by several people, in particular Akira Ikemi." Though pleased to see this meeting point, there are also differences in our outlooks. In this particular instance, I feel that Totton has interpreted my phrase to mean a 'chiasm' in Merleau-Ponty's (1968) sense, which I do not intend. I will discuss more of this at a later point in this paper. The overall aim of this paper is to augment Totton's theoretical elaborations by bringing in an angle on embodiment that seems to be missing, or that is different from his. To do so, I first present my evolving views on embodiment (Ikemi, 2014) and then discuss how this interplays with Totton's article.

Responsive Combodying

In a recent paper entitled "Sunflowers, Sardines and Responsive Combodying: Three Perspectives on Embodiment" (Ikemi, 2014), I elaborated on some aspects of embodiment. The first aspect exemplified by sunflowers comes from Gendlin's (1993, p.24) assertion that "we have plant bodies." Let us imagine a sunflower plant, for example. The sunflower has no input channels for perception, yet it knows exactly how to live. It "knows" that it is right to turn to the sun, for example. This self organizing-generating of life is not something that the sunflower was taught by its parents. The plant-body is not a blank slate upon which learning occurs. It *is* the interaction with the environment. More specifically, it *is* the organizing-generating of life in interaction with the environment. Gendlin (1973, p.324) gives another example to illustrate the same point: No one teaches a baby how to crawl. The body is capable of interacting with the environment and generating the right modes of interaction with the environment even though they might not be learned.

Moreover, every sunflower plant is different, as they are not like products produced in a factory. Some sunflower plants are taller than others, the color of the petals may differ slightly, and so forth. Each plant organizes and generates its own life from slightly differing environmental conditions.

In the vein of the above examples, my recent article (Ikemi, 2014) provides the illustration of people walking. Everyone walks in a slightly different way. If one were to devise a computer program for walking, the variables would be immense: body size and weight; the size and shape of each foot; muscle tone in the calves, thighs, hips, lower back, shoulders, and perhaps all areas of the body; the movement of each joint in the entire body; respiration; climatic conditions such as heat, wind chill, humidity, rain, snow, wind velocity, and direction; digestion (the walk differs when there is gas in the colons or when one has indigestion); cardiac output and blood circulation; emotions; schedule; the fit of shoes; items carried; road surface…. The list is probably inexhaustible. When there is a slight change in the inclination of the pavement, the body automatically adjusts. Walking on a stone pavement, where each stone varies in shape and size, I am amazed how my walk adjusts itself, even before I am aware of the pavement conditions. All this is done pre-reflexively, so that one can carry on and concentrate on a conversation while walking. A person does not need to reflect on the conditions involved in the walk, and yet the body *generates* its own right walk. The walk being generated is "right", since if it were not right, the person would be stumbling all the time. In fact, the body is "aware" of the multitudes of ever-changing conditions in the environment and *lives forward* with these.

The second perspective presented in this paper articulates how the body is a "body-in-the-universe". Some sea turtles lay eggs on the night of the full moon. The moon "inhabits" the body of the turtle, as well as the tide, the sandy beaches, the birds that prey on the eggs, the baby turtles to be born, the whole universe. Gendlin (1973) gives an example of a squirrel raised in a metal cage.

> ... a squirrel raised from birth in a metal cage, having never seen a nut on the ground, when given a nut at a certain age, will "bury" it. That is to say, it will scratch the metal floor, will pick up the nut, place it at the spot at which it scratched, and heap imaginary soil on the top of it. (p.324)

The soil, the earth, is "in" the squirrel. The body is "in" the universe and the universe is "in" the body. Human beings are "in" not only what humans call nature, but also so much more, including the situation, symbols, and historicity such as language, culture, and history. For instance, in the human body, it is not uncommon for blood pressure to go up when

stocks go down. Our bodies are "in" the symbolic world, and the symbolic world is "in" our bodies as well.

The word 'embodiment' sounds Western and dualistic to me. The prefix "em-" means "to put in". Thus, to 'embody' means to "put into the body", as if souls are incarnated into the body. The word itself implies a dualism of body and spirit or soul and matter. Therefore, instead of using this word, I have coined the term *combodying* where the prefix "com-" means "altogether with". The term is also a verb, implying the ongoing process of generating life.

Combodying is always already situated and interacting with the world, the universe. I do not mean it in the sense of the 'chiasm' (Merleau-Ponty, 1968), which is described originally in Merleau-Ponty (1962, p.92) as a tactile perception of the right hand touching the left hand. As with the sunflower example above, the body interacts with the environment even without perception, since the sunflower has no perception channels. In another article that Totton referenced (Ikemi, 2013), I elaborated on a sense of someone watching me, which is a bodily sentience lacking direct perception. Gendlin (1992) attempts to carry forward the important understanding of the body that Merleau-Ponty initiated. I agree with Gendlin that the body is already relating to the world before perception and that starting the study of intentionality from perception greatly limits the intricate relating of the body. Thus, although my gaze of an other includes her gaze of me in a 'chiasm', it is not only the gaze, not only perception. My body is sweating, and I perceive the perspiration on my skin only after the sweating has well started. And maybe she and I are both emitting some pheromones, which again is not perception. So much more goes on in 'embodied relating' than literally meets the eye.

In the third perspective articulated about the body (Ikemi, 2014), combodying forward is seen as a pre-reflexive process, and yet one's reflections about aspects of combodying can change the ways one combodies. For example, ancient Chinese medicine discovered meridian points in the body. Stimulating these meridian points changes how bodies combody. Even intensive surgery can be done with acupunctural anesthesia. Similarly, when one turns one's attention, in a mindful way, to the chakras while walking, one will notice that the walking changes immediately. Together with this, breathing changes, posture changes, and so many other aspects of combodying change instantly. The body responds to and combodies differently when there are concepts and procedures that have precisely such effects. Thus, many concepts and procedures in body psychotherapy are capable of altering the mode of combodying, i.e., how the body interacts and lives forward from the present situation.

From the Ground Up

I am much for "from the ground up" instead of imposing concepts on combodying. Totton adapts an "up-hierarchy" so that there are four levels, "physiological activation" at the base and then upwards into "feelings", then "fantasies" and finally "thoughts and beliefs" at the top. I am somewhat hesitant to make a critique of this because Totton himself writes that this hierarchy is "plainly over-simplified" and much more work is "required to come anywhere near an adequate depiction". However, I deliberately choose to dwell on this because it illustrates the differences in how we think.

From my point of view, there seem to be too many concepts here already, with which Totton's explication hierarchy is structured. First of all, what is meant by "up"? And how does the concept of "hierarchy" function? It would seem to function by organizing thoughts into a coherent system of relationship between concepts wherein the higher on the hierarchy, the more dis-embodied one gets. Are not these concepts imposed on the body? Moreover, the base of this hierarchy is "physiological activation" which is already a concept. The body in itself and physiology are not identical; physiology, rather, is the science of how the body functions. "Activation" is also a concept.

Being mindful of the body, one might notice, for instance, that breathing is fast, or that the body is hot and sweating and yet feeling cold and chills, that the body is wanting to lie down and rest, or that there is some felt sense in the chest. Combodied existence is pre-conceptual or pre-reflexive. One needs to reflect on aspects of combodying so that meaning can be generated. One might reflect on a body whose breathing is fast, and which is itself hot and sweating, yet cold and wanting to lie down — and try out the concept of "fever". If the thermometer shows that indeed it is fever, some meaning is created and an appropriate next set of behaviors can be conceived. But more refinements continue. Is it a cold? Or the flu? What if the symptoms of a common cold or influenza don't appear — what then? One needs to reflect further. Or what if the thermometer shows a normal temperature reading? One needs to turn away from the instrument (in this case, thermometer) and reflect using much of one's capacities — feelings (is it an affective reaction to something?); recollection (is it alcohol or was anything else ingested?); thoughts (was the day's work exhausting? Is it lack of stamina or insufficient exercise?) thoughts-feelings (should a medical examination be pursued?); and Focusing (shall the felt sense in the chest be focused on?).

Instead of making a set of classifications such as "physiological activation", "feelings", "fantasies", and "thoughts and beliefs", I prefer to keep it simple, so that, on the one hand, there is the pre-reflexive and, on the other, reflexive awareness. Reflexive awareness makes use of different modes of reflection including recollection, thinking, feeling, and Focusing. However, since it would be difficult to make arbitrary distinctions between these modes — one can be recollecting and thinking and feeling at the same time — I prefer not to distinguish them and instead choose to keep them all within reflexive awareness.

In fact, one can engage each of Totton's hierarchy stages with reflexive awareness by reflecting upon feelings, fantasies, thoughts, beliefs, and the body. It is the interplay of the pre-reflexive and reflexive awareness that I wanted to emphasize in another article (Ikemi, 2013) that Totton references.

The Implicit and the Unconscious

Totton writes, "Something that emerges strongly from work on embodied cognition is the important role of implicit knowledge in human learning." He seems to equate implicit knowledge with preconscious or unconscious patterns and, referencing other authors, he goes on, "…we rely on preconscious or unconscious patterns of activation and behaviour which we developed when first learning the activity". In the next paragraph, he uses this model to understand 'engrams'. He explains, "Our embodied relational engrams, then, are formed in our earliest relationships; and we use them, for better or worse, as blueprints in each attempt to negotiate new encounters." Apparently, Totton is trying to explain embodied relating or the bodily sentience of relating by hypothesizing about how they came to be.

Here, it seems evident to me that a popularly employed conceptual framework is imposed on the bodily sentience of relating. It is seen as a product, as it were of previous learning. When a person wonders about a product, frequently asked questions are: "How was it made?" "When was it made?" "Who made it?". Totton seems to be asking these questions about bodily sentience.

Assumed here is that the product is already made, a *fait accompli*. So one looks to the past to see how it was made. But is bodily relating a *fait accompli*?

Totton seems to equate implicit knowledge with the psychoanalytic concepts of preconscious and unconscious. Psychological contents, in psychoanalytic theory, are assumed to be based in memory. Gendlin (1990) argues that this is so because in many theories and philosophies, including psychoanalysis, human nature is seen as being unable to generate its own order. Therefore, in those theories, human nature must be conditioned by patterns imposed on it. Without learning, human nature is thought of as blank, with no order of its own. Thus, in this line of thinking, any bodily sentience would be seen as a representation of what was learned in the past and stored in memory.

In contrast, "the implicit" implies something that is not-yet in Gendlin's philosophy. My felt sense of hunger at this very moment, for instance, seems to be implying something like dahl curry at a particular Indian restaurant. My bodily sentience of hunger points to something that is not-yet, the future, since I am not at the Indian restaurant yet. Of course, I can think of reasons why I want dahl and look for past events that may have shaped this direction. But past events alone cannot determine the body's forward projection. A sniff of Chinese food cooking at the restaurant on the corner may change my body's implying. Then, all the reasons I have thought about for why I want dahl tonight must be altered. As in walking, the body pre-reflexively integrates the ever-changing multitudes of information and constantly adjusts and generates the next novel steps of life.

Dance, Play, and Therapy

Yes, therapy can be symbolized as dance and play. On the dance, Totton writes, "Each forward movement of one dancer's limbs implies and elicits, gives meaning to and takes its meaning from, a backward movement of the other, and vice versa. And listen, they're playing our tune: the dance is a unique synthesis of the two partners' relational engrams, in which each constitutes an exogram for the other. Again we are encountering circular causality, mutual co-arising."

And here is my version: First there's the rhythm, the music, and the commitment to dance with this partner. These interactions, including the relationship with the partner, come first. Each of the dancers is combodying in the interaction with this partner, with this music, with these surrounding people, with this occasion for the dance, and much more, as the two "co-arise" in the dance. The body begins to generate its own movements, instead of just repeating the same steps. Novel bodily movements arise. Why did I sway my torso this way? Before I can reflect on this, more new movements arise. The other's movements blend into my movements in a sense of oneness, and at times surprise me when novel movements by the other catch me off-guard. The oneness is temporarily suspended with an outstanding otherness of the other. The other arises, and then falls back into the oneness.

Rather than the particular movement of the limbs, there would be an encompassing sense of dancing with this person in this situation. That felt sense would be difficult to express in words. One would have to reflect on the mutual pre-reflexive bodily living of the relationship with the other person. It is such reflexive activity from the felt sense of the relationship that creates new meanings and carries forward the relationship. Blueprints, as engrams and exograms do, play a part in the dance. However, the dance is not a repetition, not a reliving of the script in the blueprint. Combodying incorporates the past and the whole present situation, and yet it newly lives forward. And this is what happens in therapy as well. The newly living forward changes both the client's and the therapist's existence.

It is my hope that this response to Nick Totton's article will shed light on an aspect of embodied relating that is not emphasized as much in Totton's article: the perspective of novelty, the forward life-generating process. I do not downgrade the importance of understanding persons through their personal histories and narratives. But just as much as with attending to the past, I value reflecting on discovering the newly developing living-forward with the relationship and with the whole situation, which are implied in combodying.

BIOGRAPHY

Akira Ikemi, Ph.D. is professor of psychotherapy at Kansai University, Graduate School of Professional Clinical Psychology. Having met Professor Eugene Gendlin while studying at the graduate school of the University of Chicago, he has since continued to study Focusing, serving as a former board member and the current certifying coordinator of the Focusing Institute, one of the founders and past-presidents of the Japan Focusing Association, a current board member of the World Association of Person-Centered and Experiential Psychotherapy and Counseling, and a former board member of the Japanese Association for Humanistic Psychology. He studies, teaches and practices Focusing-Oriented Psychotherapy.
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Response to Commentaries by Stanley Keleman, David Boadella, Akiri Ikemi and Will Davis

Nick Totton

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I very much value and benefit from a collaborative, cooperative approach to the development of theory; and I have generally experienced a lack of this in the field of body psychotherapy, apart from a small group of close colleagues. So I am delighted and honoured to have been asked to contribute a paper in this format, and to receive responses from such a distinguished group of practitioners.

At the same time, I have of course felt, as I suspect everyone does in this situation, frustration and disappointment, a sense of being misread! After an initial bout of spluttering, though - "Haven't they noticed the paragraph on page...", "Can't they see that I'm saying the exact opposite..." - I realised that 'misreading' is better understood as 'critical feedback': that I am being shown exactly what is unclear, confused and missing in my paper. For which I am, reluctantly, grateful; especially since I have this opportunity to clarify what I thought I was saying, what I intended but failed to communicate.

I shall start briefly with Stanley Keleman. Disappointingly, Keleman has chosen to say almost nothing about my paper, but instead to write, interestingly, about his own interests. This is of course itself feedback of a sort. In the first of the two paragraphs (literally) where he refers to what I say, I was alarmed to read how I fail to grasp that relationships are 'somatic patterns of behaving that cue responses between infants and adults', and fail to identify engrams as 'synaptic neural-muscular re-embodied maps'. I agree with both formulations, though the first strikes me as oversimplified (relationship styles start that way, but are altered by the responses we get) and the second overcomplicated (what does 're-embodied' mean?)

Keleman's sole other reference to my paper mentions Merleau-Ponty, then goes on 'Totton may not realize that he's implicitly saying that there is an unembodied realm influencing the bodied realm'. I don't know whether 'he' is me or Merleau-Ponty; I hope the latter, since I'm quite sure that I am saying nothing of the kind. I agree that in some passages (not the ones I use) Merleau-Ponty is arguably caught in aspects of the paradigm he is trying to leave behind. And that is really all I can say about Keleman's paper, without reversing the intended process and commenting on his ideas rather than him commenting on mine. David Boadella's brief response is pleasingly positive. There are two ways, however, in which our positions seem to differ. Firstly, Boadella seems to think that neuroscience offers *explanations* rather than *redescriptions* of what we experience in relationship: in other words, that to speak of 'mirror neurones' and 'anti mirror neurones' is is to say *more* than one does when speaking of 'the balance between "you" and "I"'. Taking a phenomenological view, I would suggest that in some ways it says *less*, and at best says the same thing differently. This overvaluation of what neuroscience can offer runs through all four responses.

Secondly, and importantly, Boadella still gives relationship only a secondary place in body psychotherapy, with the primary place still occupied by work with and on the client's body and energy field. I of course agree that 'establishing the right frame of emotional contact is essential for all body psychotherapists, in particular ... in order to avoid retraumatisation'. But my paper tries to go a lot further than that, arguing that both body and verbal psychotherapy depend wholly on the embodied relationship between client and therapist. I will say more about this below.

I feel much more community of understanding with Will Davis and Akira Ikemi: I don't know how old in years anyone is, but my sense is that the three of us are in the same conceptual generation, and share a lot of common ground. I value Ikemi's emphasis on 'the forward life-generating process' alongside understanding how the past has shaped the present; this is, I think, an important aspect of my own practice, which I didn't look at in this paper. The work of therapy, the work of life in fact, is to create a future out of the material which the past has given us: to transform limitation into possibility.

Where I think Ikemi and I may disagree is around the relationship between thinking and embodiment, concepts and bodily experiences. Ikemi seems to maintain a sharp and simple dichotomy between the two, and to believe that it is possible to occupy a 'pre-conceptual or pre-reflexive' space. (But doesn't 'pre-' imply the same hierarchy of disembodiment which he finds in my paper?) He points out, quite rightly, that 'physiology' for example is a concept; but seems to assume that it is therefore disembodied. However, 'body' is equally a concept! Not only can we not discuss *anything* without using concepts; we cannot consciously *experience* anything without using concepts. I disagree with the commonly held view that this intrinsically alienates us from our experience, and my brief discussion in the paper of 'full' and 'empty' speech is intended to address this issue; following on from it we can maybe speak of 'full' and 'empty', embodied and disembodied, thought as well (Sheets-Johnstone, 1990).

Ikemi responds in a reflexively negative way to the word 'hierarchy'; but a logical hierarchy is quite different from a hierarchy of value. He says that 'the higher on the hierarchy, the more dis-embodied one gets'. But I stress in my paper that 'each of these levels ... expresses emergent properties of the one below'- embodiment provides the ground and core of psychological functions. I quote John Heron:

> In an up-hierarchy it is not a matter of the higher controlling and ruling the lower, as in a down-hierarchy, but of the higher branching and flowering out of, and bearing the fruit of, the lower.
>
> (Heron. 1992, p. 20)

I was perhaps over ambitious in trying to squeeze so much into one paper (I am currently writing a book about embodied relating, for which this exchange will be very helpful). Another aspect which I think I failed to explain adequately is mutual or circular causality. This concept, which I learnt from Gregory Bateson and Joanna Macy, is of fundamental importance in suggesting ways forward on several pressing issues – notably the environmental crisis (Totton, 2011). It is also my answer to the questions raised by Will Davis, in his very thoughtful paper, about issues of cause and effect.

Several of Davis's points are ultimately about causality. For instance: 'it seems Totton is using engrams as both innate, pre-existing patterns, archetypes, gestalts or programming and, at the same time, as learned cultural experiences through interaction with others.' This is exactly right - and a good example of mutual causation; as I say in my paper,

> While our embodiment is the ground of social relations it is also constructed *through* social relations. This is paradoxical from the viewpoint of formal Western logic, but such chains of mutual or circular causation are common from the perspective of ecological and other cybernetic systems, and are the foundation of Buddhist ontology.

I have realised that I would need to say a good deal more about mutual causation in order to make my position really clear. The same goes for the overall systemic approach that takes us beyond the either/or impasse. Davis writes of infants that 'face recognition seems to exist independently of relationship and that relationship is built on this innate ability'. This implies an either/or: either what infants do in imitating facial expressions *is* relationship or it *isn't*. Such formulations are fundamental to western logic; but over the last century or so, we have become aware of so many situations with which this logic cannot deal. Babies imitating adult expressions neither *are* nor *aren't* relating; but they are doing what later takes on relational meaning for them, and already takes on relational meaning for the adults who respond to it – and if it didn't, the babies might not survive. Everything grows from this act of proto-relating.

I would respond similarly to Davis's earlier wrestling with issues of transference, counter transference and so on: basically, he is asking 'is it the practitioner or the client who is responsible for what is experienced?' I tried quite hard in my paper to argue that this is another false either/or: it is always a matter of *both* – aspects of client and practitioner which resonate with and respond to each other. Whatever is constellated in a given therapy session is co-created through and in relational interaction.

There is a great deal more to say here; but it will probably have to wait for my book! Again, I am grateful to those who have responded to the paper; and also grateful to the IBPJ and to Asaf Rolef Ben-Shahar for inviting me to write it, at exactly the right moment. I hope that the process has contributed in some small way to strengthening the spirit of collegiality in the networks of body psychotherapy.

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INTERNATIONAL BODY PSYCHOTHERAPY JOURNAL THE ART AND SCIENCE OF SOMATIC PRAXIS

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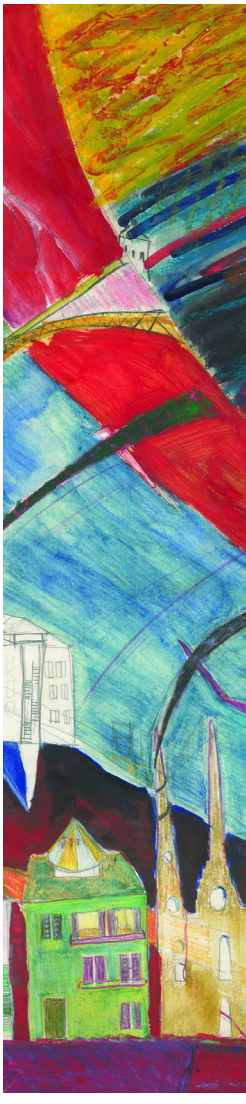

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