

Connecting body, mind and soul

Kathrin Stauffer, chair of the Chiron Association for Body Psychotherapists, introduces this issue of *The Psychotherapist*, which features a modality that emphasises the need to integrate body, mind and soul

This issue is dedicated to body psychotherapy. Body psychotherapy has formed part of the spectrum of psychotherapeutic modalities represented in UKCP since its beginnings. At that time, it was represented by the Chiron Centre for Body Psychotherapy, which went on to become the UK's largest training organisation for body psychotherapists, with over 350 trainees in over 20 years, of whom about 150 are currently registered with UKCP. Sadly, in July 2010, the directors of the Chiron Centre, Bernd Eiden and Jochen Lude, retired, and the centre is now closed.

Finding our place

Organisational membership of UKCP and its accrediting function were transferred to the Chiron Association for Body Psychotherapists (CABP) in 2008. This meant a shift from a well-established training organisation to a relatively young

professional organisation that is still attempting to find its place in the world of psychotherapy.

CABP is also the national association in the European Association for Body Psychotherapy (EABP). The process of engaging with our continental European colleagues has highlighted just how differently body psychotherapy is viewed in most other countries. It is often not part of mainstream psychotherapy but aligned more to complementary therapies or psychosomatic medicine, while the various theoretical frameworks are sometimes idiosyncratic and not easily reconcilable with more psychodynamic theories.

An integral view of human beings

By contrast, at least partly thanks to its involvement with UKCP, CABP has engaged with the project of bringing body psychotherapy and psychodynamic psychotherapy together. It has thus created a modality that connects body, mind and soul: a truly integral view of human beings. It is this view that we aim to present to you in this issue, in the spirit of honouring the people who have contributed to the development of body psychotherapy and to share the richness of the profession with our colleagues.

The starting point for all of the articles are two simple questions: why should psychotherapists want to pay attention to, or make use of, bodies in their work?

“A modality that connects body, mind and soul: a truly integral view of human beings”

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What does integration between body, mind and soul actually mean?

Theoretical perspectives

Different theoretical perspectives are offered. My own view, and that put forward by Elya Steinberg, proposes a holistic view of health. A number of other contributors illustrate how including the body in psychotherapy can illuminate particular issues and processes: Clover Southwell's paper on different levels of consciousness and contact; Claire Entwistle's case history with a traumatised client; John Waterston's contribution on the important topic of revenge; and Anita Ribeiro's article on her work with families. We return to a more theoretical approach in Gill Westland's article about touch and in Michael Soth's historical and theoretical treatise. Carmen Ablack's paper addresses the creative processes in body psychotherapy.

I hope that you find these articles interesting and that they will inspire you to discover more about body psychotherapy. CABP offers postgraduate training to other psychotherapists in various subjects and techniques particular to body psychotherapy.

For more information visit www.body-psychotherapy.org.uk. 



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Including the body in psychotherapy: what can we gain?

Kathrin Stauffer asserts that integrating the body into psychotherapy can add immeasurable depth to a therapist's practice

Most psychotherapists accept the notion that the human soul is embodied – that is, it is not a purely spiritual and non-material entity but dwells in, and is shaped by (and sometimes limited by), a living human body. Moreover, it is enmeshed with this body to the extent that it is impossible to clearly separate the two. Indeed, attempts to do this invariably lead to an artificial fragmentation of our experience. But what does the unity of body and soul mean for the practice of psychotherapy? Does it have implications? Is there anything to gain if we attempt to depart from the traditional Cartesian mind–body dualism and towards a more holistic view of people?

Clinically effective

It seems to me that there is no straightforward answer to these questions. Undoubtedly, psychotherapy has been going for more than 100 years without paying much attention to the body and it has been pretty successful on the whole. It is also true that many approaches that involve the body in some way turn out to be clinically effective. I am thinking in particular of the various approaches to working with trauma such as EMDR or EFT that have become quite widespread (Shapiro, 2001; Mollon, 2008). We also find practitioners who use their own bodies as a sounding board to add complexity and accuracy to their countertransference responses (Orbach, 2000; Soth, 2006). Many therapists place value on cathartic techniques such as those developed in bioenergetics (Lowen, 1994), and the popular approach of Family Constellations makes use of body sensations (Hellinger, Weber et al, 1998). There are many more examples that could be quoted here.

Some colleagues might make a distinction between approaches that rely on body sensation only, such as those used by many mindfulness-based and psychospiritual approaches, and those that use more active physical interventions such as exercises, massage or other forms of touch. Some of these approaches treat the body as a tool; others include a conceptual framework that attempts to formulate a holistic view of the human organism.

Psychotherapy and neurobiology

Clearly certain aspects of the study of the human body have a great fascination for psychotherapists. In particular, there has been tremendous interest in recent years in neuroscience. Many excellent theorists have attempted to marry psychotherapy with neurobiology (Schore, 1994; Kandel, 1998; Cozolino, 2002; Etkin, Pittenge et al, 2005; Wilkinson, 2006; Hart, 2008). I have reservations about this project. If I were to rely too heavily on these rather objectifying speculations about what might be happening in my client's brain, I would be in danger of losing sight of the subjective experience of the person sitting opposite me. The resulting loss of empathy would surely diminish the quality of my therapeutic work. Finding a narrative of what is happening in my client's brain is probably a useful therapeutic intervention in some situations, but generally I feel it is much more my job to get a sense of what it is like to be them. I have commented on this point extensively elsewhere (Stauffer, 2008, 2009). However, there is no doubt that neuroscience provides us with many valuable images, metaphors and insights into the many possibilities for mental and emotional functioning that we may come across (Carroll, 2003).

I would now like to summarise some of the ways in which we could think about

“The ‘basic fault’ between my experience of myself on a sensory and emotional level and the image I have of myself in my mind’s eye is real and cannot be readily bridged”

the relationship between body and mind in therapeutically useful ways. The most important principle for the relationship between body and soul was formulated by Wilhelm Reich (1972/1933), who originally phrased it as a ‘functional identity’ between a person's habitual ego defences and their habitual muscle tension patterns. Both could be seen as arising out of an impulse that was thwarted and which therefore had given rise to undischarged energy, experienced as anxiety. Both ego defences and muscle tension served to contain this anxiety and in such a way that there was a partial gratification of the original impulse. Both thus represented a true neurotic compromise, defending against a need while simultaneously partly gratifying it, and all the time decreasing the anxiety produced by the associated conflict.

The principle of functional identity

On further exploration, we find that we can use this principle of functional identity to think about all physiological systems: we can always propose a functional identity at the level of psychological functioning. Body and soul are two different aspects of the human organism and they describe, in the end, the same phenomenon. Their perspectives are different, and the words are different, and the focus of the

experience is on a different level, but the underlying reality is the same. Whether I describe a process of restructuring in my brain or an experience of insight, it relates to the same event.

Keeping this principle in mind, I will describe some of the ways in which I might 'map' bodily experience onto emotional experience and vice versa. First, I can view the physical events in my body as the ground on which my emotional experience rests. From that point of view, I would say that both mind and soul are emergent properties of the complex dynamic system that is my living body (Carroll, 2003). In this way of thinking, I am ascribing a sort of primacy to the bodily aspects of my experience and I could be excused for stating that, unless I attend to my body and its sensations first of all, I will not be able to attain wholeness.

Second, I can think of my physical experience as an aspect of the totality of my experience. This view puts both aspects of experience on a level but makes it clear that both are necessary to complement each other and to form a whole. What we can say is that bodywork, used in this way, is a very powerful technique for accessing a more unified experience and for amplifying feelings, images and fantasies (Eiden, 1998). Equally, in this view, the body turns out to be an extremely valuable resource for containing feelings that might otherwise overwhelm our normal ego functioning, as for instance in states of shock and trauma.

Symbolising the experience of the soul

Third, I can use my body as a tool for symbolising the experience of my soul. This could be seen as deviating from a fully holistic understanding of human beings, as it relegates the body to something that is to be used. However, it is very easy and very commonly done, and often therapeutically extremely fruitful. Part of what makes it so easy to do is that our everyday language is

“ I have experienced the integration between body and soul as a difficult therapeutic process ”

“ Bodywork is a powerful technique for accessing a more unified experience and for amplifying feelings, images and fantasies ”

so full of colourful physical metaphors. Starting from these, we can easily amplify and develop meaningful narratives of our experience, narratives that resonate with our soul (Ferrucci, 1982; Landale, 2002). Such narratives can, of course, be more or less accurate in terms of the biological processes that actually go on in our bodies. I may add that using images derived from neuroscience probably works pretty much in the same way.

Whichever of these approaches we use for bringing together body and mind, in the end we will have to undergo a process of integration, a process of putting things together that don't 'fit' in a straightforward manner. It is not just a question of completing a jigsaw puzzle, of slotting bits of information into pre-existing gaps: the 'basic fault' between my experience of myself on a sensory and emotional level and the image I have of myself in my mind's eye is real and cannot be readily bridged. Personally, I have experienced the integration between body and soul as a difficult therapeutic process, which has included stages of being stuck, sitting with conflicts and dilemmas, banging my head against various brick walls, retelling the same story over and over again, and generally being quite uncomfortable, until eventually I become – by sheer grace – able to see myself from a different point of view that includes the original two perspectives and also transcends them, as described in Ken Wilber's elegant description of nested hierarchical systems (Wilber, 1996).

It is here that I see the biggest potential gain for psychotherapy but at the same time its greatest difficulty: the integration of the body into psychotherapy is a long and often painful process that results in greater maturity, and greater embodiment, for the therapists who have gone through it, and adds immeasurable depth to their practice. **P**

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Somatic integration to systemic therapy

Anita Ribeiro-Blanchard presents aspects of the systemic nature of somatic processes, which validate a systemic use of body-oriented interventions

Continuing its tradition of delivering innovative treatments to improve the wellbeing of individuals and their families, systems therapy has been gradually integrating body-oriented interventions into practice. There are inspiring works, such as the developmental play therapy of Viola Brody tailored to adoptive and foster carers and their children and the school system; the body psychotherapy of Maria Gonçalves with institutionalised children and their carers; and Ian Macnaughton's body-oriented interventions in family therapy with couples.

Body-oriented interventions

This article presents aspects of the systemic nature of somatic processes to validate a systemic use of body-oriented interventions. Neuropsychological and neuroscientific studies provide substantial support for this idea, for example: Damasio's research on the somatic interweaving of emotions, feelings and reasoning; Siegel on the neurobiology of interpersonal



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experience; Gallese on embodied simulation and shared circuits (mirror neurons) and their function in relationships; and Herbert on complex trauma and its somatic interlock.

Clinically, there has always been a demand for the inclusion of somatic work in systemic therapy. Disorders such as self-harming, anxiety, panic, depression, attachment and PTSD all have extensive impact in the client's organism. Furthermore, the intensity of physical symptoms in these disorders renders clients powerless and vulnerable and with a weakened ego that feels unable to cope.

Symptoms are frequently dealt with through medication because their impact can prevent verbal therapy from producing changes. This only serves to show the dominant position that can be played by the somatic aspect if it is not treated as an inseparable aspect of the psyche. It can be not just part of the problem but also *part of its solution*.

The embodiment of a family

Symptoms, however, are just one aspect of the psyche-soma relationship. In families, relationship patterns are interdependent and maintained by complex somatic dynamics, which include conscious and unconscious bodily relations. These bodily relations constitute the embodiment of a family: a dynamic entity or field in which conscious and unconscious bodily information is gathered and accessed by its members. It is constantly adjusting and regulating itself – a mother's depression will trigger siblings to quarrel to bring her back into action, with the purpose of keeping the system running, providing containment and nourishment for each family member's needs.

Understanding the somatic basis that sustains a family's repertoire

“There has always been a demand for the inclusion of somatic work in systemic therapy”

of engagement allows for systemic interventions on multidimensional levels: physical/behavioural, emotional, cognitive, and interpersonal. Body-oriented interventions in the form of movement, breath, body awareness, touch, sensing, etc bring new and effective resources and broaden clients' awareness of the essential nature of family relationships – that primarily rooted in the body. Most important, they bring depth and greater intimacy to family life, enhancing mutual trust at a deeper level.

Integrating the shadow

This deeper level refers to overcoming shame and integrating the shadow associated with bodily things, especially in small systems such as families in which members are perceived as witnesses to – if not judges of – one another's mistakes and vulnerabilities. Jung states that the body is a taboo because there are too many things about it that cannot be mentioned; therefore, it often personifies the shadow of the ego.

Furthermore, dysfunctional families are the place in which the body is hurt, abused and exploited, and there is need for healing and integration. Angelo Gaiarsa, a bioenergetic psychiatrist, describes the family as the most dangerous place in the world. Again, Jung suggests that integration of the shadow (body) is necessary in order to facilitate healing and proposes that, instead of getting rid of the shadow, one should learn how to live with it.

Including the body in healthy ways not only decreases fear and shame associated with its instinctual life but also establishes new references of appropriate interactions and boundaries, enabling individuals to have their needs met at all levels, strengthening the ego, expanding confidence to relate within systems.

Embodied relationships

Several aspects of the embodiment of family relationships contribute to sustaining adaptive or maladaptive patterns. Some of these aspects work at conscious or explicit levels, such as behavioural repertoires of physical gratification and punishment, body language, postural and visceral tensions and stress, our daily routine (or the things we do to care for ourselves on a daily basis). Other aspects engage family clients in unconscious or subliminal processes, such as the exchanges between two or more autonomic nervous systems, neuroendocrine and chemical communications, embodied simulation (mirror neurons), somatic transference and countertransference. Other non-verbal exchanges include symbolic aspects and even subtler levels of interactions. I will briefly address these levels within the scope of this article.

Somatic cues

A five-year old client drew all her family members in a picture, placing a floating oval form with eyes between her parents. She explained that the floating form was 'a ghost'. The girl's mother had recently learnt about her husband's love affair, an issue that both parents protectively hid from their children. Whether the ghost represented the tension between her parents or the sensing of another person's energy in the family field, the fact is that the parents' problem was felt as a presence. According to Jung and Bentzen, the developing ego of a child is essentially a bodily ego, apprehending the world through bodily sensations and interactions with inner and outer environments. Thus, children are sensitive to somatic cues – also intuited through mirror neurons, the subliminal mechanism of shared experiences and empathy.

At the conscious level, symptoms are the result of an imbalance in the individual's organism. But they also function at the unconscious level: symptoms may be a perverted (unintentional) attempt to

“The contemporary family system is faced with numerous challenges”

have one's needs met or a disruption in normal development to make a statement about the family's affairs. The language of the body is sensations, images, emotions, feelings and thoughts, and its communication can be understood if individuals notice bodily sensations–experiences–feelings, attuning to oneself at the somatic level. If not acknowledged, it may escalate to a symptom.

Reconnection with bodily feelings

A six-year old client was brought to therapy for aggressive and defiant behaviours. Play and art therapy produced poor results, as he was very guarded. In session, his mother displayed little emotional resonance and wanted a quick fix. However, the boy agreed to receive gentle bodywork, which his mother would learn and use with him at home. Usually, I invite parents to observe, as a way of engaging them at subliminal and unconscious somatic levels and to have a chance to restore the child's self-regulation first. After the bodywork, the child appeared relaxed and drew a road with a rainbow to the right, a slug to the left and in the middle foreground a butterfly with its right wing shaded. He explained that the butterfly's shaded wing was broken. His family had suffered drastic changes in the previous year, first a divorce, then a new family and four stepsisters. Bodywork reconnected him with his bodily feelings and from that experiential basis emerged a profound and poetic symbol that best integrated his broken sense of self. This process of re-establishing communication with the body helps modulate emotions and is in itself healing.

Somatic transference and countertransference are in the background of the intersubjective field formed in relationships. In this domain, previous relationships interfere with new relationships and adjustments: an assertive stepfather may bring out anxious behaviours in a child who has had a previous experience with an abusive father. This reaction may shape their interactions on a negative basis and the stepfather may withdraw, unable to tolerate the child's

anxiety. Body-oriented interventions could facilitate new patterns of interaction, as well as giving permission to the child to self-regulate in the presence of others.

A biological clock chart

The subliminal communication that occurs at neuroendocrine levels orchestrates more or less intensely different life stages and at neurochemical levels produces adjustments (entrainment) among family members. For instance, at some point, teenagers and their parents will be represented by opposite curves in a biological clock chart: one curve is moving towards sexual maturity, another towards declining hormonal levels. These intense adjustments cause frantic ups and downs in mood and stress in families. Conversely, cases of affective deregulation impacting the neuroendocrine system are well known in psychosomatics.

The autonomic nervous system is the systemic mediator. It regulates the functioning of vital organs and involuntary functions, co-ordinating rhythms and cycles, and instinctual responses for survival and self-preservation. It has a collective basis, which explains how a stressed parent can throw the whole family out of its state of homeostasis without saying a word. As Jung explained, it also provides the somatic basis for sensing others' innermost life and exerts an inner effect upon them without the mediation of cognitive processes. The ANS rules the self-regulation mechanisms that maintain the organism's optimum levels of functioning. This is the reason why self-regulation could serve as a definition of health. Jung identified that both psyche and soma have self-regulating capabilities that can be overridden by a person's will. A chronically deregulated organism results in stress, maladaptive patterns and eventually neurosis.

The ideas of affect regulation, modulation of emotions, dyadic regulation, etc have a somatic basis to them and were conceptualised from the innate and autonomous mechanisms of self-regulation of the body. The dyadic (mother–baby) regulation occurs through appropriate physical and behavioural interactions to meet each other's needs. From these early experiences, which are essentially bodily experiences, individuals learn to tolerate frustration, to feel safe and loved and to regulate emotions and the mind.

Implications for clinical practice

The contemporary family system is faced with numerous challenges, such as early childcare placement, divorce(s), short-lived relationships, domestic violence, sexual and physical abuse, drugs, blended families, immigration, unsafe neighbourhoods, excessive virtual time, etc. These circumstances, at times intergenerational, make it difficult to provide consistent and sufficient experiences of dyadic regulation in childhood, and consequently the individual's self-regulating ability is compromised (chronically deregulated).

Many children and adolescents with mental health problems have never had consistent experiences of dyadic regulation, self-regulation or feeling safe, and they live in a chronic state of hyper-vigilance, anxiety or depression. Furthermore, many have never experienced being regulated and relaxed in the presence of others – a frightening possibility to them – and systemic engagement sets them off. They learn how to self-distract and dissociate and they reach out for meaningful contacts through bullying and aggression. The use of body-oriented interventions can provide corrective

experiences of physical and (consequently) emotional regulation, which are the necessary conditions for developing adaptive thoughts.

The core method

In Brazil, I learnt and practised Petho Sandor's method, Calatonia and subtle touch, a combination of non-invasive body-oriented interventions and Jungian psychology. It focuses on restoring the client's self-regulation capacity, on gradual development of body awareness and dissolving of maladaptive somatic patterns. It also involves the use of passive movements, breathing, vibration of specific points of the body, use of sounds, and education and coaching for self-regulation. To this core method I have added and integrated several other non-invasive techniques and exercises from other schools.

Later, in the USA, I worked as a systemic psychotherapist treating severely emotionally disturbed children, adolescents and their carers. They had histories of neglect, abuse, attachment problems and were in foster care or residential programmes. There I treated several groups of siblings, both individually and in sibling

sessions. Their poor repertoire of techniques for making interpersonal contact consisted of a mixture of abusive or passive-aggressive interactions, teasing and bullying or excessive neediness that made any form of contact unbearable or unsafe.

I adapted body-oriented play (non-invasive touch and/or movements structured in defined sequences) for sibling groups, to reorganise their interactions and modulate affect in a safe way; in individual sessions, I worked on dyadic regulation. This also included working with carers and children in session, to transfer dyadic regulation to them.

This work evolved to somatic systemic therapy with families in private practice, in particular to treat early or developmental trauma. It has also proved very effective with families with attachment issues, allowing the child(ren) to take the lead in modulating the intensity and frequency as part of restoring dyadic and self-regulation. **P**

References

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Promotion of health and biodynamic psychotherapy

Dr Elya Steinberg asserts that, by integrating all human dimensions, biodynamic psychotherapy promotes the restoration of health as advocated by WHO

In biodynamic psychotherapy, we emphasise the importance of an integrated approach to promoting health that brings mind, emotion, body and spirit into a deeper connection and reawakens wellbeing. Health is defined by the World Health Organization (WHO) as: 'A state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity. Health is a resource for everyday life, not the object of living. It is a positive concept emphasizing social and personal resources as well as physical capabilities' (WHO, 1986). WHO also suggests that health promotion is 'the process of enabling people to increase control over and to improve their health'.



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Dualistic thinking

In the 1930s, the idea that there is an emotional base to somatic diseases was revolutionary. Today, the concept is holding us back (Antonovsky, 1998). Its very existence suggests that there are diseases that have an emotional base and there are diseases that do not. The term 'psychosomatic illness' supports dualistic thinking and prevents us from understanding that all forms of human suffering happen to a complex organism, that every disease has a psychological aspect and a somatic aspect (as well as spiritual, social, ecological and political aspects).

The search towards health has brought me to Professor Aaron Antonovsky's concept of 'salutogenesis' (Antonovsky, 1979). Antonovsky stated that disease and stress occur everywhere and all the time and it was surprising that organisms were able to survive with this constant mass exposure. His conclusion was that chaos and stress were part of life and natural conditions. The interesting question that came to his mind was: how come we can survive in spite of all this? In his world health is relative on a continuum and the most important research question is what causes health (salutogenesis) not what are the reasons for disease (pathogenesis) (Lindstrom and Eriksson, 2006).

The re-establishment of health

Biodynamic psychotherapy provides a model of integration of non-verbal communication and verbal communication, based on acceptance of intrinsic affective and physiological states and their communication explicitly and implicitly through appropriate active contact between minds, spirits and bodies in every degree of intimacy as a frame of work. This model promotes salutogenesis, the re-establishment of health.

Gerda Boyesen's (1972–1976, 1980, 2001) analytical observation of the healthy and unique nucleus of a person in its physical, mental and spiritual aspects looked towards new theoretical horizons. In biodynamic psychotherapy, the objective is not only to help alleviate and decrease physical and emotional pain and suffering. It also aims to promote health by enabling pleasure and inner happiness through the development of innate personal potentials present in every person, the subjective truth and the finding of one's personal vision, meaning and sense of agency, thus supporting a sense of coherence in oneself.

Gerda Boyesen named the approach biodynamic psychotherapy because of the dynamic integration of the biology and the psychology of the person through the therapeutic process. The uniqueness of biodynamic psychotherapy comes from the use of body psychotherapy techniques guided by certain philosophical principles. The three main tools are biodynamic massage, rooted talking and vegetotherapy. These methods are used by biodynamic practitioners as pillars to promote natural movement towards health. This idea has recently received support from natural science, which recognises an innate capacity for physiological as well as emotional

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regulation (van der Kolk, 1996; McEwen, 1998; Schore, 1994, 2003a,b; Ogden, 2006; Fonagy, 2004; Phillips, 2008; Yehuda, 1991, 1993, 1995, 2009).

Multidimensional levels

Biodynamic psychotherapy relates to a multidimensional level of subjective experience and phenomenology at any given moment. In biodynamic psychotherapy, this phenomenology contains the non-verbal experience and crosses the boundaries of spoken language. It relates to the innate 'communicative musicality' (Trevarthen, 2004, 2005, 2009), to rhythm and prosody, to voluntary and involuntary movement manifested in micro-movement and macro-movement, to breath, to the position of the body, to the ability to move and the quality of the movement, to external and internal signs and symptoms of the autonomic nervous system, to echoing sympathetically with the other and the ability to use mirror neurons and adaptive oscillators.

We have learned from current neuroscience and psychotherapy (Van der Kolk, 1996, 2006) that most experiences are automatically processed on a subcortical level, that is, by unconscious interpretation that takes place outside awareness. Insights and understanding have only limited influence on the operation of these subcortical processes when addressing the problems of traumatised people, who, in a myriad of ways, continue to react to current experience as a replay of the past. There is a need for therapeutic methods like biodynamic psychotherapy that do not depend exclusively on understanding and cognition but on perception of self through body awareness and the physiological ability of the body to process and regulate stress and emotions.

Inner resources and resilience

During a biodynamic psychotherapy session, we explore traumatic responses of the past at different developmental levels. Traumatic memories are often dissociated

and may be inaccessible to verbal recall or processing. Therefore, in biodynamic body psychotherapy, close attention is paid to the development of inner resources and resilience to deal with dysregulation and helplessness, as well as to careful timing of the exploration and processing of the traumatic past and present. For example, in such a session, we may support integration of sensory input with motoric output to enable effective movement and action in perceived life-threatening situations, rather than being trapped in helplessness and hypoarousal states. Or we might help to find an internal framework which enables self-regulation of the hyperaroused state on a bodily level using, for instance, biodynamic massage as a means of stimulating the parasympathetic nervous system and working towards physiological equilibrium, as well as translation of the experience into communicable, verbal language.

Biodynamic psychotherapy is a comprehensive method, which looks at the broad spectrum of health, resilience, healing and hope along with careful examination of the pathogenesis. It has added the dimension of the body to the therapeutic discourse. It stresses the spiritual dimension in addition to the physical dimension, the importance of movement as well as the spoken word. This integration of all human dimensions promotes the restoration of health as defined by WHO. [P](#)

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Levels of consciousness and contact in biodynamic psychotherapy

Clover Southwell explains how biodynamic body psychotherapy works with varying forms of therapeutic interaction across a range of levels of consciousness, both interpersonal and intrapsychic

Biodynamic psychotherapists work in a variety of physical positions, each suitable for a different kind and level of interaction and each furthering in the client different levels of consciousness and exploration. Whether we are working with words, touch or in silence, we are reaching to the whole person and expecting our work to affect body and psyche together.

1. Client and therapist sitting face to face This is the most natural position for interpersonal work – for reflection, making sense of experience, drawing things together. In this position, the work will be mainly at the conscious level, but it will also integrate what has been emerging from the unconscious. At certain junctures the therapist may draw a client's attention to how they are sitting, their breathing or body sensation, so that they have a felt experience of themselves as they speak ('rooted talking').

2. Therapist and client standing up This is a position of assertion and mobility. Allowing free movement in the room, it gives the client the chance – literally – to determine their distance from therapist and to 'hold

their ground'. Work in this position evokes the client's will and intention; it supports a sense of agency, of being in charge.

3. Client lying on mattress, therapist sitting alongside Their respective eyelines do not meet, so the client can relax deeply, allowing their eyes to close with no sense of rudely shutting the therapist out. This position is ideal for working at a deep, intrapsychic level (biodynamic vegetotherapy).

In the three positions above, the client engages in an active process of exploration.

4. Client lying on massage table, therapist works standing Various forms of biodynamic massage support the therapeutic process in specific ways, developing more sense of structure and containment (see 'building up' below) or enabling the client to become more sensitive to their own inner world ('opening up'). The touch may seem light, but the work will set off cascades of change through all levels of a person's being, affecting their mood and their dreams for days afterwards. To see biodynamic massage as 'bodywork' is to miss its essence. Depending on the client's earlier experiences of touch – caring or abusive – the massage may bring pleasure or anxiety. Some clients will experience the massage on an intensely interpersonal level, staying alert throughout the session to monitor what the therapist is doing to them. Another might drift off into a wonder world of fleeting images, ungraspable yet deeply enriching.

My position in relation to my client on the psychological level will also vary. How closely am I following – aligned with – my client's point of view? Is my client currently revisiting an early symbiotic stage, where close attunement can be vitally reparative? What have I in mind? Am I feeling and

thinking transferentially? What am I observing, looking and listening for? How separate am I from my client? At what distance? How explicit are my boundaries? Is my consciousness broader than my clinical thought?

As a client appears for a session, I ask myself, is this person likely to benefit more today from opening up or from building up? By 'opening up' I mean deepening the client's capacity for feeling, broadening their vision, opening unconscious layers. By 'building up' I mean furthering a client's capacity to feel 'on top of the situation' and to deal better with their life and feelings. This means strengthening their emotional equilibrium and motoric ego, both of which have biological aspects. Such an agenda will underlie the session but is not a template for the work, which arises from what the client brings.

Building up

A client easily overwhelmed by ineffectual emotional energy needs to build up emotional equilibrium. They are very aroused, they take rapid little gulps of breath and they may be sniffing back tears. This only winds them up more. They are suspended in a no-man's land above their feelings. We suggest they blow their nose, so they aren't holding back fluid by distorting breath. We ask them to 'let the breath just come easily'. If they manage that, it has a settling effect and can be a step towards detaching from addiction to arousal. When they resume talking, it will probably be on a very different level and about something more essential.

To build up the motoric ego in clients who cannot say no, who find it hard to make decisions, who doubt they have the right to choose, we may suggest making the issue concrete in the room. The client stands.



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We help them develop a consciously felt connection with the ground. They explore how it is to – literally – ‘stand up for myself’. They get a feel for ‘putting my foot down’. Practising this vis-à-vis the therapist, who may represent a parent in the past or someone in their life now, brings to light developmental and transference issues which we may then explore verbally, back in our chairs. Typically, it will be the client who does most of the talking, finding their own way to their own truth, with minimum intervention.

Opening up

On the other hand, we sometimes have an opposite intention, wanting to help the client open up to their inner sensations, thoughts, images and feelings. With ‘stoned’, armoured clients we may first use some form of biodynamic massage to help them feel their body and what is moving inside. Then they can better reach into their inner world, to uncover elements of themselves that they have hidden, disallowed, suppressed or not developed.

For this active exploration, the client lies on the mattress and we invite them to be aware of their sensations. ‘Feel your body – let it breathe – see how far down inside you feel the breathing’ (biodynamic vegetotherapy). Gradually they sink into awareness of their inner world, defences soften, allowing little stirrings to arise within. This ‘dynamic updrift’ may come in the form of sensations, emotions, memories, images or something less definable. They may report what is happening, or they may not.

The client is entering the uncharted ocean of the unknown. For some this is an adventure; for others it feels like a risk. The client’s trust in the therapist is crucial, allowing them to ‘forget’ the therapist while following a path of discovery. The connection between therapist and client is like the rope of an anchor. As the therapist speaks or moves, the client feels the connection like a little tug on the rope. Adjusting the length of the rope is a therapeutic art. When the therapist gives a longer rope, the client feels greater space and freedom. A shorter rope gives more sense of security, as well as more guidance.

Observing the silent client, we might soon see the breath get calmer and lighter. This suggests that the client may have shifted to another level of consciousness, where to shape the experience into words would be a huge effort, and break the journey. With

“The connection between therapist and client is like the rope of an anchor”

more silence comes more spaciousness. Thirty minutes can pass without a word. The client may be moving towards a state of consciousness where time no longer counts, and two minutes by the clock feels like eternity. Eventually, they will ‘come back’, perhaps with some small movement, opening their eyes, and having a luxurious stretch. Even then, will it be appropriate to speak? A delicate question. The client has been in a silent world and should move out of it in their own time. Language may not have words that fit, so talking now could reduce the experience to match the words available.

Temporary regression

Vegetotherapy sessions can develop in a very different direction. Lying on the mattress the client settles into themselves. As before, the ‘dynamic updrift’ from their inner world begins to impinge, but now appears as signs of restlessness such as a slight twitching of the right hand. We invite the client to ‘feel the movement’ and then to ‘let it get stronger’. We are using non-personal language forms. As yet, the hand movement means nothing to the client. If we ask ‘What are you doing with your hand?’ they might stop the movement: the ego-mind filtering out what it cannot make sense of, censoring what it cannot allow.

Now the movement grows stronger and comes into focus as an emotional gesture, perhaps of disappointment or clutching at something. We ask the client to feel what age they are – ‘quite young’ – and then to feel, in this age-state, where they are and who is with them. We are now moving from ‘it’ towards ‘I’. ‘Talk to that person, tell them how you – this child – are truly feeling.’ As the client speaks out their truth, they feel it in their adult body, more and more. Soon they are past the regression, coming home to themselves, reclaiming a silenced aspect of their intrinsic potential. Such work requires the client to stay aware of their adult here-and-now self, while at the same time casting themselves into the regressive experience.

We adjust our language forms according to the level of consciousness we want to

engage. By deliberately postponing the ‘I’ level at certain stages of the session, we can move with almost imperceptible shifts through the borderland where ‘it’ and ‘I’ run into each other like colours of paint. Involuntary runs into voluntary, unconscious into conscious, and we are working seamlessly with ‘mind’ and ‘body’ as one. When we question or confront, this will be at moments when the client is in their here-and-now consciousness. When something is just tentatively emerging from the core, a question could give a deep biological shock. Just as a toddler is clumsy as he tries to pour juice into his mug, so the undeveloped individuality of an adult, particularly if they have repressed a lot of emotional feeling and behaviour, may be both shy and clumsy as it pushes up towards manifestation. A question would speak to the wrong part of the brain.

The dynamic of the therapy

As I see it, each individual from conception on has a unique potential, and this potential is ultimately more significant than pathology. We hold the vision of our client’s unique and as yet unrealised potential, what some call the person’s essence. Our sense of this person’s potential cannot be a precise one. We simply know that far more is possible than has yet become manifest in this person. Their intrinsic biodynamic grows physically into their particular human shape and realises and fulfils their true self: mentally, personally, spiritually. We work in alliance with this intrinsic dynamic, which is also, in the basic sense of the word, psychodynamic. It is the motor of the therapy.

Our therapeutic relationship is its containing membrane of the therapy. At different points in the process, our presence may be that of a counsellor, parent, reliever of pain or guide to the unconscious underworld, as the client awakens to aspects of themselves they had lost touch with and begins to reclaim them and develop them into mature form. Whatever else may be happening at a more interpersonal level, we want to sustain connection with our client’s deepest source. Like a constant bass note sounding beneath everything else, this energy level will underpin and infuse the whole session. It generates and sustains the therapeutic process. Somewhat like the pull of a magnet, this energy in the therapy room seems progressively to draw forth the inner being of the client to manifest and express itself. **P**

Flight path

Claire Entwistle explains how a chance encounter with two osteopaths in a health food shop led to a rewarding professional alliance

The queue in the health food shop was so long that the customers started talking to each other and I got into conversation with two local osteopaths. Soon we were comparing notes about our work. I was interested to hear they used traditional methods alongside cranialsacral work and they were intrigued by the idea of using talking psychotherapy and touch together. Both said they had patients who would benefit from this approach. Before we reached the front of the queue we had exchanged business cards and agreed that they would refer patients to me when it seemed appropriate.

I am not trained to work like this

That was three years ago and a referral comes through every few months. Clients fall broadly into two types. Some are referred because their chronic pain, stress or misalignment has not responded well to osteopathy and the practitioner feels that the client's inability to 'unwind', to

use their term, is due to 'layers' of intense, unexpressed emotions. Others are referred because they need more emotional support than the osteopath can give. Cranialsacral work is very nurturing, very healing, and naturally some clients form strong attachments to the practitioner or want to talk deeply about their problems. Transference, countertransference and projection occur in these relationships, as they do in psychotherapy, and can be overwhelming. 'I'm not trained to work like this,' said one of the osteopaths, phoning one Sunday to ask if I had space for an intensely anxious new client of hers.

We decided to work out the practicalities as we went along and this process has been quite straightforward. The frequency of sessions is negotiated separately with each individual but we both tend to work with the client concurrently, with the client seeing me weekly and the osteopath less frequently. Often the psychotherapy is short term and the osteopathy continues for some time after it finishes, once the client is more open to this work. If everyone agrees that body psychotherapy alone is most appropriate, the osteopathy sessions may finish first. Conferring between us is kept to a minimum, though one of us occasionally asks the client's permission to contact the other. If money is short, we may each offer a reduction for the period the client is seeing us both.

Fear of flying

Suzette came to me after receiving several weeks' cranialsacral treatment, which she found relaxing but not helpful for her severe, frequent headaches. She presented as an independent young woman, adept at dealing with life and containing her feelings. Her health had been excellent until the headaches started a year ago. She seemed highly functional. She lived with her partner, worked as an ITU nurse and regularly visited relatives abroad who relied on her for financial and emotional support.

Suzette explained that she had always disliked the idea of psychotherapy, or 'digging up the past', as she put it. She had come largely because she trusted her osteopath's opinion but also because she had one serious problem – she was terrified of flying. The phobia had started 'out of the blue' the previous year, around the same time as the headaches. Sessions with a specialist counsellor had not helped. With typical courage, Suzette continued to fly for family and work purposes, despite the terrible feelings this entailed.

Suzette made it clear that she wanted to work short term and exclusively on her fear of flying. I agreed to make this our focus, at least initially. We agreed to start by exploring exactly how she experienced the phobia and, hoping to discover what triggered it, how her life was when it started.

A sense of helplessness and doom

Suzette described a sense of helplessness and doom that began the moment she entered the plane, a feeling of being at the mercy of chance and the unknown pilot and crew. She expected disaster every moment of the flight, anticipating the agonising impact, the fall through the air, the moment of death. She described her physical symptoms of fear: increased heart rate, shallow breathing, dizziness.

Suzette's life at the time the phobia started sounded full and enjoyable, though also stressful, with frequent reminders of mortality. In the previous few years, several members of her family abroad had died following accidents or illness, as had patients on her ward. But this kind of stress was familiar to Suzette and she still enjoyed life.

A mixture of talking therapy and touch

We started working with a mixture of talking therapy and touch. Suzette's body was strong and heavily armoured,



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“They used traditional methods alongside cranialsacral work and were intrigued by the idea of using talking psychotherapy and touch together”

especially around her chest, jaw and throat. We gradually broke down a little of the armouring using massage and breathing. Soon Suzette began to talk of her childhood and to feel the sadness, anger and fear that she had not been able to ‘give in to’ at the time. She had been orphaned very young and taken responsibility for her younger brothers and sick grandparents. She acknowledged that she had never felt protected, always relied on herself and did not trust others to behave responsibly or kindly. This seemed to be reflected in her terror of plane crew, or passengers, making some careless or destructive move. She also got in touch with deep resentment at still being the one her family turned to in any crisis.

We worked initially on grounding and creating a ‘safe place’ to which she could return when danger loomed and on establishing stronger boundaries with her somewhat demanding family. Suzette found visualisations helpful, especially an image of an aeroplane that flew supported by extending legs that could walk over land and along the ocean bed. We talked about death and what it would mean to lose her life and, in one sober session, acknowledged that it might be impossible for Suzette, with her experiences, to return to a state of not knowing in her heart that her days were numbered. She could only go on to find a way of living with that knowledge.

So much insight, so little difference

As Suzette allowed herself to experience and express these feelings, her headaches eased. She understood that the phobia might be expressing her insecurity, her lack of trust, her conflicting feelings about taking or losing control. But the phobia persisted. Each time she returned from a trip reporting no change, we both

felt disappointed, and frustrated, that so much insight was making so little difference.

Six months into the therapy, Suzette told me she had suddenly remembered an event that took place shortly before the phobia started. She had spent the night alone in an ancient caravan in a field during a thunderstorm. The bed was a narrow bunk beneath a tiny, storm-battered window. As Suzette climbed into the bunk she noticed a dark mole on her shoulder. She imagined melanoma, secondary cancers, imminent death. The caravan had no mobile phone coverage so she could not follow her impulse to ring her partner. She sat out the night alone, in terror. The next day she felt unable to ‘burden’ her loved ones with her fears but she did see a doctor. After tests, the doctor reassured her the mole was harmless, leaving her relieved but despising herself for having panicked over ‘nothing’. She had put the incident out of her mind until the day before this session but now realised that her next flight had seen the start of the phobia.

Traumatic flashback

As Suzette spoke, she began to re-experience the physical responses she had that night in the caravan. Remembering Babette Rothschild’s work on PTSD, I treated this like a traumatic flashback. We spent the session integrating the thoughts and feelings, past and present, that were associated with that time, especially her feeling that she was powerless and unable to ask for help. As she talked we paid attention to body sensations. Whenever she started to get overwhelmed, we used muscle tensing in her legs to mediate the sensations of panic and suffocation in her chest and throat. We identified her emotions – terror, rage, despair, self-disgust – and the thoughts that went with them, in particular the belief that she had no right to ‘make a fuss’ when under pressure.

That session Suzette made the connection between the sensation of curling up in the uncomfortable bunk beneath the exposed caravan window, and the feeling of being confined in a plane window seat. She thought that the terrible sensations she felt when she sat in a plane must recall her experiences during that forgotten night of solitary dread.

“Both osteopaths and psychotherapists need to allow for the differences in the relationship and expectations”

New insight

Suzette left the session intrigued by her new insight. The following week she arrived late, saying she had nothing in particular to work on. When I asked how she had been after the previous session, she said that she had felt fine and could not recall what we had talked about – was it her cousin’s job application? She had completely forgotten both the recovered memory and our work on it. When I reminded her, the sensations of shock and fear returned and we repeated much of the work from the previous session. The next time we met, she remembered the event clearly while remaining balanced and calm.

At about this time, her osteopath told her that her body was in a much more open state and the cranialsacral work on her tension and headaches became more effective.

The following month Suzette flew to Egypt, and on her return told me she had quite enjoyed the flights, which she had spent listening to music and chatting about her holiday. She decided to stop seeing me soon afterwards, continuing to visit her osteopath when she felt the need. She rang me a year later to let me know the phobia had not returned.

Dramatic change

I found this piece of work fascinating, partly because I found it surprising that an adult should completely forget a significant recent event – twice – and partly because I had never observed at first-hand such a dramatic change following the recovery of a traumatic memory. I wonder whether it was the fact that Suzette was unable to speak about it at the time that drove the event temporarily into her unconscious, and whether her life-disrupting phobia and headaches were created in some unconscious way to bring her into therapy, so that she could express some of her feelings about her traumatic childhood and explore the viability of her self-image

“ Might body psychotherapy alone or talking psychotherapy alone have been equally effective in completing this piece of work? ”

as the ‘strong one’ who always helped others.

I also wonder whether the bodywork was particularly appropriate in helping Suzette to relax her defences enough for the memory to return, and how crucial the osteopathy was to the process. Might body psychotherapy alone or talking psychotherapy alone have been equally effective in completing this piece of work? Impossible to say. But it is true that, for Suzette and others who were referred in the same way, their osteopath’s insight encouraged them towards a type of therapy that they would not otherwise have considered.

Professionals working as a team

The advantages of several professionals working as a team, especially with clients with more serious problems, are well known, and apply in a small way to the one osteopath/one psychotherapist team. If the osteopath feels overwhelmed by a client’s emotional distress, they can suggest the patient take it to psychotherapy. If the psychotherapist is concerned about severe physical pain, immobility and so on, they have the assurance that this will be investigated and treated if necessary. As always, there are potential disadvantages too. Osteopaths usually speak of their ‘patients’, psychotherapists of their ‘clients’. Both need to allow for the differences in the relationship and expectations. The psychotherapist needs to watch out for, and work with, any splitting that might occur. And it is expensive for the client to work with both at the same time.

My chance encounter in the health food shop led to some rewarding therapeutic work that has taught me a lot. It has left me wondering how common this level of co-operation between psychotherapists and alternative health professionals is and what the possibilities are for formalising this kind of alliance. [P](#)

Can it be possible to interrupt the impulse to revenge?

John Waterston has observed revengeful processes in operation to some degree in most of his clients and in himself. This article presents a body psychotherapy approach to this most destructive of impulses

Half the harm that is done in this world is due to people who want to feel important. They don’t mean to do harm but the harm does not interest them. Or they do not see it, or they justify it because they are absorbed in the endless struggle to think well of themselves.

(Eliot, 1950)

Revenge is an irrational act, which Remanates from the human imperative to protect the self from pain. In essence, it is a defensive manoeuvre constructed in order to shield the individual from experiences of impotence, humiliation and grief. It is a ubiquitous phenomenon in the human condition, an enduring historical and literary theme and a source of immeasurable suffering. The

species Homo sapiens is singular in its engagement with revengeful practices – it appears that one of the features of human consciousness is that it begets a self-import which renders this species uniquely vulnerable to narcissistic wounding and hence the vicissitudes of revengeful thought and action.

Revenge is commonly viewed as a form of retaliation, like for like, although not all retaliation is revenge. Retaliation might be strategic, rational and outcome-oriented. For example, the threat or actual execution of force and injury against an aggressor is deterrence, not revenge. The essential character of the retaliation that is revenge is the pursuit of the experience of self-soothing and a re-establishing of psychic and organic equilibrium.

Revenge is not about justice

Acts of revenge are essentially retributive but this may not imply that any offence or wrongdoing has actually taken place, and ‘illegitimate’ grievances can give rise to revenge. Psychotherapeutic case studies appear to be riddled with stories wherein revenge is enacted solely because contemporary events are enough like historical injuries or, more commonly, because contemporary events cause an acute and destabilising mortification of the client’s narcissistic state, thereby triggering the psychic cascade of the revenge scenario.

It is enough for the revenger to *feel* injured for them to set about seeking revenge. Revenge here is wholly irrational, intrapersonal and non-instrumental – its ultimate motivation lies in the vicissitudes



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of psychosomatic equilibrium and not in the realms of justice.

To my mind, revenge is payback for an injury by injury and motivated by the imperative to establish a secure and bearable psychosomatic equilibrium whereas vengeance is retaliation against offence. In terms of process, revenge appropriates massive anxiety from a need to re-establish the integrity of the self-image, particularly in terms of potency, and animates the resources of primitive aggressive, sadistic impulses. On the other hand, vengeance appropriates moral indignation, born of cultural constructs, consequent upon perceptions of injustice or misconduct.

Thus, revenge is a particular kind of retaliation and involves an intended object who is being paid back for an injury for which they are perceived to be responsible. That this locus of responsibility may be transferred onto a substitute object further supports the contention that the primary motive is internal to the revenger. Experience suggests that where the original source of injury is forgotten or unavailable, a substitute will suffice. Revenge therefore can be misdirected but will always involve *paying someone back in order that the psychic discomfort of the revenger is relieved.*

Revenge is a defence for the defences

Before I move towards some understanding of the particular contribution that might be made through body psychotherapy, I would like to make a bridge between the foregoing and the formulation that revenge is intimately concerned with narcissistic equilibrium.

The Montenegrin Serb reactionary Milovan Djilas writes:

Revenge is an overpowering and consuming fire. It flares up and burns away every other thought and emotion. It alone remains, over and above everything else ... vengeance ... was the glow in our eyes, the

“ Carrying out acts of revenge can bring joy, meaning and heightened self-worth to the revenger ”

flame in our cheeks, the pounding in our temples ... vengeance is not hatred, but the wildest, sweetest kind of drunkenness, both for those who must wreak vengeance and for those who wish to be avenged.
(Djilas, 1958)

Clearly, this man is describing a peak experience achieved through acts of revenge. In my terms it is probably correct to say that he is speaking more of vengeance for offences committed, but the ecstatic component, the psychic corollary, clearly proceeds from the element of revenge present. Here is the clue to the beginnings of the psychotherapeutic exploration: carrying out acts of revenge can bring joy, meaning and heightened self-worth to the revenger. In other words, it can transform the individual's internal state from an unendurable state of impotence, humiliation and grief to one of dominion, self-pride and self-possession.

Thoughts and acts of revenge are attempts to ameliorate painful psychosomatic states and this is essentially what differentiates revenge from other kinds of reciprocal acts. While I would not wish to suggest that all who engage in thoughts and acts of revenge are *per se* pathologised by this thesis, I am proposing a strong correlation between *degrees* of narcissism and *degrees* of engagement in revengeful actions. Revenge is solely concerned with influencing intrapsychic events.

The impulse is not a primary drive or instinct but resides at a level immediately adjacent in the realm of what might be called the reflexive psychic response. The impulse owes its existence to the development of the narcissistic elements of the self and, while appropriating the primitive aggressive elements of the id, is essentially an ego defence. Following Freud, Khantzian and Mack (1983) describe this level of function as 'ego instincts', and particularly relate these to relational survival drives and expound on their function as self-preservative and self-soothing. The impulse to revenge might reasonably be located in this realm in consideration of its self-soothing function. To extrapolate further: a narcissistic injury gives rise to an impulse to revenge through generating a cascade of intolerable affect, at the core of which is a feeling of powerlessness and terror. This affective flooding of the

“ Revenge is a ubiquitous phenomenon in the human condition, an enduring historical and literary theme and a source of immeasurable suffering ”

ego causes a devastating fragmentation at the core of the sense of mastery of the self. The impulse to revenge provides the fragmented individual with some comfort in the promise of reconstitution and redemption of self-mortification. Thoughts and actions of revenge seek to achieve this by mobilising primary aggressive drives to control the narcissistic core self. At the same time, it reasserts this control, attempting to re-establish and maintain potency and relational ascendancy in the face of threatened powerlessness over unendurable experiences. Herein is revealed the tragedy so beloved of playwrights and authors: the impulse to revenge is simply a desperate attempt to re-establish the equilibrium of the narcissistic state and thereby ultimately condemns humanity to an eternally circumlocutory pattern of brittle, highly vulnerable, disequilibrium.

The violent evacuation

Bion elaborated on Klein's original conception of projective identification by establishing categories of normal and abnormal projective identification (1959, 1962). He proposed two functions for projective identification: the violent evacuation of an unbearable state and the aggressive forcing of that state into another with the additional intention of intimidating or controlling the other; and to insinuate that state into the other in order to communicate with them about this state.

This process of 'violent evacuation' is precisely what the revenger wishes to achieve. Specifically, the revengeful thoughts and actions are no less than a violent evacuation of defeat (impotence), humiliation, shame and grief. The return of that which has been visited upon us, combined with the omnipotent cognition, is a form of (abnormal) projective identification as evacuation and communication.

Therefore what I am proposing is that, in seeking to defend threats to the narcissistic equilibrium (arising from external reality), the revenge response appropriates all the aggressive and sadistic mechanisms of the narcissistic state and seeks to evacuate back into the external world all the unbearable states of mind and body that would otherwise remain within the subject.

The body psychotherapist, armed with a cognitive analysis and the technical ability to work with the underlying narcissistic state, will also be in a position to attend to the somatic manifestations of this scenario. On observation, it will be found that, prior to action, the revenger will be in a profound state of physical contraction and in the grip of an unbearable, cognitively ill-formed state of anxiety combined with an overwhelming and ill-defined impulse to action. An acute imperative to resolve this state will consume the sufferer's conscious awareness to the exclusion of all else. As these tremendous forces coalesce into an idea they will centre on a single thought – that of not letting them get

“ Instructions and physical promptings to change patterns of breathing, chronic muscular contractions and physical posturing ”

away with it. The awfulness of the state cannot be overstated, particularly as it is commonly found that they have already got away with it and there's nothing that the revenger can do to change this. Similarly, my experience shows that once the cascade has reached this point of thought, the reflex has proceeded to a point of no return and modification is very difficult. Attempts to influence the client at this point through rational argument, or appeals to maturity, will only meet with a 'yes, but ...' response, will frustrate the impulse ('because you don't understand') and the impulse is highly likely to be discharged into the consulting room. At this late stage, there is simply no resource available to the client that may

influence the reflex to a different course.

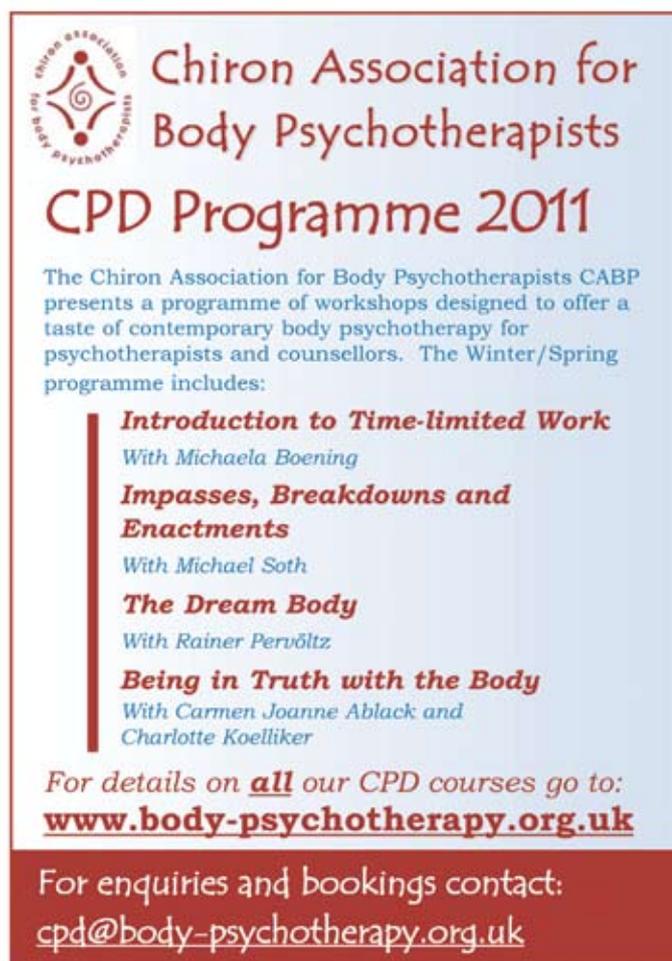
To be held in the grip of an impulse to revenge is a deeply unpleasant experience yet, as I have shown, to evacuate this sensation does little more than re-establish an already fragile narcissistic state and will only leave the individual vulnerable to future breakdowns. It is important to move towards the ability to use the resources of the body to internally process the imperative to evacuation. In essence, this involves a reversal of the

physical reflex to contraction that begins the cascade of internal devastation and ultimately revengeful action. This is most difficult to achieve as it involves 'catching' the reflex at its earliest stages. The process requires a considerable degree of activity on the part of the therapist, involving both interruptions and physical promptings, which may be unusual, or even uncomfortable, for many therapists. Instructions and physical promptings to change patterns of breathing, chronic muscular contractions and physical posturing would be indicated where the therapist watches carefully for the beginnings of the cascade during the narrative of the client. Gross signs can be noticed and commented upon and physical promptings or physical contact may occur to interrupt the cascade. More subtle signs revealed by the autonomic nervous systems moving towards contraction and into the 'pre-evacuation' state may also be attended to and interrupted more subtly by word or deed on the part of the therapist. Such interruptions present the client with the opportunity to directly explore alternatives to evacuation as a means of 'bearing the unbearable' – this is where the analytic and the psychosomatic realms may reconverge in therapeutic intent and practice.

In the chronically entrenched revengeful client the combination of narcissistic imperative and psychosomatic reflex makes for a difficult, at times unattainable, positive therapeutic outcome. However, I have found revengeful processes in operation to some degree in the majority of clients and I feel that the theoretical isolation of the intrapsychic component, together with an understanding of the psychosomatic component, has proved helpful with this most destructive of impulses both in my own struggles and those of my clients. **P**

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Relating through physical touch in contemporary body psychotherapy

For Gill Westland, touch is a central part of communication at all stages of life and the possibility of its inclusion in psychotherapy is vital. While caution should be exercised when using touch with borderline, traumatised or potentially psychotic clients, for some individuals it is the main way to relate

Touch is the foundation of all senses (Montagu, 1971/1986), and it is no surprise that physical contact is at the heart of building and developing the relationship between the mother or father and their infant.

Touch is the first important area of communication between a mother and her new infant. Mothers respond to upset babies by containing them, shutting down on their disturbing motor activity by touching or holding them. By contrast, fathers are more likely to jiggle or rock babies in a playful, rhythmic fashion (Dixon et al). Touch is a message system between the caregiver and the infant – both for quietening and for alerting and arousing. (Brazelton and Cramer, 1991: 61–62)



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The Sterns have described the exquisite touching that the mother does as she gets to know her newborn on the outside for the first time. And when the baby is feeding at the breast, the mother (or perhaps the baby) orchestrates a shifting back and forth between them to maintain the right level of arousal for the feeding to continue 'at a reasonable clip'. Touching, gazing and listening are integral to the dance between them. And the 'highest point of feeling secure, where one experiences a safe haven' comes from a chest-to-chest embrace. 'A baby held in that way faces the world without fear' (Stern and Stern, 1998: 162).

Touch remains a major part of adult communications. Indeed, at times, touch says more than words can convey. Giving a warm embrace conveys love and companionship to the bereaved. It says, 'I am with you', when that is all that can be offered. And in intimate relationships touch speaks to the other of our deepest feelings.

However, many adults have difficulties expressing themselves through touch, although they may not seek psychotherapy. The robust looking person with the limp, clammy handshake is a clichéd example. Deficits, invasions and traumas in early life can impact on the capacity to express emotions through touch and to receive tactile communications.

Touch in psychotherapy

Prior to the development of psychiatry and psychoanalysis, touch and massage were part of the cures offered to the insane and those suffering from 'nerves' (Shorter, 1997). The forefathers of body psychotherapy such as Janet, Ferenczi and Reich used touch in therapy. And it is well known that Freud in his cathartic phase used touch

to elicit memories. Reich spent time in Norway, and while he was there the training psychoanalyst, Braatøy (1954), attended Reich's seminars. Braatøy collaborated with the renowned physiotherapist Aadel Bülow-Hansen, and although he recognised the benefits of abstinence with certain hysterical patients, he also wrote about instances where he hid behind the abstinence rule because of his own fears and was aware of the message this conveyed to the patient. Indirectly, Braatøy has influenced all of UKCP's body psychotherapy organisational members.

Touch is integral to body psychotherapy

Body psychotherapy has retained touch as part of psychotherapy and accordingly has developed considerable expertise in this area. Communicating through touch is a core competency learned by body psychotherapists during training, particularly if they have trained at the London School of Biodynamic Psychotherapy, the Chiron Centre for Body Psychotherapy or the Cambridge Body Psychotherapy Centre. This training is experiential and sits alongside theoretical and ethical considerations. The main vehicles for the exploration of touch are biodynamic massage and vegetotherapy, a 'free association of the body', developed by Reich in the 1920s. This form of touching is more than transferring social modes of touching such as hugs and handshakes to the consulting room. Trainee body psychotherapists also experience touch in their individual psychotherapy. This gives them an in-depth knowledge of their own issues relating to touching and being touched. It also gives confidence in relating through touch and provides the foundations for thinking about and exploring touch

in clinical work. Supervisory relationships support this and deepen understanding.

Clients seeking out body psychotherapy

Many individuals seek out body psychotherapy specifically because it may include touch. These clients know that they have impairments around touch that they want to explore literally, not symbolically. Intuitively, they know that verbal language alone will not resolve the issues encoded bodily. The clinical vignettes given later in this article are composites illustrating touch in body psychotherapy.

In the contractual phase of body psychotherapy, touch is discussed explicitly and agreements made about its use (or not). Touch is multilayered and complex in its meanings and the psychotherapist keeps these in mind, even if they are not always discussed. This way of beginning a psychotherapy relationship is different from other modalities of psychotherapy where touch is for exceptional circumstances or might be used cautiously and 'sparingly'. This understanding of touch opens up a range of therapeutic possibilities not available or indeed hard to imagine in other psychotherapeutic modalities (Westland, 2009b, 2010, forthcoming).

Touch as contact

Therapeutic touch is a learned skill, which becomes embedded over time in the being of the psychotherapist and a major mode of communication. Body psychotherapists consider touch as 'contact' and are taught to use 'contactful touch' (Westland, 2009a).

Jenny's psychotherapist, Elaine, held her hand as she described her painful feelings. They had agreed this to help Jenny to stay present to her experience. However, Jenny felt the 'absence' of Elaine in her touch and knew that she, too, was terrified, and had 'gone'.

This snippet of interaction invites further exploration and is the stuff of body psychotherapy. Was Jenny misreading the touch? Was Elaine out of contact? Did she know it? Could they talk about it? Could Elaine find her way back and become present in her touch? Could Jenny express her feelings? Was Elaine becoming merged with the Jenny's experiences? What happened next?

Contactful touch is a complex, intersubjective interaction. It involves

“This training is experiential and sits alongside theoretical and ethical considerations”

moment-by-moment, here-and-now awareness (mindfulness of sensations, thoughts, images, feelings), accompanied by curiosity to be brought to what is happening in the relationship between client and psychotherapist. The relationship flows back and forth, co-arises in a joint endeavour and, as it unfolds, depends on the presence and intention of the psychotherapist. Contactful touch requires technical skills, expertise in timing, assessing the ambience around the transferences and having some idea of what might be forthcoming on touching or being touched by a client. It is always exploratory and unpredictable, although a skilled therapist may have some inkling of what might arise. The psychotherapist should know how to explore what arises either non-verbally or using a combination of words, touch and perhaps gaze.

Touch is a direct communication

Touch is a direct communication between the client and the psychotherapist. It goes both ways – the client knows the psychotherapist and the psychotherapist knows the client. This direct communication is not always possible to translate into words: touch and verbal language are different forms of communication. Indeed, words cannot express the subtleties of experience, including emotion, and moving to verbal communication can prematurely cut off further exploration of experience. Touch shows the defence system of both client and therapist and the availability for intimacy and contact. It is potent and reveals the relationship in stark concreteness. For this reason, touch, as a form of communication, is threatening to some as it fails to leave enough privacy for client and psychotherapist alike.

I felt safe with my psychotherapist as she was holding me, and told her something that I had not mentioned before. Her words suggested that she was receptive, but I felt her hand startle almost imperceptibly with my revelation.

Body psychotherapy tends to relate more from a 'bottom up' sensorimotor, emotional, experiencing process than from a 'top down'

cognitive process. However, in practice, both modes of access to experience occur. Similarly, contemporary body psychotherapy shifts between more intrapsychic focus and more interpersonal relating and attention to emergent intersubjectivities. Sometimes the 'conversation' in body psychotherapy will be directly via touch with little verbal back up.

Relating through touch

Touch is the choice of interaction with some clients as it creates space away from the intensity of the interpersonal relationship. It can give a way of being in contact with another without the pressure to fend off a supposedly hostile world, which has to be defended against.

As Martha (psychotherapist) speaks, Susan (client) reacts by speaking more rapidly and justifying herself in well-trodden explanations. Susan is hyper-aroused, has quickened chest breathing, and a heightened awareness of every nuance of Martha's being. Martha could sit silently and hold the client energetically and listen until the 'emergency' passes. However, touch is possible with Susan, and Martha decides on this way of going on. The predictable structures of biodynamic massage enable Susan to have brief moments of being with Martha and feeling the human-to-human contact in a low-key way. Her system calms, her breathing deepens, and gentle tears spill and trickle down her cheeks. There is no need for either to say anything.

Susan's mother had apparently been inconsistent, sometimes invasive, sometimes distant, and not able to 'be' with her infant. Intellectual understandings had substituted for authentic emotional meetings between them. Sometimes Martha felt compelled to talk and to comment on the process, but it only interfered and took Susan back to the cognitive level. What was needed was just to be in the immediacy of the moment tracking feelings, thoughts, images and somatic responses.

Touch can also connect emotion and inner sensation to language.

Alex speaks in a monotone about her son. She says something about his dark, unreachable despair. She continues to speak of not cleaning the house, a problem at work, a visit from a friend. Life is a list of problems to deal with. Her sentences seem coherent, but are unintelligible, despite her considerable vocabulary. There are also no

“At times, touch says more than words can convey”

changes in tone or intensity or emphasis as she speaks. Conveying her inner life with its body sensations, emotions or images is a mystery to her and questions or comments about it produce blankness. Alex continues in the same tone of voice. Paul (psychotherapist) instinctively reaches out and takes her hand. It is icy cold and in that moment he recognises Alex's almost frozen terror. Alex takes a breath, and Paul says, 'You are terrified about what your son might do to himself. You think that he might take his own life.' Alex silently nods. This is another small step towards recognising internal sensations and feelings and translating them into word language.

Sometimes touch opens up to spiritual experience.

All artistic and spiritual experience – perhaps everything truly important – can be implicit only: language, in making things explicit, reduces everything to the same worn coinage, and as Nietzsche said, 'makes the uncommon common.'
(Gilchrist, 2009)

Jane recounts her experience after receiving biodynamic massage:

I was vaguely aware of you, but more with myself. I became suffused with feelings of utter peace and joy – I was me, and I knew that you were you – and we were all one with everything – I was in the world – and the world pulsed in all my cells.

Conclusions

Touch is such a central part of communication at all stages of life that the possibility of its inclusion in psychotherapy is vital. However, touch is powerful and should not be undertaken lightly in the therapeutic endeavour. Caution should be exercised with including touch with borderline, traumatised and potentially psychotic clients. Nevertheless, each psychotherapy relationship has its own unique potential and for a trained psychotherapist who is adequately supervised it may be possible to include touch. For some clients it is the main way to relate. **P**

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Please contact the author for a full list of references

The return of the repressed body – not a smooth affair

Michael Soth suggests that therapists who are keen to include the body in their practice should absorb the lessons learned in the development of body psychotherapy over the past 20 years

As valid and urgent the impulse is becoming to (re-)include the body into the predominantly verbal practice of psychotherapy, there is increasing evidence that this project can backfire. Frequently, I am hearing stories about breakdowns in therapeutic relationships following attempts by the therapist to 'work with the body' (Soth, 2002).

The return of the excluded and repressed can never be a smooth affair, and that seems to be true also for the body in psychotherapy. How can we seriously imagine that bringing the body back after 100 years of disembodied 'talking therapies'

is a question of just a few new techniques?

Those modern approaches that would simply have us graft the body back onto established therapeutic practice tend to overlook the long-standing and ingrained conflicts that resulted in it being excluded and repressed in the first place (Soth, 2006a).

A whole paradigm shift is involved. When neuroscience encountered the same questions in the 1990s, such a shift shook the discipline right down to its foundations and basic principles.

What can we learn from neuroscience?

The three sibling disciplines of neuroscience, genetics and psychoanalysis were all born within the *zeitgeist* of the late nineteenth century. Whereas our practice is still deeply embedded in what I call the 'birth trauma' of our profession (Soth, 2006b), neuroscience and genetics have at least partly managed to extricate themselves from the positivist and dualistic assumptions of their origins. Consequently, there is a lot we can learn from how neuroscience has re-envisioned the body-mind relationship.

Body and mind as parallel and mutually correlated processes

Take, for example, this quote from Damasio (2004: 217): 'What is Spinoza's insight then? That mind and body are parallel and mutually correlated processes, mimicking each other at every crossroad, as two faces of the same thing.'

This is a long way away from how psychotherapy is being practised. To this day,



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most of our theories and techniques give primacy to the reflective mind and verbal interaction. As a profession, we do not work as if spontaneous somatic and feeling processes are mutually constitutive with thoughts, beliefs, insights and decisions. We may pay lip-service to Damasio's idea, but when it comes to the nitty-gritty of clients' painful patterns, most therapeutic practice relies on finding solutions, meaning and identity in symbolisation, words and conscious choice over and against supposedly pathological impulses, urges and internal states.

Addiction is fought by insight and will. Panic is reflected upon in terms of its traumatic sources. Compulsion is interpreted for its unconscious drivers. Negative self-images are corrected by rational thought. Uncomfortable feeling states are counteracted or overridden by conscious strategies. Self-destructive patterns are overcome by healthy new choices.

Across the modalities, whatever the psychological problem, the answer is sought in mental understanding, left-brain strategies and verbally communicated content. The implicit assumption is that the avenue towards psychological health leads via the consciousness of the reflective mind, and pathology resides in the irrationality of physical and emotional impulses.

Therapy as right-brain-to-right-brain interaction

The spontaneous, pre-reflexive, non-verbal dance between client and therapist – communicated via the bodies and mediated via the right brains – is going on all along, right under our unsuspecting noses, sometimes supporting, sometimes scuppering our left-brain efforts and intentions. It's just that for a century we have trained ourselves to override the significance of that dance and ignore the overwhelming multitude of non-verbal messages as irrelevant data. In the context of neuroscience's abstract insights (Schore, 2009), it seems profoundly last millennium to continue with this. And so the urgent question arises: how – in actual moment-to-moment psychological practice – do we include the bodies and awareness of the bodies? How do we do justice to the quickfire reciprocity of spontaneous and reflective processes – sensations, feelings, images, thoughts – and the parallel process feedback loops ricocheting throughout

“ How are psychological conflicts embodied, and how does somatic experience structure and shape mental processes? ”

the complex body–mind system? How are psychological conflicts embodied, and how does somatic experience structure and shape mental processes?

Common pitfalls in attempts to re-include the body

Unfortunately, alongside much-needed interest, research and contemplation, these questions have also quickly generated a host of new techniques and simplistic answers, which short-circuit the subjective complexity and conflictedness of the body–mind relationship.

Importing neuroscience wholesale

One tendency, for example, in recognition of neuroscience's groundbreaking input, is to import its objectifying, scientific paradigm wholesale. We then easily end up confusing our clients by incongruously oscillating between contradictory stances of therapist and neuroscientific expert, between relating and instructing, typically switching into 'medical model' interventions in moments of hyperarousal. Often, clients will unconsciously interpret this as the therapist's anxiety, abandoning the pain by taking refuge in practical strategies and manoeuvres.

'Using' the body

Another tendency is to use the body as an alternative avenue or therapeutic vehicle in moments of stuckness or impasse, for example, to circumvent an otherwise insurmountable resistance, as a gratifying shortcut towards reparative nurturing, as a route for accessing primal catharsis, or for somatic psycho-education.

But in all these procedures, what part of me is using what other part of me? Is my body an object? Or is my body me as the subject? Are my body and mind one or two?

You see, both sides are partly true, and partly untrue; partly healthy, partly unhealthy; partly wise, partly unwise.

I can ride roughshod over these apparently abstract subtleties, but *using* the body – for whatever purposes, including therapeutic ones – is liable to exacerbate the ways in which clients *use* their already objectified bodies, out of a fundamental condition of disembodiment (Soth, 2006a).

In this condition, an identity – presumed to be originating in the mind – then decides to use the body for its purposes much in the same way that a man might use a horse.

Ken Wilber puts it neatly: 'I beat it or praise it, I feed it and clean and nurse it when necessary. I urge it on without consulting it and hold it back against its will. When my body-horse is well-behaved I generally ignore it, but when it gets unruly – which is all too often – I pull out the whip to beat it back into reasonable submission.'

There are many disciplines, including bodywork and other complementary and holistic therapies, which helpfully educate the body in terms of posture, breath or movement. While their theories recognise the interplay between body and *psyche*, they are not necessarily capable nor designed to address disembodiment: they do not work psychologically *from* the client's experience of their body as the potential ground for embodied and relational subjectivity – what Winnicott calls 'indwelling of the *psyche* in the soma'.

Mindfulness

Another example is the inclusion of the body in mindfulness practices for therapeutic purposes. While undoubtedly based on precious principles, too often this ends up with therapists instructing a disembodied and defensive ego in the kind of mindfulness which – in the territory of the wounding – the ego is precisely incapable of. Mindfulness – starting from the Buddha's first noble truth of suffering – requires an embracing of the wounding. However, we could argue that, at least unconsciously, clients come to therapy because their ego is chronically and systematically at war with the wounding.

What kind of relationship facilitates 'bodymind integration'?

Both in infant development and in therapy, the 'indwelling of the *psyche* in the soma' or 'bodymind integration' is a function of intersubjective, emotional relating. This requires a delicate dance between mental

and physical awareness, between body and mind as two and as one, between merging and mirroring versus recognition of difference and separateness, between the body as object and the 'felt sense' of emergent subjectivity.

Any approach that takes a fixed therapeutic stance, exclusively identifying with one or the other side of these tensions and failing to stretch across these contradictions and paradoxes, cannot hope to address the wounds and bodymind incongruities at the root of disembodiment. The development or recovery of an organismic or embodied self depends on room for spontaneity as well as mental impositions. Most important, it needs a space and a relationship in which the inherent, pre-existing conflicts can be experienced, felt and addressed.

A prolegomenon to including the body in psychotherapy

As you can gather from the above examples, in my view, we are not quite ready to re-include the body in psychotherapy. Some paradigm-shifting recognitions need to be embraced first.

The client's existing matrix of body-mind relationships

We cannot work *with* the body and embodiment unless we take as our starting point the client's existing body-mind relationship with its characterological patterns of conflict, disembodiment and dissociation. Without recognising the psychological significance of these habitual body-mind patterns (the tensions, 'ripeness' and robustness of the system, its tendencies for defensiveness, hyper-arousal or splitting off), making body-oriented interventions is like giving driving instructions without knowing whether we're driving on a motorway or on hairpin bends in the mountains. It is the psychosomatic landscape of the client's identity, their incarnated life story as present in front of us here and now, which constitutes the context for engaging with the current bodymind state and its charge and relational implications.

Such an understanding would not be difficult to establish throughout the profession, as it can be derived, with some adjustments, from existing theories in body psychotherapy, neuropsychanalysis, process-oriented psychology and others (Johnson, 1994).

Working with the body – a question of techniques?

As psychotherapy has taken decades to recognise, it's not the technique that in and of itself does the work. However, when it comes to including the body, we jettison that precious recognition, and revert to body-based *techniques*. But it's just as true in relation to the bodymind as it is in relation to the *psyche* or the client's subjectivity, that 'it is the relationship that matters'.

When it comes to doing justice to the person in front of us, all techniques, general external guidelines and standards become secondary. It does not matter what is true, what is healthy, what is a good idea in principle. What matters is how it is received by the client's idiosyncratic being; how our input and response are refracted through the lens of *their* particular woundedness; how general truths operate within *their* individual psychology. It does not matter so much what I do, as the therapist. What matters is how it arrives inside the client.

The bodymind sense of the working alliance

To deepen our sense of how it arrives, how the therapist's contribution is received, processed and apprehended, to monitor the state of the relationship beyond the ego-ego left-brain-left-brain alliance, our perception of the bodies – the client's and the therapist's – is essential. The non-verbal and pre-verbal working alliance is a bodymind process, which for most therapists is largely subliminal and unconscious. However, this is not simply a human given; it is a culturally constructed function of the profession's traditional disembodiment. A therapist's own lack of embodiment within the therapeutic position far outweighs in its effect any positive benefits that derive from the use of body-oriented therapeutic techniques.

The more we are attuned to the client's and our own non-verbal, spontaneous reactions and the corresponding ebbs and tides of the working alliance, the more it becomes apparent that there is no therapeutic approach or

technique which is immune against feeding into countertherapeutic dynamics and exacerbating the pre-established psychological conflicts in the client's bodymind system. It is in providing avenues into recognising the phenomenon of enactment as central to the therapeutic relationship that a bodymind perspective can make its greatest contribution to the field (Soth, 2008a).

Learning from 80 years of body psychotherapy

Body psychotherapy has been trying to include the body for the past 80 years, going back to Wilhelm Reich's work in the 1930s. At the Chiron Centre in London we have been struggling with the profound potential as well as the pitfalls and fallacies of that tradition for the past three decades.

Having been part of this coming-of-age process, I have attempted elsewhere (Soth, 2008b) to describe recent developments by distinguishing four phases. However, most readily available published material on body psychotherapy belongs to the first two phases, before the integration of other approaches and what I call the 'relational turn'.

To therapists who are keen to include the body in their practice, I suggest to not simply refer back to the days when body psychotherapy was a young and idealistic discipline but to avail themselves of the often painful and difficult, but ultimately rewarding, learning that has occurred in body psychotherapy in the past 20 years (Soth, 2002, 2005, 2007; Totton 1998). **P**

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Spinning coins, jumping sticks and weaving the web

Carmen Joanne Ablack explores creative process work in integrative body psychotherapy using polarities, conflict and dialogue

‘Ah, well it’s like spinning coins or jumping sticks,’ she said. ‘You just don’t know where you will land or how things will play out.’

She first appeared in a dream when I was about eight or nine years old. For many years I had dreams of her that, as an adult, I was to recognise were shamanic in content. Jumping sticks involves two broomsticks being moved back and forth across the ground; the jumper tries to step in and out without getting hit on the ankle!

Exploring polarities

My heritage includes shamanic and spiritual practices, from Brahmin through to Carib, with slices of French Creole, Bolivian Indian, Celt and African in between. My journey has been steeped in exploring polarities, addressing my conflicted self, engaging in internal and external relational dialogues, and attending to my transpersonal awareness throughout, including training in shamanic and other spiritually based practices.

In *Fiction’s Madness* (2009), Liam Clarke explores, through specific texts, links between madness and literature: ‘Why tell of mental distress through fiction? ... literary narratives might augment



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psychological knowledge and, consistent with current service user involvement, validate the unorthodox against professional ownership of ideas, thus establishing a more democratic, reflective, psychiatry.’

As a client, psychotherapy teacher, trainer, supervisor and practitioner, I draw on literature and other art forms to help me process and understand, and also as tools in the work itself. Embodied experience using art forms, extracts from literature and creating with the client in a shared exploration of the material is important to my work.

Body psychotherapy lends itself well to this. The unspoken invitation of the approach – in your body, with your body, beside your body looking in – gives a validation of unorthodox and professional ownership that extends beyond ideas to a consciously and unconsciously shared energetic and visceral experience of experimentation and knowing.

It seems that the combination of embodied attunement and creative awareness, when it works best, allows client and therapist to discover more about being and the human condition and to understand further both our individual and our co-relational space in this (van Deurzen and Young, 2009). Such understanding leads to identification of polarities, paradoxes, conflicts and a fuller, more meaningful dialogue that supports. I often work with clients in borderline states, post-traumatically stressed and with multiple identity issues. From these states of being and non-being something important can emerge: a kind of knowing through body awareness-based imagining, metaphors and wonderings. It comes before thinking or deliberation; it just is.

The violinist

Anton (not his real name), a concert violinist, came for brief therapy. He felt that his career was based on technical skill and ability only. He finally admitted having never felt the

connection to music he first experienced as a child: ‘its as if something fled the more I practised and perfected my craft’. Tears welled in his eyes and he tried to sniff them away. ‘I’m not really there when I play. I haven’t been there for a long time ... I miss me, Carmen. I just miss me.’ He cried like a ‘banshee’, howling, and finally threw his head back and allowed a full-throated sound to emerge. He literally made the windows of my clinical room rattle.

For a few weeks before this, we had worked on and off with his awareness of his spine and spinal column, an area of the body he used particularly when playing. He mimicked playing Schubert for me, to show me how his body moved; the flexibility and range of spinal movement was phenomenal. When he admitted often having no sense of what he did with his body, it was a surprise. We explored why this might be a good thing in his playing, and why it might not.

Holding polarities

When working with performers, I almost always start at a position that there is a reason they perform the way they do, that it contains something that matters and holds important information for them, holding the polarity of *it is against the polarity of does it need to be this way?* to see what really needs to emerge.

Anton liked a passage we read together in *Job’s Body* by Deane Juhan (1987). He had come across the book on my shelves and asked to look at it. Almost immediately he turned to the end of chapter one, where Juhan writes:

[Working with the body] generating the streams of full and precise sensory information which compose the largest and most concrete part of this self-awareness ... we can facilitate the mending not only of our own bodies, but also of those gaps in our objectified world view – a world view which has led us dangerously far away from our sense of this vital participation in our fates. (page 19)

'That's it,' he shouted. 'That's it ... oh god, yes ... I'm too far away from, um, what did he say? Yes, from my, my own participation, and not just in the music either!'

He started to laugh and then blew me away with his next words: 'It's like I've been a ... a ... a coin ... spinning and spinning and spinning ... And, you know, not coming to rest long enough to see myself.'

'And now?'

'Well, now, I am slowly stopping and feeling, umh ...'

'You're biting your lip, and I notice I tense my belly as you do this.'

'Yeah, I'm not sure, Carmen.' He bit his lip again. 'I suddenly feel like if I don't spin then I have to deal with, um, with not being in constant motion ... I didn't know I was in constant motion!'

'How's your back, your spine as you say this?' Mine was suddenly killing me in my chair; I could feel every vertebrae.

'Funny you ask. I can feel every bit of my spine, it's like it's waking up and yet telling me it's been working too hard. Odd, huh?'

'Is it really odd?'

'Um, more like I'm having to notice how much it hurts. I do the right things for my body but I don't participate fully with it ... That's it, isn't it?'

'What's it Anton?'

'I don't fully participate with my spine, with other things, like the book says?'

'You feel the spinning, the slowing down and the tension in your spine ... some of this is new and some is known?'

I consciously breathed into the different vertebrae of my spine, aware of holding my breath slightly. I lost a sense of exactly where my feet were in the space. I reconnected my own sense of self and allowed this to inform my attention to Anton.

Anton took a huge breath and let it out. He then breathed more deeply than before: 'I'm scared to stop spinning, and I'm excited to stop spinning, and I don't know what it means if I just stop, or do I slow down, or do I stop and start, or ...'

'Ok Anton. I have to tell you my head is beginning to spin with the possibilities, like a constant motion.' Anton nodded and smiled his agreement. 'Given there are all these possibilities, how do you want to explore them with me?'

'I think ... no, I sense (he smiled again), I want to just be with each one for a while. If I let myself feel my spine, I can feel how much, um, energy there is with all this.'

'Yes, I sense energy here with you.'

'Yeah, my potential to participate!' He smiled shyly, and then grinned like a schoolboy.

'Be nice to get to choose for a change, eh, Carmen?'

'I believe so, Anton, it has real possibilities.'

'Yeah ... yeah...'

Clients will often choose books from my shelves to read bits of, look at in sessions or to take away for a while. I have always allowed them to borrow books. One client decided my books, by title alone, were just perfect to represent his family. He explored imagining the text that the title implied for each family member. He sculpted with his body illustrations to go with the text. Greatly freed by this work, he made some vital connections to his own conflicted feelings for each family member.

I am Yalom's book

I really enjoyed the moment a client with multiple identities decided that *The Theory and Practice of Group Psychotherapy* by Yalom (1985) was the book to hold all her complexity:

'I'm like a whole group, aren't I, Carmen? ... Guess it's a good thing my really grown up bit remembers to pay you 'cos my other bits don't even always know that they are here in a group with you.'

Well, that was an interesting discussion topic with one of my peer supervisors later. The client brought the comment back, making a drawing in another session of her 'group and me'. The drawing was important to her understanding of her own disparateness. Being in the room was extremely oppressive at times; she literally vomited at the impact of being in the space. We had worked in one other room and she had a similar response.

We imagined and then in reality walked outside on the pavement a few times, while she spoke about being in the room and not being in the room. This intolerance for the enclosed space was shared across a couple of her 'aspected' selves. The conflict of being contained and being able to challenge the containment was one she needed to explore in each aspect of self, occasionally realising that her experience changed when through her body awareness she felt a sense of change.

The drawing became *the* symbolic object that allowed her to believe it was possible for all of her to be in one space with me.

I have done a lot of work with art over the years, clients choosing to bring it into the space or not as they need. With this client the art itself became another figure in our relationship. Sometimes she needed me to hold it safely out of sight, sometimes to bring it to the centre of the room and simply to reflect that she had experienced a sense of being fully present (with all her selves present). This was long, glorious, painstaking, challenging work and her courage and self-compassion even in her harshest moments was deeply touching. A moving countertransference moment happened as she looked up one day from the drawing and said: 'I guess it's a bit like you, Carmen? You must have so many aspects of your own self to hold? I knew right away from your room that you have a lot of cultures.' (My room has books, images on cards, paintings, objects, drums and art materials.)

It was a complex comment with many layers, but in the moment I could feel my heart moved by her recognition, I looked at her and simply said, 'Yes.' She looked gravely into my eyes and said, 'That's what makes you safe for me; you don't run from them, you show them to me and to anyone who comes, don't you?'

'Well, sometimes more, sometimes less, but yes, I do ...'

'Good,' she said, 'then I can meet them and perhaps you'll have enough of them to let my parts be with your parts, 'cos your parts talk to each other ... don't they?' (said with a long pause and holding of breath).

'And that matters to you?' 'I'll not go there, I thought. From my experience, my 'parts' sometimes talk to each other and sometimes they take split second holidays from each other.

'Ah,' she said, nodding her head sagely, 'guess I'm client again,' and then she grinned at me.

I loved working with her – she was so darn smart. **P**

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