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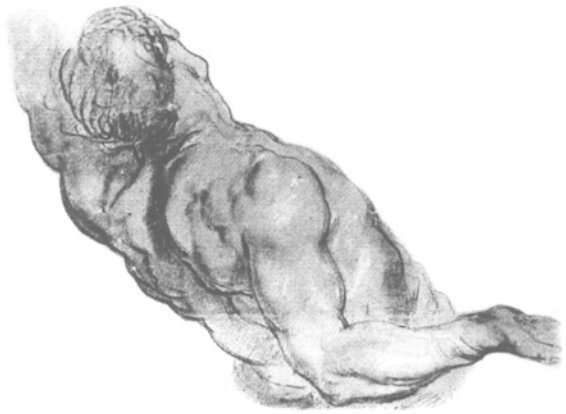

USABP Mission Statement

The USABP believes that integration of the body and the mind is essential to effective psychotherapy, and to that end its mission is to develop and advance the art, science, and practice of body psychotherapy in a professional, ethical, and caring manner in order to promote the health and welfare of humanity.

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Two themes seem to us to dominate this issue. One is the state of research and training in the field of body psychotherapy. Courtenay Young's survey of the "The Current Situation" brings this into sharp focus. Articles by Leslie Ann Costello and Fernando Ortiz give detailed accounts of both an undergraduate course and of the traditional training of body psychotherapists in Mexico exclusively in modalities. The second theme is integration: what other fields of interest and expertise can contribute to the practice of body psychotherapy. Deborah Harkin and Jerome Liss, exploring adolescent neuroanatomy and subcortical structures' relationship to the stream of consciousness respectively, demonstrate the importance of neuroscience to both client and practitioner. Julianne Appel-Opper and Asaf Rolef Ben Shahar explore ways to integrate various streams of relational psychoanalysis into their body-based practices.

In this second part of his four-part exploration of The Science of Body Psychotherapy, entitled "The Current Situation" (See USABPJ 8#2 for Part I) Courtenay Young continues his comprehensive survey and analysis of the field. Including both American and European experience, he examines the relationship between various forms of science and body psychotherapy at the present time.. Decrying both the paucity of research and describing as well as crediting what has been done, he makes several trenchant suggestions for what is needed as well as how that might be accomplished. He also considers the politics of body psychotherapy training and research, making reference to the few academic programs which include degrees in this area.

Body Psychotherapy is increasingly being taught at the undergraduate as well as the graduate level. In an effort to further communication among academics involved in this endeavor, we have included in this issue an article by Leslie Ann Costello in which she describes in detail the course she taught at the Unversity of Maine, entitled "Teaching the Whole Student: Experiential Activities in an Online, Undergraduate Course in Somatic Psychology." Academics who teach in somatic programs have the benefit of colleagues with whom to share their work, but we think it is important to encourage also those who, like Peter Fernald, (see USABPJ 7#1) who taught Bioenergetics non-experientially and the present author who taught an experiential course online to share their work. It is our hope that this will encourage more of our readers to build on their experience and undertake similar courses.

A very different kind of education of body psychotherapists is described by Fernando Ortiz Lachica. In "A Tale of Four Body Psychotherapists: The Training and Practice of Mexican Practitioners" he describes the initially often chaotic and haphazard route taken by body psychotherapists who begin their training in various modalities without regard to any university training. Unlike the US, in which psychotherapists in most states need university training in order to practice, in Mexico psychotherapy is completely unlicensed. As Ortiz illustrates, this frequently resulted in people beginning to participate in trainings and workshops purely for personal growth and then ultimately going on to other workshops and trainings and then practicing as psychotherapists. Some of them eventually sought university training, but only after completing a variety of experiential work. The author, by contrast, holds a Master's degree and is presently completing a PsyD degree, of which the reported research has formed a part.

In this second and concluding section of The Adolescent Brain(Part I is found in USABPJ 8#2), Deborah Harkin takes up clinical applications of the neuroscientific findings she discussed in Part 1. She points out that adolescence is beginning to be recognized as a second critical period (in addition to prenatal and infancy) in brain development, making these years particularly receptive to new learning while at the same time susceptible to the impact of adverse stimuli: accelerated development combined with increased vulnerability. She describes how specific processes occurring at this time affect the development of integration and self reflection. Adolescents need to stay in connection to adults who can help them learn *how to think* rather than be told *what to think*. Both adolescents and those who relate to them can benefit from an understanding of what is happening in their nervous system. She counsels all who deal with adolescents to above all *listen first.* In a brief section at the end she discusses the susceptibility of adolescents to various addictive substances.

In "From Ballroom Dance to Five Rhythms: An introduction to Relational Psychoanalysis and Psychotherapy" Asaf Rolef Ben-Shahar introduces the reader to some basic concepts and philosophical underpinnings of relational psychoanalysis in order provide the groundwork for its application to body psychotherapy. In this first of a four-part work entitled "The Relational Turn and Body Psychotherapy" he weaves together the threads of attachment, object relations, and transference and countertransference to form the tapestry of an intersubjective approach to body psychotherapy. Subsequent articles will expand on intersubjectivity, attachment and dyadic selves; the connections between somatic organization, relationality and the place of the self in body psychotherapy; and finally the use of somatic countertransference in body psychotherapy within a relational framework.

Julianne Appel-Opper, worked for many years in Great Britain, and presently resides in Berlin. She applies selected relational psychoanalytic concepts to body psychotherapy, focusing on the therapist's physical resonances and the ongoing nonverbal dialogue between therapist and client. After a brief introduction to relational and Gestalt conceptualizations she illustrates these concepts in several case vignettes.

Jerome Liss, in his intriguing article, "Streams of Consciousness: The Impact of the Positive Relationship in Contrast to Prolonged Isolation " explores the subcortical mechanisms involved in the reinforcement and prolongation of repetitive negative thought patterns when we are alone. He calls this state the "impasse". A series of diagrams and tables help to illustrate how such patterns become embedded and how they can be ameliorated by contact. Utilizing systems theory as well

as nervous system anatomy, he emphasizes how important contact, especially therapeutic contact, which involves these subcortical areas, is to the resolution of such impasses.

I hope you enjoy this issue as much as I have.

Jacqueline A. Carleton, PhD
NYC, March 2010

The Science of Body Psychotherapy: Part 2. The Current Situation

Courtenay Young

Abstract

Part One essentially described the various definitions of body psychotherapy and a historical overview of Janet and Reich's scientific work up to the Second World War (Young, 2009). In Part Two of this four-part series, the post-war scene of psychotherapy and body psychotherapy is examined, with a description of what is now being meant by "science" in psychotherapy (especially in Europe) in this context. The differences between the different forms of science, natural "objective" science, social science, medical science, and political science are examined. The current state of science in psychotherapy is also examined here, as well as two reviews of science in body psychotherapy. What is also mentioned is where there have been significant failings to use science in body psychotherapy, and what was focused on instead. Some abstracts of recent scientific research projects in body psychotherapy are given in the appendix. In Part Three, what is appropriate science, and what is not, is discussed further with some solutions being proposed. In Part Four, there is an examination of various aspects of neuroscience that impinge on body psychotherapy.

Key Words

Body Psychotherapy – Development – Political Science – Clinical – Medical Research – Reich – Modalities – Training

Post-War Scientific Developments

Body psychotherapy, as a reaction to various rejections, first of Reich by Freud, then of Reich in Europe, and then later in post-war America of Reich by the FDA, was, in the late 1950's, left in the hands of a very few people mostly trained by Reich, such as Ola Raknes in Norway, Elsworth Baker, Alexander Lowen, John Pierrakos, Myron Sharaf, Eva Reich, and a few others in the United States.

As a result of the various attacks against Reich, body psychotherapy, as a method, had generally began to focus on developing different themes, social theories, methods of practice, clinical skills, and other refinements, perhaps as a way of staying acceptable. Yet it did not, individually or collectively, try to challenge the "rejection" from its peers and from society for many years. However, these post-war developments did not involve much "science."

The "orgonomists," a very small group of largely American psychiatric practitioners, mostly trained originally by Reich, then later by Elsworth Baker, a pupil of Reich's, continued to follow his clinical and scientific work, albeit fairly rigidly. "They have kept Reich's central concepts clearly in focus and have developed many of them. Some orgonomists have done important original research which expands Reich's ideas." (Sharaf, 1983, p. 481) The backlist of the Journal of Orgonomy is very comprehensive and constitutes, in itself, an impressive "body" of science within the wider field of body psychotherapy[1]. However, they do keep very much to themselves, and their publications are not widely listed. In addition to this, many body psychotherapists have never really heard of them. Their development of the science of body psychotherapy has been mainly in the clinical application of many theoretical aspects (case histories, character studies, mental health, sexuality, and the application of therapy), and here they have interestingly paralleled developments in other psychotherapies. They have also done some research into other non-therapeutic aspects of Reich's work, including research on "bions," cosmology, and weather control.

In the aftermath of Reich's trial, imprisonment and death, body psychotherapy (though it was not called that then) went into a decline for a few years. Then in the 1960s, body psychotherapy – as a field – found itself, quite suddenly, mostly unforeseen, in a rather comfortable place, being largely accepted within the Human Potential Movement, in association with various body-therapies, and amongst the humanistic, phenomenological and existential psychotherapies (Goodrich-Dunn & Greene, 2002: p. 93-96), where it has largely stayed ever since. Part of this was due to Fritz Perls' acceptance of the body (Perls had known Reich in Europe) and part of this was due to a widening of perspective that included the body, along with the mind and even the spirit, as interconnecting aspects of the whole person. Not much "science" was done in the early days of Humanistic Psychology, and the "scientific" view was even denigrated as being impersonal. Unfortunately, the later development of the "New Age" and the continuance of non-scientific methodologies hindered any proper development of the science of body psychotherapy. There was still a solid level of exterior background support from educationalists, psychiatrists and social thinkers like A.S. Neill, R.D. Laing, Arthur Koestler, and the anthropologist Bronislaw Malinowski (Sharaf, 1983). Reich's work had also influenced people like Frank Zappa, John Lennon, Bob Dylan, Itzhak Perlman, Fritjov Capra, Saul Bellow, Alan Ginsberg, Norman Mailer and William Burroughs, (Mannion, 2002), as well as William Steig,[2] Orson Bean,[3] and even Kate Bush.[4] These people all helped, one way or another, to popularize Reich's work after his death.

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[1] http://www.orgonomy.org/Main_Publications.html (accessed 11/12/08)

[2] Popular cartoonist and artist for Wilhelm Reich's (1972) 'Listen, Little Man!' London: Souvenir.

However, this placement within humanistic psychotherapy and amongst the *cognoscenti* also meant that body psychotherapy did not really have to "prove" itself, particularly as the humanistic field, especially in the 1960s & 1970s, seemed fundamentally against any form of "scientific proof." And ironically, "humanistic psychology developed as the response of a number of influential psychologists to perceived deficiencies in the psychological theory and research of this same time period" (Moss, 1999).

John Rowan (2000), an eminent humanistic psychotherapist, complains about the nature of research ethics, in that the basic ethical paradigm is one where the researcher is "in charge," "sets the rules," "remains objective," "keeps his distance," and "uses the research subjects to prove or disprove his hypotheses at his convenience". Thus the researcher meets the subject in a very role-bound way. The language is very pejorative and this affects the research, even though in Britain nowadays, the people on whom the research is conducted are called "participants." He goes on to identify several areas of research in which the most objective, basic empirical research is also the most alienated. He points out that these fields of qualitative research have a number of embedded ethical problems. In wider forms of research, or in more quantitative ones (that is to say in those that are more in the field of human enquiry), the role of the researcher changes, and the research is more so done *with* people, rather than *on* people. Maslow's work is important here, but the field also includes hermeneutics and phenomenology and it has been strongly influenced by social movements such as feminism. Rowan also looks at another less well-known field of research; that of critical social action inquiry. Here the fundamental purpose of the research is questioned and "the main aim of the scientist became the amelioration of the human condition." He includes two further fields, but they don't really impinge on where body psychotherapy is at the moment.

As a result of this association with humanistic psychology, body psychotherapy found itself frequently being "lumped" with body therapy techniques, like Rolfing, and other (possibly) more radical "psychotherapeutic" techniques, like Janov's Primal Therapy (Clare, 1981). And this trend continued into the 1970's and 1980's, with only a few books about body psychotherapy being considered as actually respectable (Lowen, 1958; Boadella, 1976). However, none of these radical "body therapies" or "primal" techniques really has anything to do with body psychotherapy. As a reminder, the term "body psychotherapy" still did not exist yet, so it is being applied retrospectively. The common terms of the time were the names of the various "modalities" – Bioenergetics, Orgonomy, Radix, or the therapies were known by the name of their founder, and the only generic term perhaps was "neo-Reichian."

During this period, there were also very few genuine "scientific" projects. Alice Ladas (2005) is perhaps one exception, as she did some research into women's sexuality[5]. This study tried to show if there were differences between the theory of Bioenergetic Analysis and the experiences of women within Bioenergetic Analysis. It was in the form of a mail questionnaire. Ladas comments in a footnote:

> Bioenergetic Analysts have done a lot of education, developed many important therapeutic techniques and taught them to many people. But there is no published research apart from clinical observation. (Ladas & Ladas, 2005)

This is pretty much true for most methods within body psychotherapy and mind-body therapies in this period. In a large meta-analysis of research on the efficacy of mind-body therapies on cardio-vascular disease, one of the conclusions was:

> Reviewers found only a handful of randomized, controlled research studies conducted in the United States. As a result, there is a lack of replicated studies with which to determine appropriate treatment dosage and the mechanisms by which many of the practices work. Compelling anecdotal evidence, the presence of some controlled research, overall cost effectiveness, and the lack of side effects resulting from mind-body treatments make further investigation a high priority. (Luskin et al, 1998, 2000)

The field of body psychotherapy was growing steadily, becoming wider and more diverse, and began having many different components and links, but it was not doing research – its energies were all going in these other directions. The exploration and diversification of techniques and methods continued apace throughout this period and into the early 1990s. Science was unfortunately sometimes somewhat conspicuous by its absence in these new and developing body-oriented psychotherapies: indeed, that type of thinking was sometimes even demonized. There was no real attempt (other than those specifically mentioned) at any form of rational analysis, nor of proper differentiation, nor of any systematic study. And that was also, as mentioned, a feature of Humanistic Psychology and New Age movement: we were all into "holism" rather than the so-called "abstractions," "objectivities" and "reductionism" of science.

Bioenergetics, one of the first neo-Reichian body-psychotherapies, originally founded by Alexander Lowen and John Pierrakos, had developed quite a numerous list of publications (books and journal articles) with a reasonably healthy scientific basis, although there have only been a few "properly" done scientific research studies. Lowen's very successful books, *The Language of the Body, Bioenergetics, Love & Orgasm, The Way to Vibrant Health,* etc., had done a lot to popularize body psychotherapy, but the only real body of "science" lies in the numerous journal articles, a few of them peer-reviewed (but

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[3] An actor who wrote about his experiences of Reichian therapy in *'Me and the Orgone'* (1971) New York: St Martin's Press, and then helped to found the 15th Street School, along the lines of A.S. Neill's Summerhill School.

[4] In a song entitled "Cloudbusting" on "The Children of the Night" album.

[5] The actual research was done in 1977

many were not), and in unpublished collections of conference papers in Bioenergetic Analysis stretching over the last forty years. Currently, there is no comprehensive single listing of all the publications, research and scientific work for Bioenergetics, nor for any of the other forms of body psychotherapy, but a single-word search in the most recent version of the EABP Bibliography of Body Psychotherapy (Young, 2006, 2009) brings up more than 250 different published references, whereas a similar search on the APA's PsychNet[6] only brought up 4 references.

The Political Science of Psychotherapy

As mentioned in previous articles, I have explored some of the history of this development and diversification in America (Young, 2008) and in Europe (Young, 2010), where, in the 1990s, the "professionalization" of psychotherapy started. This was a determined attempt, still ongoing, to create a separate and distinct profession of psychotherapy, parallel to clinical psychology and psychiatry. Some European countries have already started to pass "laws," as yet not fully tested in the courts, to restrict the practice of psychotherapy only to psychiatrists and psychologists. This would effectively have prevented any of the multitudes of non-academic or non-medical lay psychotherapists from practicing. And this was set within the context of a free labor market across Europe, established by the European Union, which means that someone who is able to practice psychotherapy legally in one country could not be prevented from practicing legally in another. It was therefore necessary to create a common standard of training, and also to define what was meant by psychotherapy.

The European Association of Psychotherapy (EAP) created the 1990 Strasbourg Declaration on Psychotherapy, which stated that:

1. Psychotherapy is an independent scientific discipline, the practice of which represents an independent and free profession.
2. Training in psychotherapy takes place at an advanced, qualified and scientific level.
3. The multiplicity of psychotherapeutic methods is assured and guaranteed.
4. A full psychotherapeutic training covers theory, self-experience, and practice under supervision. Adequate knowledge of various psychotherapeutic processes is acquired.
5. Access to training is through various preliminary qualifications, in particular human and social sciences.

The EAP currently represents about 128 organizations (28 national umbrella associations and 17 European-wide associations for methods of psychotherapy) from 41 European countries and, by that, more than 120,000 psychotherapists. More than 5,000 of these now have been awarded the European Certificate of Psychotherapy. All this necessitated putting psychotherapy – and particularly the various methods or modalities within psychotherapy – onto a more "scientific" basis, and thus the 15 Questions for Scientific Validity were established (see Appendix 1, in Part 1: (Young, 2009)).

So, in Europe, all the different methods of psychotherapy, including body psychotherapy (promoted by EABP) as a mainstream, Biosynthesis, Psycho-Organic Analysis, Concentrated Movement Therapy and Bioenergetic-Analysis Psychotherapy, have been accepted as "scientifically-valid" by a submission of substantive answers to the 15 Questions and by a peer-review process of these answers within the EAP. The "answers" to the 15 Questions on the Scientific Validity of body psychotherapy are available on the EABP website (www.eabp.org). Additionally to this, by the same process, various modalities within body psychotherapy have also been accepted as "scientifically-valid," such as Hakomi, Bodynamics, Unitive Psychology, Biodynamic Psychology, Emotional ReIntegration, Character-Analytic Vegetotherapy, Psychotherapeutic Postural Integration, etc. Some of these "answers" are also posted. Biosynthesis, Bioenergetics and Concentrative Movement Therapy have also all been "scientifically validated" independently by the EAP, though using the same protocols.

This is what I refer to as the "political science" of psychotherapy: science, but not really science, and yet the considerable body of knowledge and information contained in these '"scientific validation" documents is quite astonishing.

The Medical Science of Psychotherapy

However, all of these mainstreams and methods – and any other modalities of body psychotherapy (as well as many of the humanistic psychotherapies) – still do not meet, and perhaps nowadays need to meet, what is considered as the "gold standard" of science. These are Randomized Control Trials (RCT). This is the only form of (medicalized) "science" that seems to be accepted by governmental bodies such as Health Ministries. The RCTs also have to have all the other criteria, such as significant numbers, proper statistical analysis, publication in peer-reviewed research journals, and evidence of significance greater than the normal placebo effect, that form this "gold standard" that is being demanded by these quasi-medical, quasi-political governmental bodies. Furthermore, any studies that cross into different diagnoses are also ignored, so a study that looks at both anxiety and depression is ignored both for the evidence-base for depression, and for the evidence-base for anxiety. This is known as the "science" of an "evidence-based" practice. However, it is also very political in that it excludes a great number of methods that have value, and there is difficulty in proving these methods according to the criteria.

[6] http://psycnet.apa.org/

Of course, these Health Ministries, and in the UK, the departments that give guidelines to the medical profession as to what treatments should be prescribed for what conditions (UK NICE[7] & SIGN[8], etc), do not supply any funding for such trials; they just set the "goalposts" and they keep on upping them. So, they, *de facto,* effectively manage to "prove" only what they want to prove, or what is proven already by such exclusively "managed" criteria. This hegemony is only just beginning to be questioned (Nel, 2009).

What is also studiously being ignored in this context, for example, are the numerous meta-studies, which "show" that there is no significant difference between the various psychotherapeutic methods; all are basically better than a placebo effect. Also being ignored is that the most significant factor is actually the rapport between the therapist and the patient (a good working relationship) and the level of determination of the patient to get better.[9] Especially by the Health Ministry in the UK, the findings of a particular fairly widespread "tool," the Clinical Outcomes in Routine Evaluation (CORE) system[10], that measures both the patient's progress in therapy, as well as being able to give a measure of comparative efficacy between different therapists, are being ignored as well. Again, this shows little difference between the various therapeutic methods, which is of course inconvenient and, given the predominance of CBT, even somewhat politically incorrect.[11] So, this is another application of the "politics" of "science" in psychotherapy. In the case for the only current widely accepted "evidence-based" psychotherapy, CBT looks somewhat weaker in this light and indeed is being shown up to be less effective with certain client groups, for example, amongst schizophrenics.

Furthermore, it seems as if there is considerable resistance from within the profession of psychotherapy in general to accept, or even understand, almost any type of research. Boisvert & Faust (2006) examined practitioners' knowledge of general psychotherapy research findings and found that, whilst some psychotherapists showed excellent familiarity with outcome research, many did not. Furthermore, many had believed that the findings were less positive than reality, and had thus discounted them. This is probably as true for Body-Psychotherapists as for the other psychotherapists. So, we need, at some point, to look at what lies behind our resistance to "science" and "research": are we scared that it will take us away from our bodies? Some "science" certainly does. But, whilst we need to meet the parameters of the outside world, we also need to do it in a way that does not compromise our integrity as "natural scientists."

What body psychotherapy therefore probably needs to do, **in this context,** is to produce, say, four to five substantive research studies, possibly from different countries, dealing with a particular condition, such as depression. In addition to this, each study would have sufficient numbers (say 50-100), with a properly randomized control group, a sufficient number of follow-up studies, a degree of "scientific" rigor, and a statistical analysis (published in a reasonably prestigious, 'scientific' peer-reviewed journal) in order to show a significant degree of efficacy that cannot be explained by the placebo effect. These sorts of studies then need to be repeated for anxiety, for OCD, for trauma, for phobias, etc (see later).

So we will have then "proved" body psychotherapy to be "evidence-based" to *their* satisfaction. One of the next sets of questions are, "with who, how, where, and with what funding do we do this?" I believe this is the role of the national association for body psychotherapy in each country, possibly working together, and translating any findings of projects within their country into English: or from English into their own language. These translations will help people in other counties access the research, and so it can be used in that country. It is a task that cannot and should not be confined to one modality or another within body psychotherapy. It is a task that will take about fifteen years. And this is, again, another form of "science."

The Present Science of Body Psychotherapy

There are, thankfully, several other ways of looking at the "science" of body psychotherapy. The latest version of the EABP Bibliography for Body Psychotherapy (Young, 2006, 2009) lists about 500 results for the single-word search "Research" (206 entries from Books or Chapters; 277 Journal articles; 7 Papers; 6 Tapes; 1 Thesis; 1 Video; and 9 websites), whereas there are only 132 results for the single-word search "Science" and only 22 results with the single-word search "Efficacy". This is out of just over 4,000 entries, and most of these with abstracts. This Bibliography is now being published on the Internet, via the EABP website: www.eabp.org/bibliography. It is a comprehensive searchable database, thus similar to PsychLit or PsychIndex (the APA databases). This means that people can now check what is out there, and there is also a facility to enable people to add new material to it. Non-English entries have an entry in their language, as well as an entry in English. There are also categories for student theses, conference papers, tapes & films, websites and website-based articles. We want to encourage body psychotherapy training schools to adopt this database, and, it is hoped that with a little encouragement, the number of entries will soon grow to about 10,000. This then becomes a very powerful "scientific" research tool in body psychotherapy.

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[7] NICE: UK National Institute for Health and Clinical Excellence: a governmental body that checks out the 'science' – and cost – of medicines and treatments and recommends which can be used by the National Health Service in England & Wales.

[8] SIGN: Scottish Intercollegiate Guidelines Network: develops evidence based clinical practice guidelines for the National Health Service (NHS) in Scotland

[9] "The Efficacy of Psychotherapy": retrieved 5/12/09 from APA website: www.apa.org/practice/peff.html

[10] CORE: www.coreims.co.uk/index.php

[11] Barkham, M. et al. (2006) Dose-effect relations and responsive regulation of treatment duration: The good enough level. *Journal of Consulting and Clinical Psychology. Vol 74(1), Feb 2006, 160-167.*

Stiles, W.B. et al (2008) Responsive regulation of treatment duration in routine practice in United Kingdom primary care settings: Replication in a larger sample. *Journal of Consulting and Clinical Psychology.* Vol 76(2), Apr 2008, 298-305.

Other than this, there have been two substantive English-language articles on the topic of the present science of body psychotherapy published fairly recently in the last few years (May, 2005; Röhricht, 2009), and there are some other foreign-language articles, but these are less accessible. There was also a chapter on empirical research in the Handbook of Body Psychotherapy in the German edition (Loew & Tritt, 2006), which was rather limited and is hopefully going to be improved in the forthcoming English-American edition.

John May, a clinical psychologist and respected body psychotherapist in St Louis, MO, USA, attempted to survey all empirical studies in peer-reviewed journals on the outcome of body psychotherapy in the English language. He located 6 retrospective studies, 9 efficacy studies and 18 effectiveness studies (with 55 references). "More study is needed and many questions remain unresolved. Nevertheless, a body of literature is slowly developing that offers support for body psychotherapy under some conditions." (May, 2005, p. 98)

More significantly, May nicely highlights some of the basic dilemmas with respect to "science" in the field of body psychotherapy:

> Psychotherapeutic knowing is derived from three sources, which I have described as a three-legged stool. One leg represents knowledge that comes from one's own inner exploration and work. Direct experiential knowing, sometimes called primordial knowing, plays an important role in this sort of knowledge. Another leg of the stool represents knowledge that comes from experience with clients as one sits with them hour-after-hour. Direct knowing also plays a role here, as do case observations that are not systematically and objectively tested. The third leg of the stool represents objective study. This leg of the stool deemphasizes direct knowing and unsystematic case observation in favor of systematic testing with objective measures.
>
> All three legs are needed, or the stool will not be stable enough to support a large body of theory. Almost all general psychotherapeutic theories derive their inspiration and core insights from the first leg of the stool (see Atwood & Stolorow, 1993). These initial insights are developed and refined through experience with clients. How would empiricists know what hypotheses to test without insights and theories derived from these two sources of knowledge? On the other hand, if one stops here, never proceeding to the systematic testing represented by the third leg, then one is left with something more akin to religious dogma than professionally grounded theory. (Ibid, p. 98)

This is essentially the state of body psychotherapy today: a stool without the third leg … something more akin to religious dogma … And we really have only ourselves to blame. No one can, or will, do this sort of work for us. We have to become more objective – of ourselves, about ourselves - and that does not necessarily mean de-humanization. We have to find ways and resources with which to do the research, which probably means the current Somatic Psychology PhD programs and students initially. We also have to change our somewhat blinkered attitudes towards science and research.

With respect to the different "modalities," out of the thirty-four studies, John May states that Bioenergetics has the most outcomes studies (with eight), and three of these are particularly supportive and strong. Additionally, "Radix, Holotropic Breathwork, Psychomotor Psychotherapy, Gestalt Therapy, Primal Therapy and Rubenfeld Synergy all have more than one outcome study. There are prominent forms of body psychotherapy that have none however. With each passing year, this omission becomes more serious." (May, 2005, p. 115) This tends to put the weight also on the modalities within body psychotherapy to prove they are considerably better.

There are three main types of study:

- **Retrospective Outcome Studies.**
  They are easiest to perform, and "the repeated finding that large percentages of clients are satisfied is very persuasive. In addition, they provide important data about the characteristics of body psychotherapy clients." (Ibid, p. 115) Any clinic or training institute, or professional associations that encourage their members to send in such data, have the potential to perform such retrospective studies.
- **Effectiveness Studies.**
  They measure, using standardized assessment procedures (usually a simple multiple-choice form), the changes between the client when enters therapy and the changes at termination of the therapy. A little bit of rigor in the clinic or the training institute, or from the practitioner, helps to ensure that most clients actually complete a "before" and "after" therapy form.
  The Clinical Outcomes for Routine Evaluation (CORE)[12] system is a quite good one to use in this respect. The professional association can help to create an expectation that their practitioners will encourage their clients to fill in such forms and to return them for analysis. Follow-up studies involve sending the same 'end of therapy' form to the client about 3 or 6 months later, to see whether any reported benefits have lasted. Again, they are useful, but – by themselves – they are not sufficient.

[12] CORE: www.coreims.co.uk

- **Efficacy Studies**
  They are the most complicated (and expensive) and require a high degree of planning and control. They require access to a large source of subjects, with prior information about these subjects, so that homogenous groups (same age, gender, class, etc.) can be "recruited" and then randomly assigned to the different forms of treatment that are being studied. In respect to body psychotherapy, good "comparisons" might be people with the same condition being assigned to Yoga classes, to a "talking" therapy, or to a discussion group. Ideally, some people would receive no treatment by opting out and would later be asked to complete the same outcome forms. Another comparison would be to differentiate between those on medication and those not on medication. It is therefore probably necessary to locate such a study in a large clinic, most definitely with an experienced researcher, to have the study ethically checked out beforehand. It would be necessary to carefully check on how the clients are randomized, and then to check on how the results are being processed and analyzed. "They are the most widely accepted test of whether or not a treatment works, however they are sometimes the only type of study accepted by front-line scientific journals. Thus they may be worth the cost and effort required." (Ibid, p. 116)

But, again, please note that we are moving away somewhat from the concept of "therapy" to that of "treatment." This sometimes starts to grate on the sensitivities of practitioners who see themselves becoming somewhat less significant during such a study. Furthermore, as I have said, governmental bodies are only really interested in the treatment of one particular condition: i.e. depression, anxiety, or chronic pain. It is therefore sometimes easier to perform these studies in specialist clinics such as pain clinics or voluntary organizations for people with phobias, depression, eating disorders, etc.

The other wide review of body psychotherapy research (Röhricht, 2009) concludes something quite similar. Frank Röhricht is a consultant psychiatrist, a body psychotherapist, and professor at the University of Hertfordshire, UK. His literature review (80 references) is impressive. He writes:

> The heterogeneous field of body oriented psychological [BOP] therapies provides a range of unique contributions for the treatment of mental disorders. Practice based clinical evidence and a few empirical studies point towards good efficacy of so called non-verbal intervention strategies (although this is somehow misleading as all these therapies naturally work with both verbal and non-verbal interventions), particularly relevant for those disorders with body image aberration and other body-related psychopathology. Furthermore, BOP appears to offer promising additional psychotherapeutic tools in areas, where traditional psychotherapies seem to fail so far, i.e. somatoform disorders, eating disorders, psychotic disorders and chronic schizophrenia. (Ibid, p. 20)

However, Röhricht is also appreciative of the German-Swiss study:

> Arguably, the most important study concerning the effectiveness of BOP in routine care (outpatient-setting) was conducted from 2002 to 2005 and published recently (Koemeda-Lutz et al. 2006). In this multicentre, naturalistic evaluation study of BOP (eight different schools including: Hakomi, Unitive Body Psychotherapy, Biodynamic Therapy, Bioenergetic Analysis, Client-Centered Verbal and Body Psychotherapy, Integrative Body Psychotherapy, Body-Oriented Psychotherapy and Biosynthesis), the researchers aimed to investigate the effectiveness of routine therapy in outpatient settings. Patients seeking BOP (n=342 participated) were compared to other outpatients (not in RCT fashion). The assessments were carried out at baseline, after 6 months and at the end of therapy (over a maximum of two years). The instrument used to estimate treatment responses was the symptom checklist SCL-90-R. This instrument measures subjectively felt impairment by means of a 90-item self-report inventory of physical and mental symptoms occurring the preceding week. Overall, the results suggest good efficacy of BOP for a variety of symptoms or problem areas. However, the study design does not allow for more substantive statements/conclusions. (Ibid: p.16)

He concludes:

> The current evidence base can therefore be summarized as follows: BOP seems to have generally good effects on subjectively experienced depressive and anxiety symptoms, somatization and social insecurity. Patients undergoing BOP appear to benefit in terms of improved general well-being, reduced motor tension and enhanced activity levels. There is evidence from one RCT, that bioenergetic analysis may be specifically effective for somatoform disorder patients and there is substantial evidence for the efficacy of functional relaxation on psychosomatic disorders (asthma, tension headache, and irritable bowel syndrome). Patients suffering from severe physical conditions (e.g. cancer) seem to be responding well to Dance Movement Psychotherapy with regard to enhanced self-esteem, changes in body perception and improved coping mechanism. At least three RCTs have demonstrated that schizophrenia patients with predominant negative symptoms respond to manualised body oriented psychological intervention strategies, improving their psychomotor behavior, social and emotional interaction. …

> The best example for the importance of research efforts in the field is the recent publication of [draft update of the] NICE guidelines for schizophrenia in the UK. Through a robust meta-analytic process, all the available evidence base has been reviewed and body oriented psychotherapy is now recommended amongst other non-verbal/arts therapies as treatment of choice for chronic schizophrenia patients with predominant negative symptoms.

Still, this is also a great start and it has already opened the door to body-oriented therapies being considered as significantly useful by the NICE Guidelines, where one of these studies is already referenced. Röhricht also points to a possible solution to this dilemma about who actually does the research:

> One way forward could come from collaboration between the professional associations (e.g. ADMP, USABP, EABP) and the university (Masters & Ph.D.) programs: one providing the source material, through the practitioners' case loads, and the other providing the time and energy from research students with the analytic facilities and desire to publish. (Röhricht, 2010, p. 22)

This makes a lot of sense. The 'scientific committees' of the professional associations could, and probably should, commission research projects, or help design them. With perhaps a little bit of funding as an incentive (as happened in the Koemeda-Lutz study), the university programs could, and probably should, do the collection and number crunching. The field of body psychotherapy is small enough, and skilled enough, to make this sort of collaboration eminently possible, if it were not also so parochial still. However, this brings me to the next major obstacle.

The Lack of Science in Body Psychotherapy

In Europe, most of the current body psychotherapy practitioners have had absolutely no training whatsoever in scientific research from within their modalities. It is mostly excluded from their curriculum because of the now-outmoded emphasis on technique. They may have gotten some grounding in research, if they have done a Masters degree or a PhD in psychology, but this is not necessarily appropriate for psychotherapy or body psychotherapy. Many do not have this academic training. This deficit is becoming quite glaring and this leads to the paucity of any proper research. This includes thinking or writing about research, or encouraging others to do research. As a result, body psychotherapy itself is showing and feeling that deficit.

In America, some of this deficit is carried by the "requirement" that most psychotherapists have to have a Masters or PhD academic degree in order to practice. However, few do any research. Much of the body psychotherapy training is still carried on in small private schools, and the few colleges (like CIIS, JFK (Berkeley), SBGI and Naropa,)[13] are also focused on training and technique, more than on doing and publishing research projects.

Much more familiar is a "scientific" version of case study type of research (Kaplan & Schwartz, 2005). The various body psychotherapy trainings have generally been excellent on the theoretical and the experiential sides, but woefully deficient on the academic and scientific sides. Maybe there is some fear of a dilution of their methodology here. Koemeda-Lutz et al. (2005) are unequivocal about the way forward:

> For body psychotherapy schools, this study demonstrates that there is no need to fear comparison using standardized instruments of therapy research. For the future, the task emerges to formulate specific therapeutic goals and to develop suitable measuring instruments. If these were available, the indices for effectiveness discussed here could be augmented by indices that are specific to body psychotherapy. In addition, the disorder-specific effectiveness of body psychotherapy should be investigated. (Ibid, p. 28)

The changes needed here are really to be undertaken by the training schools in the various modalities and the methods of body psychotherapy. Changes also need to be undertaken by the professional associations behind them, like the EABP & USABP, who help coordinate and regulate them. The professional associations need to consider amending the training standards to ensure that science and research modules are included, to ensure that all future body psychotherapy practitioners at least have a basic knowledge and experience in research methodology and academic writing. The training schools need to recognize and promote the value of research to their trainees. There is no other way.

Links also have to be formed with university programs where some of the actual research can be undertaken at, in cooperation with the clinical aspects of the training schools, clinics and groups of body psychotherapists under the auspices of the professional associations. However, I am getting ahead of myself as this moves the argument into the third part in this series.

[13] CIIS: California Institute of Integral Studies, San Francisco, CA; JFK: John F Kennedy University, Berkeley, CA; SBGI = Santa Barbara Graduate Institute, Santa Barbara, CA: Naropa University, Boulder, CO: currently the four universities in USA that run MA & PhD programs in Somatic Psychology or Body Psychotherapy.

As a conclusion therefore, we can see that applying these principles to some of the English-language studies over the last 10 years[14] have been as follows:

- There have been a couple of examples of the classic gold standard randomized controlled trials: one is the recent study done by Berg et al. (2009), and another is by Röhricht & Priebe (2006) (for abstracts: see Appendix). Though, on deeper reflection, these are quite limited in their numbers and their applications to people with either a general anxiety disorder, or the negative effects in schizophrenia. Furthermore, the latter trial seems to have been using more of a movement-based therapy without verbal process, so whether this can be considered proper body psychotherapy, or not, might be a slightly pedantic, though pertinent, criticism. [We have to be careful how we represent ourselves to the world.[15]]
- There was also a controlled outcome study on the effectiveness of psychodynamic body psychotherapy on chronic pain (Monson & Monson, 2000), and a small, randomized proto-study on the effectiveness of functional relaxation with asthmatics (Loew et al, 2001) (also see Appendix 2). However again, on deeper reflection, the controlled outcome study is perhaps only "silver" standard. In addition, functional relaxation is also only considered by some to be an example of proper body psychotherapy, and it was a very small proto-study.
- There have been a couple of other effectiveness studies, but they do not reach the "gold standard" of Randomized Controlled Trials (RCT); the numbers were not really sufficient, nor were they published in a "scientific" journal (Pettinati, 2002) (Sullens, 2002).
- A study from Israel (Peleg et al., 2009) has been made on the effectiveness of Mind Body Therapy (a combination of soft supportive touch, meditation, relaxation, conscious breathing, listening, empathy and positive thinking) on cancer patients receiving medical treatment. Again, whilst this is interesting, is it body psychotherapy? Is it useful? Yet it comes from a body psychotherapy school.

In these ways, we do seem to limit ourselves.

APPENDIX :

Title: Chronic Pain and Psychodynamic Body Therapy: A Controlled Outcome Study.
Authors: Monsen, Kirsti, & Monsen, Jon T.
Journal: Psychotherapy: Theory, Research, Practice, Training. Vol. 37, No. 3, fall 2000, pp. 257-269.
Abstract: Forty patients (aged 29–57 yrs) with pain disorders participated in a controlled study. Half of the patients were treated with psychodynamic body therapy (PBT) for 33 sessions, and the other half received treatment as usual or no treatment. All patients were evaluated before therapy (T1), at the end of therapy (T2), and at a 1-year follow-up (T3) with a visual-analogue-pain scale (subjective experience of pain), symptom checklist, inventory of interpersonal problems, Minnesota Multiphasic Personality Inventory, and the affect-consciousness interview. The study demonstrated that at T2, the pain was significantly reduced in the PBT group compared to the controls, and 50% of the PBT patients reported no pain. The findings further showed a significant and substantial change on level of somatization, depression, anxiety, denial, assertiveness, and social withdrawal, and increased affect consciousness. The results remained stable at T3, and the PBT patients even continued their improvement on some scales during follow-up. (PsycINFO Database Record (c) 2009 APA, all rights reserved)

Title: Efficacy of "Functional Relaxation" in Comparison to Terbutaline and a "Placebo Relaxation" Method in Patients with Acute Asthma. A Randomized, Prospective, Placebo-controlled Crossover Experimental Investigation.
Authors: Loew, T. H., Tritt, K., Siegfried, W., Bohmann, H., Martus P. & Hahn, E. G.
Journal: Psychotherapy and Psychosomatics, Vol. 70, No. 3, pp 151-157.
Abstract: Background: "Functional relaxation" (FR) according to Marianne Fuchs is a body-oriented psychotherapy that involves teaching the patient a type of relaxation techniques aimed at maintaining equilibrium of the nervous system. Methods: In order to determine whether the practice of elementary parts of this therapy has an immediate beneficial effect on pulmonary function, a randomized, single-blind, prospective crossover study was done with 21 asthmatics with acute bronchoconstriction. On 3 consecutive days they were given either (1), a 5-min verbal standard instruction in elementary exercises of FR (eFR), which they were to practice during subsequent bodyplethysmographic measurement, or (2), inhalative terbutaline (IT), a β_2-sympathomimetic drug, or (3), an unspecific "placebo relaxation" technique (PRT), so that all subjects tried all 3 treatments in random order. Spirometric variables were assessed. Results: There was a significant decrease in specific airway resistance with eFR, which, though not as pronounced as with IT, was significantly greater than with PRT. This study shows that clinically relevant effects can be achieved for patients with asthma through mind-body interaction, which can be triggered by reproducible procedures. Conclusion: Further development of the FR approach could lead to a non-pharmacological and effective supplementary treatment for asthma, which is in high demand by many patients.
Key Words: Asthma, Disease, Symptomatology, Bronchoconstriction, Acute, Treatment, Body psychotherapy Relaxation, Comparative study, Chemotherapy, Terbutaline, Bronchodilator, Agonist, β2-Adrenergic receptor, β-Adrenergic receptor agonist, Inhalation, Treatment efficiency, Prospective, Follow-up study, Human, Somatic disease, Respiratory disease, Obstructive pulmonary disease.
(30 refs.)

Title: Affect-focused Body Psychotherapy in Patients with Generalized Anxiety Disorder: Evaluation of an Integrative Method
Authors: Berg, Adrienne Levy; Sandell, Rolf & Sandahi, Christer: Karolinska Institutet, Stolkholm, Sweden. Contact: adrienne.levy-berg@karolinska.se
Journal: Journal of Psychotherapy Integration, 19(1), March 2009, p. 67-85.

[14] My apologies to the researchers of projects that have only been published in a non-English language. Whilst I would hope to be able to appreciate the valuable work you may have done, it cannot be known about, appreciated and spread more widely if you do not take the time and effort to translate (at least) the title, abstract and key-words into English. The EABP website will always publish these.

[15] I am grateful to Laura Steckler for her comments in a private e-mail for the basis of this critique.

Abstract: The aim of this study was to explore the long-term effects of affect-focused body psychotherapy (ABP) for patients with generalized anxiety disorder (GAD). A group of 61 consecutive patients, 21-55 years old, were randomized to ABP and psychiatric treatment as usual (TAU). The patients were assessed before treatment and followed up 1 and 2 years after inclusion. The ABP patients received one session of treatment per week during one year. Three self-report questionnaires were administered: Symptom Checklist-90, Beck Anxiety Inventory, and the WHO (Ten) Well-Being Index. In both groups, there were significant improvements. On termination, the ABP group had improved significantly more on the SCL-90 Global Symptom Index than the TAU group, whereas the differences were short of significance on the other two scales. The integration of bodily techniques with a focus on affects in a psycho dynamically informed treatment seems to be a viable treatment alternative for patients with GAD.
Keywords: Affects, Body Psychotherapy, Outcome, Physiotherapy, Randomized Trial.
(66 refs, Appendix)

Title: Effect of body-oriented psychological therapy on negative symptoms in schizophrenia: a randomized controlled trial
Authors: Rohricht, Frank & Priebe, Stefan
Contact: Dr Frank Röhricht, Academic Unit, Newham Centre for Mental Health, London E13 8SP, UK. Frank.Rohricht@elcmht.nhs.uk)
Journal: Psychological Medicine, Volume 36 (5) May 2006, pp. 669-678.
Abstract:
Background: In order to improve the treatment of medication-resistant negative symptoms in schizophrenia, new interventions are needed. Neuropsychological considerations and older reports in the literature point towards a potential benefit of body-oriented psychological therapy (BPT). This is the first randomized controlled trial specifically designed to test the effectiveness of manualized BPT on negative symptoms in chronic schizophrenia.
Method: Outpatients with DSM-IV continuous schizophrenia were randomly allocated to either BPT (n = 24) or supportive counseling (SC, n = 21). Both therapies were administered in small groups in addition to treatment as usual (20 sessions over 10 weeks). Changes in negative symptom scores on the Positive and Negative Symptom Scale (PANSS) between baseline, post-treatment and 4-month follow-up were taken as primary outcome criteria in an intention-to-treat analysis.
Results: Patients receiving BPT attended more sessions and had significantly lower negative symptom scores after treatment (PANSS negative, blunted affect, motor retardation). The differences held true at 4-month follow-up. Other aspects of psychopathology and subjective quality of life did not change significantly in either group. Treatment satisfaction and ratings of the therapeutic relationship were similar in both groups.
Conclusions: BPT may be an effective treatment for negative symptoms in patients with chronic schizophrenia. The findings should merit further trials with larger sample sizes and detailed studies to explore the therapeutic mechanisms involved.
(42 refs.)

Title: Effectiveness of Body Mind Therapy of Cancer Patients Receiving Chemical Treatment.
Authors: Dr. Irit Peleg, Dr. Joseph Brenner, Dr. Moti Shimonov, Ofra Ravinda, Dafna Karata Shwartz.
Contact: Dr Irit Peleg, Reidman International College, 26 HAim levaon St., Tel Aviv, 63507 Israel. pelegirit@gmail.com
Abstract:
The difficulties of coping with the crisis caused by implications of the discovery and the treatment of cancer induce a sense of mental and physical distress that influences the patient's quality of life. Body-mind therapies in the framework of integrative medicine have, in recent years, become an inseparable part of the physical and mental treatments used by patients. There is considerable research evidence of the effectiveness of these treatments for cancer patients.
The research objective is to examine the effectiveness of body-mind therapy on cancer patients who are receiving chemical treatment. The research method: 24 cancer patients were sampled, some of whom received body-mind therapies and some who constituted the control group. The research process: research data were collected using a structured independently completed questionnaire that was validated. The results: four interactions were found according to group and timing, in which an improvement was found after the therapy among the experiment subjects as opposed to the control group.
In the area of psychological variables, in the experimental group before the therapy there were more physiological changes before the therapy (M=4.65) than after the therapy (M=3.97). This measure examined the degree of tiredness, appetite, pains, sleep changes, constipation, nausea, changes in monthly menstruation, general state of health, and changes in the outer appearance.
In the area of variables in the economic situation and family situation, before the intervention there were more changes for the worse among the subjects in the experimental group (M=4.92) than among the subjects of the control group (M=2.55), while after the intervention there were no differences between the groups. This index examined the extent to which the disease bothered the family members, whether the support is adequate, and the extent to which the disease disrupted the employment and caused an economic burden.
In the area of changes for the worse in behavior, before the intervention there were more changes for the worse among the subjects in the experimental group (M=4.81) than among the subjects in the control group (M=3.36), while after the intervention there were no differences between the groups. This index examined the extent to which the patient is troubled by the first diagnosis, how the disease influences anxiety and depression, and concerns and fears of future diagnoses, fear of additional cancer, metastasis, and fear of the future.
In the area of negative changes following the disease, before the intervention there were more changes for the worse among the subjects of the experimental group (M=4.91) than among the subjects of the control group (M=3.98), while after the intervention there were no differences between the groups. This index is comprised of a mean of five indices: psychological changes related to the disease, changes in the economic situation and situations in the family, changes for the worse in the sexuality and social relations, changes for the worse in behavior, and changes and concerns related to the disease.
As the cancer patient receives more body-mind therapies, his physical and emotional immune system is strengthened (2.3), his ability to cope with crisis increases (4), his tension and anxiety are reduced (5.6), his level of tiredness is lowered (6.7), he acquires knowledge to relax the body and enable it to strengthen itself, and the ability to recover vitality, essentialness. The general quality of life increases (8). As the patient adopts positive thinking on life in general and on his personal situation in particular, the changes of his recovery will increase (9) and his relations with his significant other and his friends will improve (10).

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Biography

Courtenay Young trained in (unscientific) body psychotherapy about 30 years ago, and has since been working as a psychotherapist. He has been a significant member of the European Association for Body Psychotherapy (EABP) (former General Secretary and past-President of EABP) and has represented EABP at numerous conferences and meetings, on both the eastern and western coasts, over the last 15 years. He helped establish body psychotherapy as a scientifically validated psychotherapy with the European Association for Psychotherapy (EAP). He is a founding member of USABP, and compiles the EABP Bibliography of Body Psychotherapy (on CD-ROM and now on-line). He has now largely stepped out of political work and currently works as a psychotherapist and counselor in and around Edinburgh, Scotland. He helps edit two psychotherapy journals, and has just completed a book: *"Help Yourself Towards Mental Health"* (Karnac, 2010). He has also just started to help edit the English-American edition of the massive *"Handbook of Body Psychotherapy"* (edited by Gustl Marlock & Halko Weiss: published 2006, Schattauer, in German). He has written several journal articles and chapters in books about body psychotherapy, as well as about psychotherapy in general. He can be contacted by e-mail: courtenay@courtenay-young.com

Teaching the Whole Student: Experiential Activities in an Online, Undergraduate Course in Somatic Psychology

Leslie Ann Costello

Abstract

An undergraduate course in somatic psychology introduced students to the implicit and explicit inclusion of the body in psychotherapy. As part of the course work, students participated in weekly exercises and wrote in a journal about their experiences. The final product of this experiential part of the course was a reflective paper, using their journal entries as the source material. Student responses to the activities indicated that most were willing and able to engage in these experiences on their own, deepen their experiences via journaling, and share their learning with the instructor through a final paper. Although some students did not see completely how their experiences were in fact affected by some of the aspects of the course, through reading over their submitted papers and an optional survey, it was clear that most of the students enjoyed and appreciated the experiences.

Keywords

Somatic psychology – undergraduate teaching – experiential learning

Undergraduate psychology provides students with a traditional approach to psychological science: it is typically seen as a social science that deals with mental or cognitive processes and behavior. The body is, in essence, the vehicle for behavior and cognition; a perspective to which students hold firmly and texts do not discourage. I have found that the human body makes only a brief appearance in the typical introductory psychology course, even though it is actually the housing for the nervous system, which generates the mind; the place where psychological stuff happens. The important stuff, that is. Of course this traditional, "mind over matter" approach does not reflect our current reality, particularly for those of us who are clinically involved in body-focused therapies. In fact, contemporary research indicates that any approach separating body and mind is an incomplete one at best. Thankfully, a change is happening even within undergraduate text materials: newer influences, such as research on stress and health, now routinely appear in textbooks written for the introductory course (See, for example, Myers, 2009.) Now may in fact be the right time to increase the focus on the somatic aspects of the self, of development, and of psychopathology in undergraduate education.

One way to do this is to offer a course specifically about body based therapies to educate students currently at the undergraduate level. With this in mind, we decided to invite twenty-two students to embark on the study of somatic approaches in psychotherapy. These students were from various majors and had varied backgrounds. What they had in common, though, were that none of them had ever heard of "somatic psychology."

As a psychologist, an assistant professor at a small teaching-focused university, and a bioenergetic trainee in the clinical supervision phase of my training, I allowed my interests in teaching and in body psychotherapy to converge into the development of this new course in somatic psychology; one that was designed to specifically be directed towards upper level undergraduates. The purpose of this course was to provide a way to share with students what I had been learning in my own bioenergetic training. What I had learned in my training, though, was widely discrepant from my own graduate education as a developmental psychologist, so I was aware that a body-based approach would likely be a new, unconventional perspective to students as well.

I encountered some significant challenges in preparing the course. For example, as an undergraduate course, it would be *about* body psychotherapy, not a therapy training course in body psychotherapy. However, I had a strong feeling about making it an actual experience rather than just an academic exercise. As Peter Fernald has said, in discussing teaching bioenergetics in the college classroom, "A strictly conceptual or theoretical approach to teaching and learning Bioenergetics would be woefully inaccurate….similar to teaching tennis…without ever having the learner swing a racquet and hit a ball (2008, pg. 94)." To me, a purely didactic course about working with the whole person in therapy seemed apparently contradictory, or at the very least, inappropriate to the way therapy should be learned and applied. Thus, I wanted to include body activities that would require participation and reflection, and encourage people to attend to their own experiences of being a person in a body.

A second challenge came from the unfortunate requirement to offer the course online, due to the needs of the university. How could I engage students in experiential work and the necessary self-reflection that should, I thought, be intrinsic to a study of somatic psychology, when I didn't meet with them in person? I considered the needs for safety, intimacy, and one-on-one encouragement I had found that exercise group participants required, and I wondered how I could create that atmosphere online.

A third challenge had to do with others perceiving and accepting the course as a valid academic endeavor. While I anticipated this concern, the reality of it was reflected in the comment made by a student as she decided whether to take the course. In her journal, she wrote about her process of decision-making: "Here's one [course], Somatic Psychology. Reading the description, sounds kinda…fruity and fluffy, probably won't be too difficult. Maybe I'll learn something, although my first impression is one of a touchy-feely indoctrination that I will endure, not necessarily incorporate." Therefore, my task, as I saw it, was to make a course that included direct experience in an environment of safety and support, as well as didactic learning that avoided being a "fruity and fluffy" indoctrination by a "true believer of body therapy" type of lecturer. And to do this online, in what is often referred to as "asynchronous learning," was ever more

difficult, which meant that the learning would not happen in the same place or at the same chronological time as the teaching.

The Course

I designed the semester-long course to begin with six weeks of study of background material which included an instructor-generated overview of basic neural anatomy and learning theory, as well as Damasio's much-read work, *The Feeling of What Happens* (Damasio, 1999), to enable students to understand the scientific foundations of somatic therapy. This was followed by eight weeks of study of different body psychotherapy modalities, utilizing Caldwell's *Getting in Touch* (Caldwell, 1997) to launch further exploration via the internet. In addition to typical exams, quizzes, and presentations, students participated in online discussion forums. They also were responsible for engaging independently in nine experiential activities, keeping a journal of their experiences, and ultimately writing a paper reflecting on these processes. The interactive and experiential elements were important in part because students perceived the readings, particularly Damasio, as very challenging. I wanted to provide them with opportunities to link their personal experiences with the information they were reading and struggling to understand, thus helping them to ground their new knowledge. The balance of this paper is devoted to the students' reflections on their experiences doing those activities.

The Experiential Activities

In somatic psychology, students have a personal laboratory for direct experience immediately available. This means that opportunities for experiencing were potentially limitless. As with all experiential education, it was important for the instructor to help students structure their experience and to reflect on it in order to make it most useful. I also knew that we would be learning from our studies of Damasio about ways in which the mind can hide aspects of experience from consciousness, and I knew that it was likely that some of the students in the course would have their own personal trauma histories. Being aware of this, I felt my own struggle between wanting to maintain safety for individuals and while also giving them an opportunity to experience the power of body awareness. Holding both issues in mind, I chose activities that were varied in intensity and I frequently reminded students that bodywork can bring up emotional material, which they should self monitor for. In addition, I offered the experiential activities as an open field or space for people to simply try things and see what they might discover, without there being any need to meet some expectation. The final reflective paper was a graded assignment, but grading was based on completion of the activities rather than on any depth of self-discovery or disclosure.

My hopes for the course were that these students would accomplish the following:

1. Connect the readings with their own experience of living in a body.
2. Increase awareness of body states and body experiences, including background emotion, mood, and categorical emotion. That is, to experience emotion and mood as body experiences, rather than experiences of the mind.
3. Develop a compassionate, gentle, and friendly interest in their own embodied experience.
4. Be able to articulate how body experiences relate to life (behavioral) experiences.

The list of the weekly experiential activities was as follows:

1. Free writing in the journal. The five minute freewrite procedure is to be used after each subsequent activity, thus providing material for the final paper. The directions are to put pen to paper and write until the time is up, without internally editing, judging or saying anything negative to yourself.
2. Body scan. Repeat all week. This was a self-directed body scan.
3. Repeat the body scan and add attention to skin sensations, particularly in the shower.
4. Balancing on one foot; noticing balance in the rest of your life. What do you have to do to stay balanced?
5. Progressive relaxation. Practice daily and find an everyday signal to remind you to relax.
6. Getting to know the back body: sitting on "sitz" bones and imagining a silver thread connecting the spine to the sky.
7. Look at your body in a mirror and notice your thoughts as you see your whole body. Lie on a bed and kick and hit, and then look again at your body. What do you notice?

8. Clearing a space using focusing (Gendlin, 1998), to open up space in the body. When one moves a worry onto an imagined shelf, tension eases in the body, generating a sensation of more internal space. What do you notice?
9. Identify an environmental signal and use it to become present. Notice the noise in your world. Turn down the noise and notice what happens in your mind and body.

Each activity had a page of instruction with supportive comments. Students were instructed to allow themselves to experience and then write freely about the experience. I encouraged students to explore how their experience doing the activities related to their everyday life experiences using the freewriting process.

At the end of the semester, students created a reflective paper based on their journal entries. In addition, students completed an anonymous survey that asked about their experiences with the materials and assignments for the course. Using a five point Likert-type scale, I asked specific questions about the compliance with and utility of the experiential exercises. The combination of the reflective papers and the survey results provided qualitative and quantitative information about students' work with the experiential activities.

Results:
Selected Student Responses

Here I have chosen to report on a few of the activities. Student papers were diverse and creative, and I was greatly gratified by the variety of their approaches and their willingness to risk submitting something that didn't necessarily need to look like an academic report.

Activity #1: Journal Writing

Several students reported feeling skeptical and annoyed by the journaling assignment. One student wrote, apparently encouraged by an online discussion of how our bodies respond to cognitive activities, "…out of all of the assignments the thought of having to keep a journal made me sick to my stomach and my head ache." Despite this negative impression, all of the students who referenced these initial thoughts and feelings about journaling later indicated that the activity turned out to be less onerous than expected. One student's final assessment was merely that she "finds herself not so annoyed." The content displayed in her paper suggested strongly that she found some aspects of herself in the experiential process. It was clear, at least, that students did not feel constrained to comment positively about the experiences.

Activity #2: The Body Scan

> "Upon lying on the floor, the first emotion was strong relief and gratefulness. A feeling of sudden joy was strong, as I lay flat on the floor, doing nothing, yet working on schoolwork by doing nothing. It was a lovely respite from constant activity."
>
> "Lying down is also associated with thought of suicide. The passive feeling of nothingness is so delightful that I do not want it to stop. It feels very supported and safe. I don't want to stop doing nothing. I know I will not commit suicide, but am almost sorry that I am too responsible for such an irresponsible act."
>
> "I completed the body scan several times the following week…Surprisingly, my mind did not get too distracted during the exercises, but I could not get the upper half to relax in the same way as the lower half. Each felt foreign to the other like I was disconnected at the hip. My lower body stiff; felt numb and tingly as if there was no blood flowing through my lower extremities. In contrast, certain spots on my upper body ... felt very warm….I concluded that the lower portion of my body carried all of my physical weight, while the upper portion carried all of my mental weight."

Activity #6: Getting To Know the Back Body

This activity asked students to sit comfortably on their "sitz" bones and adopt a slight forward tilt to the pelvis so that they could become aware of their backs. Considering the back, they were asked to imagine a silver thread extending from tailbone up the spine, out of the head and into the sky. Next, they were asked to imagine that the thread is becoming slightly taut; ever so gently, subtly lengthening the spine. They were instructed to notice the effect that this slight shift and image had on their experience, in order to take the experience out into their week, giving attention to their backs, their spines, and what they might think or believe about their backs as they wrote in the journal.

> "When I was doing this exercise I kept thinking about having a strong backbone and not feeling any pain while thinking about sticking up for myself. I think that this exercise really helped me figure out how strong my

back really is while relieving muscles at the same time. Even though my mind was going in all different directions about my back muscles and people walking all over me like a doormat. I think this really helped me figure out how I want to go on in life. I don't think that I have a strong backbone when it comes to sticking up for myself. I have always had a problem telling people how I feel about some things because I worry that I'm going to hurt their feelings. This exercise helped me stretch out my back and thinking about things that I should tell people instead of keeping things trapped inside."

One student chose to write his entire journal and paper in the form of poetry. His reflection on the back body is below. This extensive excerpt is included by permission of the author.

The Silver Thread

Oh, the joy of the Silver Thread.
I was raised without a spine,
After all they had no backbone
I was so wonderful, being
Spineless. They were proud, but never said.
When I met Love for
The first time, I learned about
A Spine, she had such a Lovely One.
Before she left, she exposed my
Spine to me. It flourished, for a while.
Had its setbacks, as my self-esteem grew, my
Spine began to stand tall(er) at times, but
Mostly short times. Then the 3 years of physical therapy, chiropractors, and pain.
Said it was going to break my back, but it didn't, Thank you
God.
Now as I walk I sometimes remind myself to walk upright,
This gives me pleasure. As I laid in bed,
For my weekly meditation, I remove my pillow beneath me
And feel the pleasure of extending my back even more.
When I walked this morning, I was accompanied by
Geppetto, Pinocchio's creator, but this time I played the role of pulling the strings to the puppeteer, also being played by me.
Yes, as we walked this morning, I pulled
The One Silver Thread that gently
And loving stretched my back to a very comfortable
Place of self-esteem.
God, thank you for the ability to Love myself
To allow that Silver Thread to
Stretch me to new heights. AMEN.

"The more I thought about how my back felt as I was sitting on the firm foundation of the floor, the more I realized how much weight I take on as a mother, sister, daughter, girlfriend, and friend. What I wrote in my journal was that I am not a person with a strong backbone, even with everything I have overcome in my life. I am terrified on the inside but somehow I am able to fool everyone on the outside. And although I am not a pushover, I know I am easily walked on."

"After this exercise I was able to focus on my upper thoracic region, between my shoulder blades. The tension here increases during stressful events, I think that this is where I put my stress and issues that I don't have time or want to deal with, this appears to build up and when my stress level is elevated the pain is more prominent in this location. In reflecting on this pain, I realized that it is my nature to pile on more and more commitments and duties. The thoracic region serves as my filing cabinet, my natural backpack. Like a backpack it is filled with everything and anything and all goes along with me throughout the day."

Activity #7: "Look at your body in a mirror and notice your thoughts as you see your whole body. Lie on a bed and kick and hit, and then look again at your body. What do you notice?"

Two women students found it too difficult to actually kick and hit on the bed, but each of them described lying on a bed and *imagining* themselves doing the activity, and found even that to be a different kind of experience. One woman drew from the text materials to support her decision to imagine the experience rather than to actually do the assignment. She pointed out that an imagined experience is interpreted by the brain similarly to actual experience. Both women reported emotion and ultimately relief from their imagined hitting and kicking. Other students, who actually did the activity, referenced the struggle to observe their bodies without generating negative judgments, and some talked about how some parts of their bodies get all of the attention, while other parts are left unnoticed.

> "It was not easy to look at myself completely exposed in that way and not judge or criticize what I saw. What I noticed the most was how exhausted and sad my face and body looked, like all my energy had been drained. My eyes kept going back and forth between my mouth and my shoulders, which shared the same downward turn of defeat. …I felt unworthy of praise and detached from the person who was standing there looking back at me….Although I felt somewhat foolish, I proceeded to do the hitting and kicking exercises. I noticed some resistance at first, but then found myself making the most of it. Doing this got mentally and physically tiring after a while but I also found it energizing. It was a great way to release some of those suppressed emotions and get the juices flowing again. When I looked in the mirror again, I noticed a more relaxed and accepting person."

Unexpected Outcomes

I did not particularly want people to access old material, or process wounds or wounding, but this happened regardless. One woman, in imagining herself kicking and hitting and protesting on her bed, recalled being raped twenty-five years before as she noticed that her screams were inside her head at that time, too. Her writing about this event in her life reflected gentleness with herself and clarity about what happened when there was no indication that she had been re-traumatized. However, it was a striking example of what can come up during the activities.

Several students had significant health problems, present or past, that were reflected importantly in their work. One student wrote movingly about her relationship with her body as they worked together to beat cervical cancer. She chose to see her body and herself as separate, yet working together to heal. Another student who has multiple sclerosis wrote about her experience: "I felt my legs and was so thankful that they were able to carry me from place to place. They are the part of my body I like the least, but since I have M.S. I know what it is like when they don't work. If felt so empowering to appreciate the power they held. I began to cry when I realized that I had allowed myself to disengage from these wonderful instruments." Although no student indicated distress that was unmanageable.

From other assignments in the course and direct email contact with students, I learned that many were very interested in what might actually happen within a body psychotherapy session and were unable to imagine it from their reading and study. Their reading about particular modalities tended to whet their appetites for details. It was not clear to them that the experiential activities had any relationship to the types of activities that might happen in a therapy session.

Two papers, though, were vague and lacked convincing detail. This suggested to me that the students did not complete the activities or the journaling. As we will see, there is further support for this idea in the student survey data.

Student Survey

Twelve of the twenty-two students completed the optional survey. Two responses to the question about compliance with the experiential activities indicated non-compliance, and two responses identified the activities as a waste of time (I assume that the same students gave these responses). Ten of the twelve respondents indicated that they did the activities and that they were useful. However, only half of the responding students thought that the activities helped them to connect to the text materials, which was one of the anticipated outcomes. Students also indicated an interest in sharing information with one another about their experiences in a discussion forum online.

> Four students chose to comment on the experiential activities:
> "I enjoyed the experiential exercises and was pleasantly surprised with all I learned and with the changes I made"
> "The experiential exercises were wonderful: I was able to tap into sources of energy I wasn't expecting,"
> "The experiential exercises were not helpful to me."
> "I liked the experiential exercises. They helped me tie everything together and things made more sense to me after I tried some of them."

Discussion

Earlier in this paper when I had articulated certain desired outcomes for the upcoming activities, they were contemplated in retrospect. I wondered initially about whether students would actually complete the activities and journaling, whether they would find anything out about themselves, and whether they would choose to report that new understanding in a paper to an instructor who was only an online presence. I was most happy with the result of the activities and the paper. The majority of students wrote thoughtful reflections of their experiences, including details that made it clear that they were doing the work and that they had, in fact, learned some insightful things about themselves.

The survey results, although limited in number of respondents, are useful in the sense that they can provide direction for modification of the course. There were problems in motivation for a small number, and problems in connecting the experiential activities to the other aspects of the course for many, though they found the activities useful for other reasons. There are a number of ways to address these two educational concerns. For most students, participation in any course activity is enhanced when the grade depends on it. While the reflective papers got full credit regardless of the depth of participation, for the future I have chosen to emphasize more strongly the experiential activities as relevant to the learning. To address the concern about connecting the activities to the didactic learning, I will add a discussion forum where students can explore those connections. I will also offer some video examples of body psychotherapy in action so that students can see how body awareness is relevant in session. These additional learning opportunities may enhance the connections between personal experience and didactic learning.

In the midst of this, I have learned some important things about my students, despite the fact that all of our interaction occurred over the Internet. First, students were just as detached from bodily experience as any other group of people I have met. For these people to allow themselves an opportunity to relax into the body and to feel their feelings was a rare experience, as it is for so many in the therapy room. In addition, as students, they were particularly vulnerable to wanting to do these activities "right."Also, as students who are adult learners, they were over scheduled and overworked, and it was both difficult and a great effort to take time to allow themselves to feel anything of themselves. Several of them were explicit in saying how hard this was. In particular, the "Clearing a Space" activity was difficult for people, perhaps as one student said, because they *didn't want* to put the worries on the shelf. Or as another student said, maybe I have had to shelve so many important things that I just don't want to look at what is already on my shelf.

Conclusion

"I have found through all these exercises that my body is more my own now."

Teaching online about body psychotherapy can be enhanced by the inclusion of experiential activities and a structured reflective process. Students are able to connect immediate body experience with everyday behavior and concerns. They are willing to share their experiences in a setting that is inviting and positive; they are even interested in sharing their experiences with other students. However, the course lacked explicit structure to connect the body experiences to the didactic learning; many students did not create these connections independently. More emphasis needs to be put on how the experiential work relates to other aspects of the course.

As I think deeply about the work that the students and I did together, I feel gratitude for their trust and openness. As I complete this paper in an effort to open my experience up to colleagues, I feel a bit shy and anxious. I want very much to do it "right" and be found acceptable, much as my students felt in doing their work. It is a good reminder for me, perhaps for any of us who are lucky enough to teach, of the struggles of being a student. As therapists, we invite our clients to allow themselves to be present to whatever comes up. Students don't often allow themselves this opportunity, and it has been an honor and a privilege for me to offer it within the structure of an academic course.

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Appendix

University of Maine at Augusta
Course Syllabus

PSY 356E **Somatic Psychology: Body and mind in psychotherapy**

Instructor: Leslie Ann Costello, Ph.D.
224 Lewiston Hall

University College of Bangor
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Bangor, ME 04401
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Course description:

The course is an introduction to the theoretical and empirical bases for the explicit use of the body in psychotherapy. Starting with a brief history of the somatic approach, the course surveys bioenergetic analysis, somatic experiencing, EMDR, and other contemporary applications. There is an experiential component and journaling requirement for the course. Three credits. Prerequisites: PSY 308 or equivalent.

Course objectives:

At the completion of this course, students will:

1. Describe the history of the somatic psychology movement
2. Explain the evolution of the concept of the "unconscious"
3. Identify the major historical influences on contemporary somatic psychology
4. Discriminate and describe five major treatment approaches
5. Explain and formally present theoretical, empirical, and clinical aspects of a selected approach
6. Reflect on and write about personal experiences with somatic psychology activities

A note about this course:
Online courses are tough because YOU have to structure your worktime yourself. Please plan to be online TWICE a week in this course. You will have weekly work to complete, and you will have discussions that go over a few weeks. It is very hard to catch up when you get behind. It also takes a couple of weeks to develop a pattern that works.

Each week's folder will open on Monday morning and will stay open for a full week. During this time you will read material, do your experiential exercises and write your journal entry, respond to my questions and take quizzes as needed. Please PRINT out materials that you will need. Folders CLOSE after we have used them.

You can reach me by email. If you send me an email you can reasonably expect a reply within 48 hours. Sometimes on the weekend I am busy with other responsibilities and I am not necessarily checking email continuously. However, during the week you can probably reach me more readily.

I make every effort to grade work efficiently. However, if you submit your work LATE, you should not expect me to be right on top of grading it. I try to stagger my grading load, so if you send your work in late, it is on top of work from my other classes and it is not a priority item.

I will usually post an announcement when I think I have graded all the submissions. If I post this note and you don't have a grade, PLEASE LET ME KNOW! Things DO get lost and misplaced in cyberspace, and I would MUCH rather have you ask me twice if needed than you have your work missing.

A note on what the course is NOT:
This is a course about psychotherapy, but it is NOT psychotherapy. It is also NOT therapist training. You are not going to work through your personal issues or learn to do therapy with other people in this course. This is an undergraduate course about somatic approaches in therapy. Please be aware that there is no part of this course that will train you to work therapeutically with other people. That kind of work requires graduate level training and supervised experience. If you find you have an interest in working with people therapeutically, I would be happy to advise you around getting graduate training and obtaining licensure. In the meantime, do not attempt to use techniques you learn about on your friends, family or others.

Readings:

Caldwell, C. (1997). Getting in Touch: The guide to new body-centered therapies. Wheaton, IL. Quest Books.

Damasio, A. (1999). The Feeling of What Happens: Body and emotion in the making of consciousness. New York; Harcourt.

Other readings as assigned, including web sites and articles.

Quizzes and Exams:

In the first six weeks of class, there will be five weekly quizzes over the reading material. Quizzes MUST be taken within the designated time frame. The reading for the beginning of the semester is pretty dense and frequent quizzes is a strategy that is designed to make the work more manageable than if you just had a midterm. (Reading in the second part of the semester gets a lot easier.)

You will also have a midterm and a final exam. The exams will cover material from your reading, from the class notes you will find in the course, from your web searches and from our discussions. Exams will be essay format and you will have one week to complete each of them. Exams are due ON TIME as indicated in the calendar.

Late exams or quizzes are penalized by the loss of ten points. That is, if you take the exam late or submit it late, your grade will be docked by ten points. This is to compensate for the additional time you had to prepare to take the exam or quiz. This policy will be maintained regardless of your reason for taking or submitting your late exam. Please keep this in mind.

Research paper with group input:

I want students to explore the applications of some of the body-based therapies. Because our focus is psychology, we will be connecting to the body-based therapies that have an evidence base to support their use with clients. You will do this work in collaboration from classmates.

For your paper, you will select a problem or disorder or issue that may be addressed using body psychotherapy. You will find some research support for the use of this somatic therapy in treatment of the disorder or problem. You'll write a paper that gives some background about the disorder, some background about the therapy, and tells in detail about the research support for using the therapy with the disorder. This paper will be about 8-10 pages in length. The grading rubric will be posted in the course site.

For example: You decide that you are interested in treatment of stress-related illnesses. You are also interested in Hakomi. You look for research to support the use of Hakomi in stress-related illness. You don't find any, so you have to regroup. So you decide to look at mindfulness-based stress reduction to treat stress related illness. You find quite a few articles demonstrating the efficacy of this treatment for this disorder. In other words, the treatment matches the problem. Bingo! You've got a good paper topic.

What to do: Gather your information on your disorder (make sure you use good references, such as the DSM-IV-TR for disorders) and your treatment. Share your information in the small group on your type of disorder. Check out other people's resources, too, and see what might be useful to your paper as well. (Post your materials by October 15th) Write your paper and revise it. (Have your draft constructed by November 2.) Find TWO members of your small group who agree to critique your paper. Send it to them, get their critiques, and REVISE again. Also, you will need to be a helper and critique TWO other papers from within your group. (Finish your critiques by November 9th). Be helpful and be thoughtful and also be honest. This will help everyone's papers to be better than they would be otherwise.

After you have received your feedback and revised, you can submit to your colleagues again if everyone has time or submit directly to me for a grade. Papers are DUE to me on November 16th. Late papers are penalized. Send your paper via email as an attachment. Make sure it has a title page, page numbers, and complete references in APA style.

You must submit your paper for critique to colleagues. You MUST critique two other papers. Your grade will reflect these items as well as the quality of your own paper. Each member of the group will be rating every other member on their level of participation.

Discussion:

There will be five discussion forums throughout the semester. You are responsible to participate in all of them. Participation means that you will craft an original response to my questions. Make sure that your response is thoughtful and considers the reading as well as your personal knowledge about the subject. After you have made your original post, read your colleagues' posts and respond substantively to at least THREE of them. To get full credit, you need to write an original post AND respond to at least three of your classmates. Be watchful of the DATES of the discussion forums. Posts made after the closing date of the discussion will NOT count toward your grade.

Experiential reflective journal and reflective paper:

Every week you will have an exercise to do that is designed to enhance your own experience of the interaction of your mind with your body. After completing the exercise, write about the experience in your journal. At the end of the semester you will write a reflective paper that uses the content of your journal as material. Thus you will complete a minimum of eight journal entries and use those entries as material for your paper.

Your paper may take any form that you wish. You can include your journal entries or simply use them as information sources. Please remember that I will have only your paper to convince me that you did, in fact, do the activities and write the journal entries. I am looking to hear about your OWN experience in doing the activities, and that might include your resistance, your thoughts, your feelings, and your overall mood before, during and after. There is no RIGHT way to do the activities; there are many RIGHT ways to write the paper. Please be comprehensive and thoughtful and honest.

Grading:

Quizzes	15%
Midterm exam	15%
Final exam	15%
Research paper	20%
Discussion	15%
Experiential journal and reflective paper	20%

Topic Calendar:

Week	Topic	Reading and Assignments	Discussions	Quiz	Journal writing
Week 1	Introductions		Discussion #1		Begin journal process
Week 2	What is somatic about psychology?	Caldwell, introduction and chapter 1	Continue Discussion #1	Quiz 1	Experiential activity #1
Week 3	Where has the body been in psychology? Review of some concepts in physiological	Damasio, chapter 1 & appendix (notes on mind and brain)		Quiz 2	Experiential activity #2

	psychology				
Week 4	Emotional information processing	Damasio: Chapter 2 and notes	Disc. #2:	Quiz 3	Experiential activity #3
Week 5	How the body experience creates consciousness	Damasio, Chapter 3, 4 & 5 and notes		Quiz 4	Experiential activity #4
Week 6	Body and emotion; using consciousness	Damasio, Ch. 8 & 9	Disc. #3	Quiz 5	Experiential activity #5
Week 7	Brain, mind and body: Psychoneuroimmunology	Article as assigned Caldwell, Chapter 12 **Post your research sources for your paper to your small group by October 15th**			Experiential activity #6
Week 8	Exam	Midterm exam is due March 8th	Disc. #4	*EXAM*	
Week 9	Overview of clinical applications of somatic psychology	Caldwell, Ch. 2, 3, 4 Focusing article			Experiential activity #7
Week 10	Applications of body-mind approaches	Caldwell, Ch. 5, 6, 7 **Complete your draft and submit paper to peers for critique by Nov. 2.**	Disc. #5		Experiential activity #8
Week 11	Treatments for stress and other "health" diagnoses	Articles on EMDR, mindfulness, ACT, and MBCT. **Submit your critiques to your colleagues by Nov. 9**			Experiential activity #9
Week 12	Treatments for personality change	**RESEARCH PAPERS ARE DUE ON November 16th** Articles on bioenergetics, somatic experiencing			
Thanks giving	No additional class work this week				
Week 13	Treatments for trauma				
Week 14	More on methods	**REFLECTIVE PAPERS are due on Dec. 9sth**			
Week 15	Final examination	Exam must be completed by May 6th		*EXAM*	

Note about experiential exercises:

This course asks you to reflect on your own experiences in present time. You will be asked to repeat a body scan, in which you take time to relax and notice your body responses. You will practice some expressive exercises, and you will likely experience some of your thoughts and feelings in a different or surprising way. The exercises are designed for self exploration and discovery but there are many other exercises and practices you might find on the Internet that tap more deeply than expected in this course. I recommend that you proceed carefully with bodywork, and limit your explorations to the activities in the course. You need to be self aware and attend to your responses to the activities, keeping your journal and developing your observing self. If you find a place in yourself that you want to explore more deeply, I strongly suggest that you locate and work with a therapist who is experienced with somatic approaches.

Biography

Leslie Ann Costello, Ph.D. teaches at the University of Maine at Augusta. She is a Bioenergetic trainee and a member of the Atlantic Canda Bioenergetic Society as well as a licensed psychologist. She can be reached at Leslie.costello@maine.edu

A Tale of Four Body Psychotherapists: The Training and Practice of Mexican Practitioners

Fernando Ortiz Lachica, PsyD

Abstract

This paper describes the training and practice of four Mexican body psychotherapists, each of which have completed three or more training programs and were interviewed in depth regarding them. This paper attempts to construct an ideal type of experience, through following a golden thread that integrates the narratives of the participants, from their initial contact with body psychotherapy to their current integration of concepts, methods, techniques and personal experiences.

Keywords

Body – Psychotherapy – Training – Integrative Psychotherapy

Training in Body Psychotherapy: Diversity and Integration

With more than 30 varieties in Europe alone (Young, 2008), body psychotherapy (BP) is characterized by diversity, so much so that Martlock and Weiss, editors of the *Handbuch der Körperpsychotherapie* (2001), state that it does not exist as a theoretically and clinically unified field. I (Ortiz, 2007a) have discussed the reasons for this diversity elsewhere. We can see that on one hand, there have been enormously creative founders of schools who have made a synthesis of existing methods and have discovered new and exciting ways to work with the body and the mind, and on the other hand, there have been many pioneers who were not aware of these developments. Yet there are many gratifications both personal and economic to be found in starting a new school, even if it means inventing new names for old concepts and procedures.

The number of schools, concepts and techniques can be baffling, and the therapist-to-be has to choose among various training possibilities. As some schools of body psychotherapy do not recognize or communicate with each other (Young, 2005) and some of the founders and leaders do not tolerate even minor deviances from their creed, trainees and certified practitioners often have to pledge loyalty to their tribe and ignore or debase other modalities. In fact, many practitioners are certified in two or more modalities in Europe (Heller, 2001) and the U. S. A. (Burns, personal communication, September 10, 2008). We can only guess the reasons that motivate each therapist to complete two or more trainings, which may range from the limitations of their first training to their continuing drive for professional and personal growth. In fact, that is the case with psychotherapists in general. One-quarter to one-half of American clinicians consider themselves eclectic or integrative (Norcross, 2005), making it the most common orientation in the United States.

Even if some body psychotherapists are loyal only to one school, one must bear in mind that many modalities are, themselves, products of the integration of many schools. Consider, for example, the number of founders that were influenced by Gestalt itself an integration of Psychoanalysis, Reichian character analysis, psychodrama and the Alexander Technique, to mention but a few (Shepard, 1983). If psychotherapy is a craft and not a science (Young & Heller, 2000), then we can expect every clinician to develop his or her own integration of concepts and procedures, regardless of initial allegiance to a particular school. The aim of this paper is to describe the training and practice of four "integrative" Mexican body psychotherapists.

Body Psychotherapy in Mexico

Body psychotherapy became established in Mexico in the 70´s, through the work of Rafael Estada Villa, Héctor Kuri and Agustín Ramírez. Each one of them was heavily influenced by Bioenergetics, which was at that time synonymous for Body Psychotheraphy, although they all had experience in other modalities. Both Estrada and Kuri blended diverse oriental practices into their individual sessions and workshops and Ramírez had studied with Carl Rogers and Jakob Moreno (Ortiz, 2007b).

These pioneers and their students formed institutes that trained therapists in the next decade, in what may be labeled a neo-Reichian tradition; somewhat grounded in classical psychoanalysis, with a strong emphasis on Lowen´s character types, and aimed to produce strong emotional reactions through the use of Bioenergetics and other techniques. Many of their trainees were neither psychologists nor psychiatrists, as the practice of psychotherapy is not regulated in Mexico.

Following this basic training, many therapists sought further specialization in brand name modalities. Among the founders and leaders of schools that led training programs[1] were Jack Painter (Postural Integration starting in the middle 70's); John Pierrakos (Core Energetics, which began in 1989); Wilem Poppeliers (Sexual Grounding, 1996); Luciano Rispoli

[1] In most cases the trainings continued to be led by the Mexican or foreign students of the first trainers.

(Functional Psychotherapy, 1998-2004); Ron Kurtz and Donna Martin (Hakomi, 1999). Bjorn Blumenthal started a training program in Vegetotherapy in 2006, which was continued by Xavier Serrano in 2008[2].

These trainings consisted of intensive, four to seven day sessions that were mostly residential. That is, participants left their homes and occupations, and stayed together. Everyone looked forward to watch the masters' performance and, in many cases, to receive an individual session in the group. Expectations ran high, at least at the beginning of these trainings. It was hoped that this modality was "it," or the one that could assure growth and healing to the trainees and at the same time provide the necessary skills for a successful private practice.

Most of the training programs were experiential, so the participants did not have to read or fulfill any academic requirements in order to be certified. In the case of the foreign trainers, the students didn't usually meet between sessions, so they had to integrate whatever feelings and memories emerged quite on their own, or in individual therapy.

Thus, the therapists who completed more than one training program not only had to integrate the methods, techniques and concepts of diverse modalities, but also had to assimilate the personal experiences and material that came up in the various programs.

Method

This qualitative research attempts to describe the experience of body psychotherapists who 1) had more than ten years of clinical practice, 2) had finished more than two training programs in body psychotherapy, 3) had led or organized training programs, and 4) had lived in Mexico City. The first three criteria assured that the participants were well known experts in the field.

In fact, the participants had a mean 17.5 years of practice, with a maximum of 23 and a minimum of 13. According to Orlinsky et. al.'s (2005), two of them were established psychotherapists (with between 7 and 15 years of experience) and the rest were seasoned psychotherapists (with more than 15 and less than 25 years of practice). Each one of them had completed at least three training programs and all of them have participated as assistants, organizers or teachers in training programs.

The participants were interviewed at least twice[3] in depth about their training and practice[4], and the transcripts were codified and analyzed in search of common, emerging themes. The first draft of the analysis was sent to them for verification. All of them agreed with the content, except for one minor observation. Their narratives are an account of the history and practice of body psychotherapy in Mexico.

The Therapists' Tales

In the beginning, none of the participants intended to become psychotherapists. None of the individuals studied had enrolled in a certification course in psychotherapy after studying psychology, as was the norm for other orientations before the middle 1970's. Their training started before it began and is still not over. To say that it had started before it had begun may seem nonsense, but the truth is that they all experienced body psychotherapy as clients or participants in workshops, and it was only after they felt the effects of the therapeutic process that they entered a training program. And, even then, they were not clear about becoming therapists[5]. Thus, the first stage in their process was a personal search. But why did they need this search? On a personal level, they all had some degree of discontent, which moved them to seek change and growth.

Like the princes of Serendip, all of them found more than they were searching for: a network of friends who shared their interests and a great degree of information about their past, their emotions and their body. They also would hope to find a framework in which they could integrate the cognitive, emotional and sensory-motor experiences that were elicited in the trainings and workshops. More importantly, they found a calling in Weber's (1905) sense: they abandoned their former occupations and, in becoming psychotherapists, found a profession that has given meaning and purpose to their lives and has allowed them to forge a new identity.

The Context

The participants' training process cannot be understood only in personal terms. Within the spirit of the Human Potential Movement, with its emphasis on experience, liberty of expression and the importance of authenticity in relationships, different institutes offered workshops and training programs in which all of that had happened, without any formal requisites for enrollment. Anyone could sign up and all that was asked for was participation. The intent to change and the participant's search flowered in the zeitgeist in which three of them started to participate in body psychotherapy

[2] For information on these modalities see Painter (1987) Pierrakos, (1987); Poppeliers & Broesterhuizen, (2007); Rispoli (1993, 1997, 2004); Kurtz, (1990): Blumenthal (2001) and Serrano (2007).

[3] Of a total of twelve interviews, Marisa participated in four, Gerardo and Eugenia in three and Nadia in two.

[4] They all signed an informed consent, in which they were told about the purpose of the study and were assured that it would not involve personal information, and that their anonymity would be protected.

[5] Some of the training programs allow participants to enroll with the sole purpose of personal growth.

workshops. According to Eugenia[6], one of the participants, "we were searching for liberty within ourselves (liberty of movement, new sensory experiences and fuller expression of emotions) and outside [ourselves] (human rights, contact without prejudice)." Freedom and expression were values of the 70's in which, according to Gerardo, Reich was seen as a revolutionary. Workshops and training programs were seen as a manifestation of a new lifestyle, because things were not too good in the world and something was missing inside. Nadia remembers one of her teachers/therapists whose libertarian, revolutionary spirit got her out of the outdated ideas of the 19th century. It was, according to Eugenia, "Mexican post-hippism."

For the participants, these private institutions were their Colleges and Universities, the workshops were equivalent to courses, and training programs were equivalent to their graduate studies. It was possible to enroll in "courses" or even in training programs only with personal growth as a goal, without the explicit intention of becoming a psychotherapist.

Starting a training process by participating in workshops differs from the experience of therapists from other theoretical orientations (Godfried, 2001). Participation in workshops was important for therapists whose initial training was psychodynamic (Smith –Benjamin, 2001), cognitive-behavioral (Lazarus, 2001; Mahoney, 2001) and experiential (Beutler, 2001), but all of them enrolled in them after finishing graduate studies in psychology.

In fact, training in body psychotherapy couldn't have happened in any other way. Even if it is a discipline that began in the 19th century, it has developed, until recently, away from academia. On the other hand, the experiential nature of Body Psychotherapy makes it hard to be taught or communicated by traditional means. As Heller (2001:17) remarked, "in our field, workshops are the equivalent of articles in most other forms of knowledge. In workshops, we compare ways of doing things and integrate them." Our interviewees would agree. All of them defend experiential learning.

Workshops and Training programs: An Experience in Informal Education

Before starting a training program, all of the interviewees participated in workshops. The idea of becoming a therapist came later. In the beginning, they looked for personal growth and change.

The invitation to participate in their first workshop came from a relative, therapist or friend, and they went with the intention of complementing their individual therapy processes or to find out about themselves. Eugenia described workshops as "having a practical experience of a theoretical principle… a teacher comes, you see his practice, and you do it and hope that it gives you a life experience." The workshops offered a package of personal growth and practical knowledge of psychology rarely offered in universities and colleges. Some, like Fisher Hoffman, dealt with issues to work with, such as the relationships with parents. In others, there were demonstrations and practices of a particular form of bodywork, such as Ayurvedic Massage, and there were those whose purpose was to know and experience the work of the founder of a body psychotherapy modality (as was the case with John Pierrakos' workshop near Mexico City[7]).

The workshops had a flavor of the Human Potential Movement of the middle 60's and early 70's. They offered weekend intensive growth experiences and gathered people who seemed to have little in common except for the intention of learning more about themselves, developing their potentials, or solving a problematic situation. The intensity of the experience, the perceived changes, the experiential knowledge they gained and the social interaction that took place in the workshops made them enroll in more of them. For some this was their preferred activity, consuming much of their free time and resources. Gerardo remembers: "The thing is I *felt*: I felt such a powerful effect, I felt a powerful movement and that is what hooked me to stay… so if I had to take a workshop, I took it, and if a course was offered, I went." And they took many workshops. Nadia states: "I took all of them." They learned theories and concepts in an experiential way and they felt changes. These changes were so real, according to Nadia, that they were felt in the body and they allowed her to perceive herself in a different way. The felt changes were, in Gerardo's case, "the cause of the passion and latter "gusto" for becoming a therapist.

The combination of these factors made two of the participants feel that "this is where I belong."[8] This is not to say that all of them have similar personal traits. Marisa, for example, sees herself as "a strong, "vibrant" woman, that is, "with a lot of energy," and that is why she resonated with the intensity of the first workshop, where participants were encouraged to scream and hit mattresses. So she remembers, "that is what I had inside me." In contrast, Nadia pictures herself as shy and believes that the uninhibited atmosphere, which was the norm in the groups, was just what she needed. In brief, every one of them stayed because they perceived that they needed and wanted to do what was done in the workshops and training programs, either because that was their nature or because that was the direction they wanted to take. When asked whether she continued to use the techniques she learned in the first workshops, Nadia answers: "I feel that they transformed me more and I stayed with the techniques… I feel they forged me."

There is no clear line dividing workshops and training programs. In the participants' experience, workshops and training programs are part of a continuum that is not easy to differentiate. Sometimes, a training program is promoted by a workshop, hoping the participants are hooked with the trainer and/or method and enroll, as it happened with Gerardo and

[6] The names of the participants have been changed.
[7] These examples are actual workshops that the participants took.

[8] Some of the actual expressions are, of course, impossible to translate accurately. Nadia said (in Spanish), "De aquí soy".

Marisa. On the other hand, many training programs are structured in the typical workshop format, with intensive, residential sessions. All of the interviewees were trained this way in at least one modality and, even in the programs in which the students had to go to courses once or twice a week, the curriculum included workshops dealing with specific themes or methods.

Mentors

All of the participants spoke about encounters or special relationships with a famous psychotherapist, usually the founder of a school or leader of a training program. The therapists played several roles: teachers, workshop leaders, psychotherapists and supervisors. In many cases, they became friends and partners in latter trainings. The best word to account for the relationship is that these people were mentors: older and experienced professionals that not only helped the participants to learn their skills, but served as role models (Levinson et. al., 1978) All of them remember special moments with their mentors, which happened 10, 15 or 20 years before, with gratitude and joy. Sometimes it is something that one of them said a small jewel of wisdom that was seen as a gift from an admired person that seemed to be destined for them and only them alone, and that they treasure for a long time:

> …he told me "nothing matters except how you are" and I touched paradise in that moment, when he told me "the only thing that matters is how you are," and that is how that part of wanting to be looked at in another way began to be nurtured, that is when it started.

The mentor can be someone with admirable qualities that serves as an example:

> [I took] workshops with Adela Palcos[9]… really, to know her was very stimulating, very important. She is such a wise woman, so close, at the same time so natural.

In other cases, there is more of an ongoing relationship, as is the case with Gerardo, who had a mentor in every stage of his training:

> I see myself in psychotherapy with two or three role models, that is, people that made me say to myself 'I would like to work like that'. B, was the first one, with whom I hung around at the beginning, and for me, her modeling, her presence was valuable. Then there was A, one of the professionals that know more about the Person Centered Approach in Mexico, and I hung around him. And in Core, with S., I practically adopted him, and, and as I see it, my most important formative experiences did not come with the trainings as such, but in these relationships where I glued myself to these people… I went as an assistant, as an apprentice, as anything, as a translator with S, so I was there in everything he did [in Mexico]. And *that* was the most formative space, therapeutically speaking, right? More than the training itself. Not that I despise the training but this [relationship] took me to another level.

So Gerardo, in different stages of his training, sticks around with a mentor. In his own words, he goes as an assistant, translator, or anything in order to learn from his teachers. In that moment, he is not a participant in a workshop or a student in a training program, but an apprentice. Each one of the participants went through a similar experience. After finishing one or more of the training programs in which they enrolled, they assisted their teachers. They learned about their work from another perspective, and they continued their training under the tutorship of their mentors in a closer, more personal relationship than the common student. Gerardo remembers:

> With all of them I was in a personal process as a client, and in that moment all of them were parent figures. With all of them, as well, I became involved in a personal relationship, friendly and collaborative, and I feel gratitude and affection for them all.

The mentor-apprentice relationship, according to Levinson et. al. (1978) is not an equivalent one to the relationship with a mother or father figure. The mentor is usually eight to fifteen years older than his apprentice is and must place himself between the role of father and that of peer. In the case of our participants, the mentors were, at one time. therapists, and as such were objects of transference, but the relationship wasn't only about a patient projecting unresolved, past feelings on a therapist, but about adults in transition who found persons of greater experience that helped them to realize "The Dream:" an imagined possibility generating excitation and vitality. The dream is their calling, or *beruf* in Weber's (1905) sense, is becoming a psychotherapist. It was the relationship with their mentors that made it real for them.

[9] Adela Palcos founded the *Río Abierto* School in Argentina.

Not only do the trainees learn skills, but are also they motivated. According to Nadia, the mentor's main function is to see the potentiality of the apprentice and say to her "yes, you can." She thinks that if you admire something in someone, it is always a part of you that has not yet developed, and so: "These parts become excited, right? To step into the stage… the mentor's admired qualities invite those parts in us that are asleep, that have not been asked out." So, when she speaks about what she learned from her teachers, she makes an inventory of virtues and attitudes:

- "B taught me to 'go for it,' or to go deep, not to beat around the bush. She taught me not to be afraid of the process- to trust the process."
- "One of the things I liked about T is that he knew how to change. When he first came to Mexico he was as hard as a stick, and he let himself be transformed by Mexicans. And his body changed!"
- "What I liked most about R. is that he got me out of my context. It is as if he said 'There is another way of living, of experimenting. Don't be afraid, challenge!' He was a charismatic leader that gathered us around a table and read to us, like a patriarch, which for me was very important because fathers do that."
- "From J, I think, his joy is of living. He also is one who is not afraid to go beyond, to break paradigms. [He is] an inspiring person."

Summing up, not only did the mentors teach skills and concepts to their trainees, but also they inspired them with their attitude towards psychotherapy and towards life.

Becoming Body Psychotherapists

From Eagerness to Selectiveness

I their progress, from the first workshop to the present moment, the participants learned diverse, sometimes contradictory, concepts and techniques. They discovered things about themselves and went through intense, sometimes painful emotional experiences. The theories, skills and experiences had to be integrated in order to form a personal and professional identity. The stages of the process can be described in terms of polarities.

In the beginning, all of the participants were eager to go to almost every available workshop and training program. Marisa reflects on that stage:

> Look, I was very wild and my consciousness wasn't … [it] was crude (laughter). I couldn't discriminate those things, I mean, I grabbed everything as in a package and I didn't say 'this goes, this doesn't.' In time, becoming more refined, I could say 'this does not go.' But not at the beginning. *It is now* that something matured, something developed, that I can discriminate.

Speaking about conferences, Eugenia confesses that, at the beginning, she would have liked to participate in every scheduled workshop in a conference, and in another stage, she would probably have liked to take half of them, and then later maybe less. Now, after going through the program repeatedly, she said that she would have liked to sign up for only two. As they learned and experienced more, they became more selective.

The same thing happened with training programs. All of them had an initial neo-Reichian training, which emphasized provoking strong emotional reactions through confrontation, stressful postures and invasive massage. On finishing, they knew body reading based mainly on Lowen's Character Types, but soon they learned that it was not enough. Looking for structure and skills they did not have, three of them studied Gestalt and the Person Centered Approach and Psychodrama. According to Nadia and Ariadna, the Gestalt-Rogerian training allowed them to get the guiding thread, while Marisa says she "completed herself" a little more in learning how to interview and foster rapport. Eugenia, who studied Psychodrama, says she obtained the structure she was lacking. Summing up, all of them acquired technical skills in their first training, but they did not know how to employ them in the context of a therapeutic relationship.

After studying Gestalt or Psychodrama, all of them enrolled in other training programs in different modalities of Body Psychotherapy or other orientations. In some cases, they did not integrate the trainings into their current practice. Marisa, for instance, tell us that she studied Jung, but it didn't seem to match with Body Psychotherapy, "like, it was turning out to be a cocktail that didn't taste good," while Eugenia remembers a training program that taught her how she "did not want to work." All of them went through one training program that seemed irrelevant, as they did not mention it in their narratives. But they went on and eventually learned modalities that seemed adequate. Among them are The Hakomi Method, Vegetotherapy and Biodynamic Craniosacral Therapy.

In integrating their various programs, they went past the allegiance to their first orientation, realizing its strengths and limitations, and made a personal synthesis. Workshops and training programs were offered as in a smorgasbord. At the beginning, they wanted to eat all that was offered, and in fact, they did. Afterwards, as Marisa recalls, they needed a time to digest. Now they have learned to be more selective. Even if they continue learning about specific subjects (two of them

mentioned anatomy and neurology), or specializing in their favored modality, they wouldn't enroll in any workshop or training.

From the Wild Stage to Collaborative Relationships

As all the training programs involved working a personal process, all of the participants went through intense, sometimes difficult and painful experiences. Thus, workshops and trainings were sometimes dangerous. All of them speak about a wild period, when some leaders/therapists pressured trainees looking for catharsis at any cost. Emotional discharge was the goal, and it was achieved through pressuring the group members. Any attitude that seemed fake or defensive was confronted harshly, and techniques such as stressful postures, painful pressures on chronically tense muscles, or expressive movements such as hitting a mattress with a racket or shouting, were encouraged. All of that came with pressure from the therapist and group, which could be stated quite simply: "Get it out!" The belief behind these practices was that movement in itself was good, so one had to move the body, move energy, and move emotions because stagnation was sickly and movement and expression were prerequisites for healing. However, sometimes the movement was too much. As Marisa Remembers

> ... It was so much that was moved there, that I went through there (she mentions a training program). Oh! Images come to me of what I lived there. Well, if I tell you, in my experience it is going into madness and not staying there (laughter). It is so strong, so much. So I think that if I already went through all of that, nothing will happen. What I learned is to 'beware of not integrating! Its O. K. to unblock but it has to be balanced with closure.

Eventually they abandoned these procedures, which now Eugenia criticizes:

> In whatever way you had to hit, cry, [and] scream and that had a great value in the group because you were releasing. You were getting at *something*, right? And the more, the better. How cool! The truth is, who knows where you would arrive to, but, mm, really I don't think it happened that way. That is what workshops were about: intensive practice that included *very* intensive emotional experiences.… Yes, I think that people might profit from an emotional release some time. *Yes* of course, but then again, in comparison, so is going to a party. I had never danced, and I did, and I had a lot of fun. It made a difference in my life.

The wild stage didn't only mean invasive procedures, but an authoritarian attitude from the trainers and therapists. The four participants recall that some therapists/trainers were directive and even authoritarian. They carried their own agenda and were sometimes abusive, rationalizing their attitude based on the importance of emotional release and confrontation.

While all of them still use techniques or employ concepts learned in "the wild stage," they do it cautiously, in a collaborative manner. Otherwise, according to Nadia, "you awaken old wounds and desires and you injure them again." Speaking about his current use of unblocking the body and confronting defensive attitudes, Gerardo ponders:

> For me the therapist's attitude and intention is paramount. Because you can, you can hurt [patients] with the truth, or operating on their muscles, [or] you can use techniques cautiously, from a non-violent attitude; you can use hyperventilation, you can work on the body, and you can use emotional release…

Currently, the interviewees stress the importance of a collaborative relationship, not only with the consultant, but also, according to Nadia, who combines bodywork with psychotherapy, with the living tissue. When she touches someone's body, she tunes in with each organ or muscle, waiting, attending, gently inviting it to let go instead of pushing through the tensions. The same attitude is shared by all of them, who place more emphasis on the healing power of an attuned relationship than on techniques.

Integrating Modalities

All of the participants have made their own synthesis of methods and concepts. As in the case of mainstream therapists (Godfried, 2001), the perceived limitations of their first training made them integrate other orientations. As we said earlier, three of them studied a blend of Gestalt and the Person Centered Approach, and the other one trained in Psychodrama as a complement to the limitations of their first training. In their first years, they could be labeled "technical eclectics," according to Norcross (2005). Presently, and still following Norcross's classification, three have followed the route of theoretical integration, creating a personal synthesis that not only combines methods and techniques, but the underlying theories. All of them continue to use Reichian concepts, such character armor, but they have concepts, techniques and values from various orientations such as the Person Centered Approach, The Hakomi Method, Craniosacral

Therapy and Family Constellations. Eugenia seems to be an assimilative integrationist, as she found Vegetotherapy to be "an axis, like a Christmas tree on which you hang ornaments."

The integration of procedures from different modalities is done in the context of ongoing therapeutic relationships. To experiment with methods and techniques in the context of a workshop, with highly motivated and conscious trainees, is not the same as working "in the trenches" of everyday private practice (Johanson, 1986). Here, too, adaptation and integration are necessary.

Current Practice

The fact that our participants integrated two or more body psychotherapy modalities may explain, in part, why all of them feel nurtured by their practice. (Orlisky et. al., 2005; Godfried, 2005). For them, psychotherapy is a calling. In Weber's (1905) sense, is an occupation that fills their life with meaning and gets the best out of them. Their joy and sense of fulfillment is evident in their narratives:

- "I enjoy my work. I feel moved by my clients. Yesterday I had many sessions and I ended super satisfied, very pleased (Marisa)."
- "I live it as a mission towards myself, connected with a mission towards the world. This impeccability, this thing about doing something for much more than money (Nadia)."
- "[To work as a therapist] is almost a present. Not only do I like it, I get paid for it! (Gerardo)"
- "[I had worked with] this 26 year old girl, who has difficulty looking at people when she talked…, to work with [this issue] through the body and, oh, to reestablish the connection that was naturally there. I enjoy these simple things *so much*! (Eugenia)."

Conclusion

In Mexico, as in many other countries, it is common for psychotherapists to feel distressed when they learn that people who have not studied psychology or psychiatry work as therapists. This situation is not new. In fact, Freud argued for psychoanalysts' "need not be doctors," and that they should be adequately trained. In reading these narratives, some might think that the sound and fury of the initial stages of the participants would have been avoided if only they had had proper academic studies. Some of the trainings they had, according to their own narratives, were irrelevant or even noxious, and sometimes they had to cope with abusive, authoritarian teachers as well as painful experiences. But then again, isn't that the case with some college or graduate courses? Their never-ending search is a testimony of perseverance and commitment, for as Eugenia states:

> In general, training programs offer 'three years and you are done'. [Actually] it takes much longer. You keep on learning, but with less eagerness. I think it takes about ten years. At the beginning, *everything* changed you and [it went from a] 'let's do it this way' [to a] 'now let's do it this other way.' And you gradually develop your own style. You keep changing, but just a little.

The other participants, and their clients, would agree. All of them said that that one training program was not enough, and that it would be irresponsible to stay with only one. Even if the field of body psychotherapy is not unified theoretically or methodologically, each of them has achieved a coherent synthesis through hard work.

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Biography

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Part II - The Adolescent Brain: Clinical Applications

Deborah Harkin, PhD

Abstract

A fundamental assumption of somatic psychology is that the mind and body are not separate but function as one (Reich, 1973). Contemporary theory and research in various scientific disciplines have contributed to our understanding of how the mind and body develop and function together within the evolving self. In particular, principles and findings in the field of neuroscience are increasingly being incorporated into psychology and inform clinical work. Until recently, little was known about the adolescent brain. However, a decade of research now suggests adolescence as a critical period for brain maturation and associated capacities. Part 1 of this article presented an overview of recent research on the adolescent brain and its significance for understanding adolescence as a critical period (Harkin, 2009). Part 2 will provide a brief review of the findings and discuss the implications for clinical practice.

Keywords

Neuroscience – Adolescent Brain – Adolescent Development – Clinical Applications

The prenatal period and infacy are generally recognized as *the* critical period for brain development (Cozolino, 2002; Schore 1994, 2003; Siegel, 1999). Until recently, it was assumed that by adolescence brain development was essentially complete. Over the last decade, however, the discovery of complex patterns of growth and change in the adolescent brain provide evidence that adolescence may be a second such critical period (Giedd 2004, Giedd et al., 1999). These findings are significant because they suggest that the structure and function of the brain continue to be shaped by interactions with the environment during adolescence. It is thought that during critical periods the brain is particularly receptive to new learning as well as susceptible to the impact of adverse stimuli (Schore, 1994). As a result, the quality of experience during critical periods is essential to the future development and well-being of the individual. A hallmark of critical periods is that they represent a time of both increased vulnerabilities and opportunities (Dahl, 2004; Schore, 1994; Siegel, 1999; Steinberg, 2005). Recent discoveries in neuroscience may provide new insights into adolescent behavior as well as some of the risks and opportunities unique to this developmental stage. Part 1 of this article (Harkin, 2009), provided an overview of a decade of research on the adolescent brain. Part 2 will provide a brief review of the findings followed by a discussion of the implications for clinical practice.

A Brief Review of Neuroscience Findings

Recent research in neuroscience suggests that adolescent brain development is far from complete. Structural changes have been discovered in almost every area of the brain that has been examined. White matter changes reflecting progressive myelination have been identified in a number of important structures and circuits including the superior medullary lamina (Benes, Turtle, Khan, & Farol, 1994), amygdala (Durston et al., 2001; Giedd, Shaw, & Wallace, 2006), hippocampus (Day, Chiu, & Hendren, 2006; Giedd et al, 1996; Suzuki et al. 2005), basal ganglia (Barnea-Goraly, Menon, & Eckert, 2005), corpus callosum (Thompson et al., 2000), and the cerebellum (Giedd quoted in Frontline PBS, 2002). Most importantly, increases in gray matter have been identified in multiple areas of the neocortex, with the greatest changes occurring in the frontal lobes (Giedd, 2008; Paus, 2005; Sowell, Thompson, Holmes, Batth, et al., 1999; Sowell, Thompson, Holmes, Jernigan, et al., 1999; Sowell, Trauner, Gamst, & Jernigan, 2002).

The findings reviewed above highlight two key aspects of adolescent brain maturation. First, white matter changes allow for faster, more efficient processing and increased connectivity between different areas of the brain (Benes et al., 1994; Keating, 2004; Luna et al., 2001, Paus, 2005, Paus et al., 1999; Sowell, Thompson, Holmes, Batth, et al., 1999; Sowell, Thompson, Holmes, Jernigan, et al., 1999; Thompson et al., 2000). Secondly, substantial and previously unrecognized development occurs within the frontal lobes. Changes in the prefrontal cortex are of particular interest because of its executive role in integrating and regulating various brain functions. In addition, the frontal lobes are associated with many of the capacities that make us most human. Most higher order cognitive capacities such as language, abstract thinking, logical reasoning and the abilities to organize, prioritize and plan have been linked to the prefrontal cortex (Frontline PBS, 2002; Keating, 2004; Pearce, 2002; Steinberg, 2005). Taken together, greater interregional connectivity reflected in white matter changes and the development of prefrontal executive functions appear to allow for more efficient, complex and integrated processing that likely underlies the emergence of new capacities during adolescence.

Development of the prefrontal cortex has received considerable attention in the literature in part because of its inhibitory functions—in short, its role in impulse control. The prefrontal cortex is understood to play a role in the integration of thought and emotion, the capacity for self-regulation, the evaluation of potential risks and rewards, response inhibition and the ability to produce socially appropriate behavior (Casey, Giedd, & Thomas, 2000; Damasio, 1999; Giedd, 2004; Keating, 2004; Schore, 1994, 2001; Siegel, 1999). Certain characteristics commonly associated with adolescence such as emotional volatility, impulsivity, difficulty planning or envisioning consequences, as well as increased risk taking may be due in part to incomplete maturation of the frontal lobes (Dahl, 2004; Steinberg, 2005).

While some adolescent behaviors may be explained in part by limitations of an immature prefrontal cortex, neurophysiological changes associated with the onset of puberty likely contribute as well. Research suggests that an influx of gonadal and adrenal hormones appear to impact the balance of neurotransmitters in the brain, and in turn, emotional, motivational and reward systems (Cameron, 2004; Spear, 2000, 2008). Neurophysiological changes have been implicated in a number of adolescent behaviors including mood fluctuations, changes in drives (including romantic and sexual interest), sleep patterns, increased novelty seeking, sensation-seeking and risk taking, as well as gender differences in behavior (Carskadon, Acebo, & Oskar, 2004; Compas, 2004; Dahl, 2004; Spear, 2000; Steinberg, 2004, 2005; Strauch, 2003; Wallis, 2004; Walsh, 2004).

Research on the adolescent brain is relatively recent and much remains speculative. Nevertheless, several themes have emerged that are of particular relevance to clinicians. Research suggests that while many of the neurophysiological changes associated with puberty appear to "fire-up" the system for intense feeling, exploration, and risk-taking—the development of prefrontal executive functions responsible for impulse control, planning and envisioning the consequences of actions, occurs gradually over the course of adolescence and continues into the twenties (Dahl, 2004; Giedd et al. 1999; Keating, 2004; Steinberg, 2004; 2005). As Steinberg (2005) observes, changes in arousal and motivation systems appear to precede the development of regulatory competence, creating a potential gap between an adolescent's emotional experience and his or her ability to regulate thoughts, feelings, drives and behavior. This gap may be further exacerbated by a recent trend towards earlier puberty. A number of studies have documented a decline over the past century in the average age of pubertal onset within Western industrialized societies, particularly for girls (Dahl, 2004; Papalia, Olds, & Feldman, 2007; Pearce, 2002). While changes in motivational and emotional processes are occurring at earlier ages, there appears to be no concomitant change in cognitive development. The gap between emotional processes and cognitive controls during adolescence has been likened to having a foot on the accelerator without adequate brakes, or starting an engine without having a skilled driver at the wheel (Dahl, 2004; Nelson et al., 2002; Steinberg, 2005; Walsh, 2004). The potential disjunction between emotional and cognitive processes suggests increased risks for a broad range of emotional and behavioral problems during adolescence.

Clinical Applications

Risky Business

Dahl (2004) notes a central paradox of adolescence. At a time when adolescents are becoming stronger, faster and more resilient than before, and cognitive abilities are undergoing significant advances—there is an overall 200% increase in morbidity and mortality rates over the same period (p. 3). While the majority of adolescents navigate the adolescent transition without major difficulties, a significant number struggle with considerable distress (Dahl, 2004; Offer & Offer, 1975; Steinberg & Morris, 2001). Adolescence is understood to be a period of increased risk for a wide range of emotional and behavioral problems including schizophrenia, affective disorders, violent delinquency and substance abuse (Giedd et al., 2006; Steinberg, 2002, 2005). Adolescence is indeed a time of both accelerated development and increased vulnerability. Recent research on the adolescent brain may provide new insights into both the risks and opportunities inherent during this period.

The Integration of Multiple Lines of Development

Changes in the adolescent brain can best be understood within the context of broader developmental processes. Adolescence involves dramatic physical, emotional and cognitive changes that must be integrated within a shifting sense of self. In addition, adolescents must navigate important developmental tasks including the incorporation of maturing sexuality (Freud, 1905/1975), the integration of growing cognitive capacities and new ways of thinking and experiencing the world (Inhelder & Piaget, 1958; Keating, 2004), the renegotiation of relationships which are becoming more intimate, reciprocal and egalitarian in nature (Allen & Land, 1999; Steinberg & Morris, 2001), as well as the development of a more differentiated, integrated, and consistent sense of self—what Erikson (1968) refers to as *identity* and Blos (1978) refers to as *character*. These developmental tasks are undertaken in the face of changing expectations, new social roles and growing responsibilities within an increasingly complex world. Adolescence serves as the bridge to adulthood, and as such, the establishment of an independent identity and greater autonomy are widely recognized as central developmental tasks (Allen & Hauser, 1996; Allen & Land, 1999; Blos, 1962, 1967; Erikson 1968; Gemelli, 1996; Hill & Holmbeck, 1986).

During adolescence, physical, emotional, cognitive, social and behavioral systems undergo major reorganization. The changes within these various systems can be understood to involve different neural mechanisms. For example, signals from the hypothalamus trigger the pituitary to release hormones that lead to the development of secondary sexual characteristics that are associated with puberty (Dahl, 2004; Sussman & Rogol, 2004). Changes to emotional and motivational systems appear to involve neurophysiological changes that impact limbic and reward systems in the brain (Spear, 2000, 2008), while cognitive advances are associated with development of the prefrontal cortex (Giedd, 2004; Keating, 2004, Steinberg, 2005). Changes in social behavior likely involve complex interactions between all of the systems as well as direct experience with the environment. The various systems can develop somewhat independently from one another, yet remain intricately intertwined (Dahl, 2004; Keating, 2004; Steinberg, 2004, 2005).

An understanding of the different lines of development and their neural underpinnings can help us to appreciate the magnitude of change that must be integrated during adolescence, as well as better understand individual differences that are so

prevalent at this time. Different systems can develop along different timetables and at very different rates. Therefore, integration is not necessarily a smooth and seamless process. One teen may appear physically well developed yet be emotionally and cognitively immature, while another may be physically undeveloped yet cognitively and academically advanced (but has yet to integrate the physical, emotional and social changes associated with puberty). Developing out of sync with one's peers is recognized as a source of increased risk for emotional and behavioral problems during adolescence (Resnick et al., 1997; Steinberg & Morris, 2001). An understanding of the various lines of development can help clinicians to identify an individual's particular strengths as well as areas in which they may need support.

Integration is a process. Both cognitive science and neuroscience suggest that a period of disequilibrium (Inhelder & Piaget, 1958; Wadsworth, 1989) and disorganization (Schore, 1994) precedes reorganization. Not surprisingly, adolescents are often described as going through an "awkward stage" as they attempt to grow into their changing bodies and minds. The nose doesn't quite seem to fit the face and hands and feet don't quite fit the limbs. During this time, even the brightest, most articulate child may respond to questions with a grunt or a yes or no answer, or lash out at a parent who is "only trying to help." An understanding of the complexity of developmental processes and the challenges adolescents face can foster patience and more realistic expectations on the part of adults, including parents, teachers, employers and clinicians.

Theory and research in a number of areas such as neuroscience, cognitive science, and attachment, suggest that integration within and between the various lines of development happens much later than we might think (Blakemore & Choudhury, 2006; Fraley & Davis, 1997; Giedd et al. 1999, Harter, 1999). As previously noted, evidence suggests that changes within the prefrontal cortex proceed gradually over the course of adolescence and continue long after puberty is complete (Dahl, 2004; Giedd et al., 1999; Keating, 2004; Paus, 2005). Integration takes time and it is important to remember that even when an adolescent appears grown up, they are not.

Normalizing Behavior

The transition from childhood to adulthood involves intrinsic risks. Neuroscience findings suggest that adolescents are primed for growth, exploration and new learning (Dahl, 2004; Spear, 2000; Steinberg 2004). It appears that there is a natural inclination (perhaps a biological imperative) to move farther afield, experiment and seek novel experiences—for adolescents to test themselves (and perhaps others). Spear (2000) notes that behaviors such as novelty-seeking, risk-taking, increased social investigation and interaction with peers can be observed in adolescents of many species. Such behaviors create certain vulnerabilities, however, from an evolutionary perspective, they can be understood as adaptive. Increased exploration and risk-taking support the acquisition of new skills necessary for survival, as well as the opportunity to gain experiences necessary for future adult functioning. Spear observes that research suggests adolescents who engage in moderate risk-taking tend to be more socially competent than adolescents who take few risks or those who are frequent risk takers. In short, some exploration and risk-taking is normal, healthy and necessary during adolescence.

Greater understanding of changes in the adolescent brain can help to normalize other behaviors as well. In addition to increased novelty seeking and risk-taking, the neurophysiological changes associated with puberty have been linked with emotional intensity and volatility (Dahl, 2004; Spear, 2000; Steinberg, 2004, 2005). Research suggests that adolescents may be more susceptible to stressors (Spear, 2000) during a time when the challenges of adolescence may be understood as naturally stressful. Irritability and reactivity are common responses to stress at any age. With an added sensitivity to stress during adolescence, even an apparently minor stressor may evoke a big response.

Functional MRI research further suggests that adolescents process emotion differently than adults (Baird et al., 1999; Guyer et al., 2008; Yurgelen-Todd interviewed in Strauch, 2003). Several studies that examine processing of facial expressions suggest that children and adolescents may be more likely to act from parts of the brain primed for automatic survival responses such as fight, flight and freeze, while adults have the benefit of prefrontal functions that allow for more complex processing (including the reevaluation of stimuli), subtler distinctions between emotions, and a more deliberate, considered response (Baird et al., 1999; Guyer et al., 2008). The research also showed that children and adolescents were more likely to make errors when identifying emotions, mistaking fearful expressions for other emotions such as shock, anger or confusion (Baird et al., 1999). These findings may help to explain some of the misunderstandings so common in adolescent relationships (and feelings of not being understood), as well as some of the emotionally charged conflicts that can erupt between adolescents and their parents or peers.

Brain changes have also been linked with other "typical" adolescent behaviors such as increased appetite and the tendency to stay up late and have difficulty getting up in the morning. Studies have shown that melatonin (the neurochemical that signals the body to prepare for sleep) is secreted up to two hours later in adolescents than in children or adults, and, that adolescents need more hours of sleep (Carskadon et al., 2004; Carskadon interview in Strauch, 2003; Wolfson & Carskadon, 1998). Building new brain and body systems is energy-consuming work. In some cases, what adolescents need may conflict with what is required of them (such as very early start times in some school districts). It is important to note that sleep deprivation has been linked with excessive daytime sleepiness, depressed mood, difficulties with mood regulation, learning problems, impaired academic performance, school tardiness and absenteeism, as well as greater risk for accidents and injuries (Carskadon et al., 2004; Wolfson & Carskadon, 1998).

Adolescents are often depicted in a negative light—as moody, lazy, uncontrollable, irresponsible, sex-crazed, hostile or rebellious. An understanding of adolescent brain changes within the context of broader developmental processes can help us to

reinterpret and depathologize a number of adolescent behaviors. Many behaviors that are perceived as difficult during the teen years reflect natural biopsychosocial changes that are shaped by a major reorganization of systems and serve important adaptive functions.

While some developmental processes increase risks and create challenges for both teens and their families, critical capacities are being developed that impact the future functioning and well-being of the individual. Increased connectivity and development of the prefrontal cortex allow for better integration of thought and emotion and as a result, the ability to think rather than simply react. Growing cognitive capacities allow adolescents to reflect on and evaluate their experiences, at the same time an expanding social world may challenge old ways of thinking, feeling and being. New abilities and experiences naturally cause teens to question and to begin exercising their own judgments and sensibilities in order to make choices and decisions. Further development of abstract thinking allows adolescents to envision new possibilities and to generate creative solutions to problems. Perhaps most importantly, the growing capacity for self-reflection allows for a more coherent sense of self, and at the same time underlies the ongoing capacity for adaptation and change. Supporting self-reflection as an agent of change is central to many forms of psychotherapy and it is interesting to note that adolescence may very well be a critical period for the development of this capacity.

Many of the issues and developmental tasks that emerge during adolescence—such as negotiating autonomy and connectedness, growing the capacity for intimacy, the desire for fulfilling sexual relationships, the search for meaningful work, and navigation of changing social roles—remain important themes throughout adult life. The way in which these developmental tasks are negotiated during adolescence sets the stage for future adult functioning.

What's Needed?

Adolescence represents a time of both increased risks and developing potential. The question remains, how can we best protect teens while supporting development? As Jay Giedd, the neuroscientist who pioneered recent research on the adolescent brain states, "The more technical and more advanced the science becomes, often the more it leads us back to some very basic tenets of spending loving, quality time with our children" (Frontline PBS interview, 2002).

A large-scale national longitudinal study of risk and resilience factors during adolescence, found that parent-family connectedness and perceived school connectedness were protective against almost every health risk examined, including: emotional distress and suicidality; involvement in violence; substance use; and sexual behaviors by delaying sexual debut (Resnick et al., 1997). At first glance, these finding seem to suggest that what is needed during adolescence is good parenting and good education. However, it is important to note that the unifying theme here is *connection*. A sense of connection may very well be the key to developing potential as well as to preventing harm.

Maintaining Relationship

The greatest protective factor during adolescence may be *maintaining relationship*. This can be challenging during a period when teens naturally begin to spend more time away from their families and more time with peers. Recognizing the central developmental tasks of creating an independent identity and increasing autonomy may be key to staying in contact with teens. A person who understands development will respond differently than one who does not. When a two year-old pushes away and becomes enamored with the word "No!" it may be perceived as noncompliance ("bad") or a challenge to parental authority—when in fact it is likely a healthy expression of emerging preferences and desires, and a growing sense of a separate self. The same can be said of adolescents—although the pushing may take a different form. Awareness that some distancing, opposition and challenge is normal and necessary during adolescence can take some of the sting out of what can feel like rejection, and help parents to take these behaviors less personally.

Supporting Emotional and Cognitive Autonomy

In practical terms, most adolescents remain functionally dependent on their families during the teen years. However, a central role for parents and others who work with adolescents is to support the growth of emotional and cognitive autonomy (Allen et al., 2003; Steinberg & Silverberg, 1986). There is a common attitude within society that adolescents must be controlled and that certain ideas and values need to be instilled into them. However, a more effective way of staying *in connection* with adolescents may be to *listen first.*

Emotional and cognitive autonomy are fostered by encouraging the exploration of thoughts, feelings, ideas, preferences and options. In order to function successfully as adults, adolescents need to learn *how* to think—not what to think. This approach can feel threatening to many adults, particularly around emotionally charged issues such as sexuality and experimentation with drugs or alcohol. However, by participating in the exploratory process, parents or other responsible adults have a better chance of asking the right questions, sharing information and supporting reflection in adolescents. When teens are given the opportunity to fully express and explore their thoughts and feelings, they may be less likely to simply act upon them. In addition, self-discovery within safe and supportive relationships may provide some of the emotional excitement that teens

naturally seek, as well as support the task of identity formation. At a time when relationships with parents can be problematic, other adults such as extended family members, teachers, mentors or therapists can support this process.

Achieving autonomy can be more challenging in some situations than others. For example, Daniels (1990) suggests that separation-individuation may be complicated for adolescents in non-traditional family settings such as being in a home where parents are in the process of a divorce, single parent homes, or blended families. She observes that in single parent homes there is a risk of the child becoming the caretaker of the parent (*parentification*), or, difficulty individuating from a parent who is absent. In addition, the goal of family unification (blended families) or reunification (parental separation) may be contrary to the adolescent's need to separate and individuate. Family trauma, such as the loss or serious illness of a family member may similarly complicate an adolescent's quest for autonomy. In such cases, teens may need additional support in getting their needs met. War and poverty can dramatically limit the desirability or possibility of autonomy, or force premature independence.

It is important to note that autonomy and independence are values that tend to be emphasized in western industrialized societies where young people are expected to eventually leave home, set up separate households and function on their own. This is not the case in all groups or cultures. Independence and autonomy may be actively discouraged in some social contexts, particularly for girls. In these circumstances, adolescents may find themselves caught in a conflict between traditional group or cultural norms and those of the prevailing society. In broader terms, the task of adolescence is to find one's place within the family, culture and larger social world (Erikson, 1968). What is needed during adolescence will vary depending on the specific realities and unique circumstances of each individual.

Psychoeducation

Psychoeducation can be useful for both parents and teens during adolescence. An understanding of developmental processes can help parents to better assess what limits and boundaries may be appropriate to their teen's level of maturity. In addition, greater awareness of the developing brain and the gap between emotional and cognitive processes during adolescence may help parents feel more comfortable setting and maintaining boundaries in the face of pressure from teens. The challenge is to find a balance between protection and growing needs for autonomy. Either too much or too little structure may undermine development. When decisions are made based on communication and shared information, teens may not like the limits that are set for them, but may be more likely to respect and appreciate them.

During adolescence, capacities for judgment are not fully developed and social and emotional processes can override logic and reason (Dahl, 2004; Steinberg, 2005; Walsh, 2004). Research suggests that adolescents are more likely to take risks in the presence of peers than when they are alone (Gardner & Steinberg, 2005), and risky behaviors often occur in group situations that create intense excitement and euphoria (Steinberg, 2004). Walsh (2004) suggests that teaching teens about how the emotional brain can hijack the thinking brain can promote a sense of responsibility for managing impulses. (This may also be a welcome alternative to repeated lectures on the dangers of peer pressure.) In addition, learning to recognize the signs of emotional over-arousal and the use of self-regulation skills can provide teens with a sense of mastery.

Both teens and their parents can benefit from learning self-regulation skills. In highly charged situations, lower areas of the brain associated with automatic emotional responses normally become engaged while prefrontal executive functions that allow for more reflective responses become less active (Levine, 1997; Schore, 1994; Siegel, 1999). In situations involving high excitement (either positive or negative), it is easy to imagine how adolescents may become involved in risky behaviors, or how a highly charged conflict between parent and teen might escalate.

Parents and teens can learn self-regulation skills by increasing awareness of bodily reactions associated with over-excitement and sympathetic nervous system hyper arousal. Creating a pause in the action and making the cognitive shift to attend to somatic cues may in and of itself help to slow things down enough for the thinking part of the brain to come back online. However, in addition to somatic awareness, grounding exercises and the use of conscious breathing techniques can be taught as tools to calm the nervous system and promote reflection. Learning and practicing self-regulation skills in unstressful or moderately stressful situations (such as a therapy session) may help teens to utilize these techniques to cope with the stresses of daily life, or in highly activating circumstances when no parent or responsible adult is present to intervene. When passions override rationality and adolescents exercise poor judgments, they need to be supported in learning to think about what happened, take responsibility, consider what other actions they might have taken, and what they might do in similar situations in the future (Walsh, 2004). In this way capacities for self-refection are developed and adolescents have the opportunity to learn from their experiences.

The principles and skills of self-regulation are important at any age but may be particularly relevant during adolescence, at a time when the emotional system is being reorganized (Spear, 2000, 2008, Walsh, 2004) and teens experience a host of physical, emotional and social changes that may be inherently stressful. Parents, too, may face challenges, in addition to parenting, that are rooted in their own circumstances (such as an impending empty nest, marital difficulties, job stress, financial concerns, health issues, or the care of an aging parent). Adolescence can be a stressful period for both teens and their families. Adolescents need adults who model self-care, good communication skills and self-regulation. Conflicts that arise between parents and teens can provide a catalyst for developing and improving these capacities.

Developing the Whole Person

A superficial understanding of adolescent brain changes and critical periods as a time for optimizing development can lead to an over-emphasis on cognitive skills, academic performance and achievement during the teen years. Adolescence is indeed a time of major cognitive advances; however this is only part of the story. The central theme of adolescent brain development is *integration* (Harkin, 2007, 2009). It is the integration of thought and emotion, different modes of information processing, as well as the development of prefrontal executive functions that appear to underlie emerging capacities during adolescence. A broader understanding of adolescence as a critical period for brain maturation and the integration of multiple lines of development suggests the importance of focusing on *process* rather than product. Integration is achieved by emphasizing development of the whole person.

From a neuroscience perspective, relationships and activities that promote brain integration will enhance development during adolescence. The arts, music, dance, recreational, and sports activities may be especially valuable for teens. For example, some aspects of music making involve the analytic capacities of the left-brain (such as reading music or structuring a composition), while other aspects utilize the more holistic, emotional and intuitive capacities of the right brain. Activities that promote development of each hemisphere and their integration may support adolescent brain development. In more general terms, art, education and recreational activities when focused on development of the whole person can serve to support emotional and cognitive development, as well as the development of interpersonal and social skills. Such activities also provide a means of self-expression and identity formation at a time when teens may not always have the words to describe what they are experiencing. It is unfortunate that the arts, recreation and sports programs are viewed as luxuries rather than as essential, and are often among the first to go when budget cuts are deemed necessary.

Channeling the Energies of Youth

Perhaps one of the most effective ways to support development and minimize risks during adolescence is to channel the energies of youth. As Dahl (2004) notes, adolescent processes appear to create high levels of arousal and excitement that create "both a great deal of vulnerability among the young as well as a great opportunity to harness these emotions in service of positive goals" (p. 20). Adolescence is an ideal time for developing interests, skills, and the unique gifts and talents of each individual, as well as the desire for contribution (for example through extracurricular activities or volunteer work).

Within many traditional societies tutelage by village elders and *rites of passage* guide the transition from childhood to adulthood and ensure ongoing connection with the larger community. These ceremonial rituals transmit values and traditions from one generation to the next and serve to redefine the individual's role within the group (Frankel, 1998; van Gennep, 1961). In contrast, within contemporary American society, adolescents tend to be isolated together with less supervision or participation by responsible adults (Hersch, 1998; Hine, 1999). The complexities of modern life have moved us further and further away from formal demarcations of adult status or clearly defined roles. This creates added challenges for adolescents trying to find a sense of identity and belonging. Adolescents can benefit from positive structures that provide some of the functions served by those lost rites of passage (or that create new ones). Adolescents need relationships and activities that provide support and guidance, create salient emotional experiences, generate deep meaning, and offer substantive challenges that help to develop the skills necessary for adulthood.

Psychopathology

Recent research on the adolescent brain was originally pioneered to study the relationship between brain development and psychopathology (Giedd, 2004). As previously noted, adolescence is recognized as a period of increased risk for the onset or exacerbation of a number of emotional and behavioral problems including anxiety, depression, eating disorders, schizophrenia, violent delinquency and substance abuse (Giedd et al., 2006; Rosentein & Horowitz, 1996; Steinberg, 2002, 2005). The unexpected discovery of structural changes during adolescence suggests that the genetic blueprint for brain development continues to unfold during this period, and as a result, both genetic and environmental factors may create additional vulnerabilities.

Research on structural and neurophysiological changes during adolescence has generated new hypotheses about the origins and progression of various mental disorders. Significant work is being done in this arena and psychopathology will continue to be an important focus of study. A detailed examination of the research on psychopathology is beyond the scope of this article. For an overview of the literature see Giedd et al. (2006) or Toga, Thompson, & Sowell (2006).

One area of particular interest to clinicians is the work being done on addiction. Spear (2000, 2008) and others note that changes in limbic circuits and the dopamine system, along with social factors, may make teens particularly susceptible to the addictive effects of nicotine, alcohol or drugs (Chambers, Taylor, & Potenza, 2003; Jackson, 2005; Strauch, 2003; Walsh, 2004). The dopamine system functions as a natural part of the learning process. As Spear (2000) describes, dopamine acts upon pleasure and reward centers of the brain, and the positive feelings generated by increased dopamine levels tend to reinforce behavior and therefore learning. Addictive substances act by triggering an initial release of dopamine into synapses or prolonging its stay. However, over-stimulation of the brain with dopamine can cause a cut back in the number of dopamine

receptors, resulting in an overall decline of dopamine naturally circulating in the body. This decrease may lead to feelings of depression that can cause an individual to seek increasing levels of stimulation through substances or behaviors that jump-start the release of dopamine—potentially leading to a vicious cycle of addiction (Spear 2000, 2008).

Research suggests that teens may be more sensitive to stressors than adults, and that elevated stress responsivity may contribute to the tendency to initiate drug and alcohol use in adolescence, given that stress has been shown to increase alcohol consumption and facilitate the onset of drug use (Spear, 2000, 2008). Substance abuse during the teen years is of particular concern, as there is a growing body of research that suggests the adolescent brain is more vulnerable to the damaging effects of addictive substances than the adult brain, with potentially long-term consequences (Chambers et al., 2003; Jackson, 2005).

Research on addiction highlights the fact that the developing brain may respond differently to substances than the mature brain. This issue is relevant to the use of psychopharmacological interventions in the treatment of children and adolescents. Until recently, the majority of drug testing was conducted primarily on adult subjects. However, new clinical trials using pediatric and adolescent populations have resulted in product warnings for some medications that include potentially dangerous side effects for children, adolescents and young adults. It is not known whether or how the use of different psychopharmacological drugs may permanently alter the developing brain—or which of these alterations may be beneficial or detrimental to future health and functioning. The full risks and benefits are not yet known (Benedetto, 2006). Until some of these questions are answered, when possible, it may be advisable to try non-psychopharmacological treatments first. When medication is necessary, it is important that side effects are carefully monitored.

Conclusion

A growing body of evidence implicates adolescence as a critical period for brain maturation and associated capacities (Dahl, 2004; Giedd, 2008; Giedd et al., 1999; Keating, 2004; Steinberg, 2005). Central to the concept of critical periods is that they create particular vulnerabilities when developmental needs are not met, as well as unique opportunities to optimize development. Many of the capacities developing during adolescence (such as greater impulse control, significant cognitive advancement, and the abilities to reflect, evaluate and choose) are essential to successful adult functioning and an individual's capacity for ongoing adaptation and change. An understanding of adolescent brain changes within the context of broader developmental processes can help to create greater compassion for the challenges adolescents face, normalize certain behaviors, as well as provide direction for how to best support growth and development.

The transition from childhood to adulthood naturally involves dramatic physical, emotional, cognitive and social changes. The major disorganization and reorganization of systems that occurs during the teen years, coupled with growing reflective capacities make adolescence an ideal time to influence the change process—to proactively provide experiences that support development, or to implement prevention and intervention strategies where needed. Historically there has been an emphasis on the problems of adolescence; however, shifting the focus to adolescence as a critical period highlights its tremendous potential.

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Biography

Deborah Harkin, PhD earned a doctorate in Clinical Psychology with a specialty in Somatic Psychology at Santa Barbara Graduate Institute (SBGI) in 2007. Her dissertation synthesized traditional theories of adolescent development, attachment theory and recent discoveries in neuroscience on the adolescent brain (Harkin, 2007). She currently serves as an academic administrator at SBGI and can be reached at dharkin@sbgi.edu.

The Relational Turn and Body-Psychotherapy

I. From Ballroom Dance to Five Rhythms
An Introduction to Relational Psychoanalysis and Psychotherapy

Asaf Rolef Ben-Shahar, PhD

This is the first of four papers, together forming *The Relational Turn and Body-Psychotherapy.* These papers will examine the touching points between body-psychotherapy and the exciting and encompassing field of relational psychoanalysis. This first paper will explore some basic concepts in relational psychotherapy and track its philosophical roots. At the same time, it will point to the relevance of relational thinking to the history and practice of body psychotherapy. The second paper: *Something old, something new, something borrowed, something blue,* will expand on intersubjectivity, attachment and dyadic selves, examining the balance between regressive and novel aspects of intersubjectivity. The third paper: *Salsa Lessons and the Emergent Self*, will explore connections between somatic organization, relationality, and the place of the self in relational body-psychotherapy. Lastly, the fourth paper: *Gliding on the Strings That Connect Us,* will demonstrate the use of resonance (somatic countertransference) in body psychotherapy within a relational framework.

Abstract

Relational psychoanalysis has been a highly influential development in the therapeutic milieu, dialoguing with and enriching the thinking and practice of many therapeutic disciplines, including body-psychotherapy. The paper examines some of the historical roots of relational psychoanalysis, and then explores a few of the tenets of relational thinking. This paper ponder the position of the therapist in the therapeutic dyad, the role of transference and countertransference, the theory of mind in relationality, and the concept of intersubjectivity. It will also further examine the role of the body in relational psychotherapy. Serving as the first of four papers in the series, *The Relational Turn and Body-psychotherapy*, sets the ground for discussing relational body-psychotherapy by clarifying certain concepts and relational jargon. Demonstrated through theoretical structures and clinical vignettes, this paper attempts to show us how psychotherapy can be an art form, where co-created selves attempt to engage intimately with one another as deeply as they dare.

Key words

Relationality – Intersubjectivity – Attachment - Wider-mind

Introduction

"*We emerge out of and are saturated with relations with others. Yet we (in Western culture) organize our experience into selves with what feels like distinct, inviolable interiors, with boundaries, partly negotiable and partly non-negotiable.* "
-Stephen Mitchell[1]

Wishing to attain scientific credibility, Freud had endeavored to present psychoanalysis as first and foremost a scientific discipline and had formulated his theoretical framework according to the Cartesian-Newtonian paradigm. His drive theory described psychological interactions in terms of physical, biological forces impacting on one another, and had therefore accepted the presupposed dichotomy between body and mind, me and you, or man and God (Capra, 1982; Fromm, 1942). The traditional analytic setting aspired to create an analyst who abstained from impacting and influencing the analysand, instead adopting an attitude of *evenly hovering attention* (Field, 1996, p.5), or ideally, a scientific observer. Not only did this role *save* the analyst from the powerful impact that would later become the bread-and-butter of relational work, but it also gave the analyst the illusion of order: a protocol-type form to work with. Such a move was probably a necessary step in the evolution of psychotherapy. Psychoanalysis began as a science, not an art. It was an attempt to create an accurate form of a healing "dance" between two people: a dance where rules are clear and the steps are known.

Many years later, Abraham Maslow would argue that a Newtonian physical science was an inappropriate model for psychological phenomena (in Keeney, 1983, p.96), and systemic therapist Bradford Keeney (ibid, p.95) reiterated that "the use of an epistemology of billiard balls to approach human phenomena is an indication of madness." But at the end of the nineteenth century, notwithstanding the dissociative price we have all paid (such as becoming minds split from bodies), Freud's attempts were not made in vain. Psychoanalysis gathered support and recognition and became a highly valued discipline; it was becoming recognized that our unconscious lives are valid entry points for the discovery of certain very relevant information.

Relational psychoanalysis is not a singular model, but a movement that includes different theoretical and clinical schools, all of which challenge Freud's traditional emphasis on drives and instead view humans first and foremost as individuals who seek relationships, or humans are (object seeking). Man is understood as an organism in need of connection. Relationalists believe that the self cannot exist in isolation, but that it rather emerges out of and is organized in dialogue with the interactions it experiences with others (Mitchell, 1993).

[1] (Mitchell, 2002, p.75).

The relational psychoanalytic school began in the 1980's, gathering different analytic voices which emphasized the centrality of real and imagined relationships to our mental health and to psychotherapy. The first book to present a coherent relational model was probably Jay Greenberg and Stephen Mitchell's (1983) *Object Relations in Psychoanalytic Theory.*

Greenberg and Mitchell used the term *relationality* to bridge the traditions of interpersonal relations, which emphasized the real relationships in the external world, and the British movement of *Object Relations* (Mitchell & Aron, 1999, p.xi). They depicted the shift from an understanding of the mind as constructed from drive-based impulses and defenses, with man a small and isolated animal struggling to control its animalistic sides in order to be accepted into society, to understanding the mind as built from relational molds and interactions (Mitchell, 2004, p.533).

With this in mind, we can refer to how philosophers have long debated the reality of communication. The question arose of whether we were bound to only respond through our inner prisms of reality and principally only have relationships with these inner worlds, or whether a real connection was possible. The tension between the inner domain, or intrapsychic, and the external relational domain, or interpersonal, was addressed in relational psychoanalysis through a cybernetic[2] shift (Aron, 2003). The intrapsychic reality and the interpersonal reality were no longer seen as opposing and contradictory, but instead as constituting a mutually dialectic process. The person cannot be said to be either: it is the dialogue between in and out, personal and interpersonal, fantastic and reality. It is the place the *self* emerges from. The psychic organization depends upon the relational organization (Loewald, 1977, p.211), yet at the same time, relationships are constituted by individual selves.

While paradigm shifts often occur as revolutions, a cultural and philosophical maturation is still needed as a catalyst for their growth (Kuhn, 1962). The dialogical philosophy of Martin Buber, the important discoveries of Erich Fromm, the interpersonal psychiatry of Harry Stack Sullivan, the bold and experiential psychoanalysis of Sándor Ferenczi, and the writings of Hans Loewald (among others) have all prepared the ground for the emergence of a new tradition. The next two sections will briefly look at attachment theory and object-relations, two of the main theories that contributed to relational psychoanalysis.

Attachment and Relationality

> *The individual discovers himself within an interpersonal field of interactions in which he has participated long before the dawn of his own self-reflective consciousness. The mind of which he becomes self-aware is constituted by a stream of impulses, fantasies, bodily sensations, which have been patterned through interaction and mutual regulation with caregivers.* -Stephen Mitchell[3]

"Even if viewed from a purely *biological* point of view," wrote Margaret Mahler and John McDevitt (1982), "the newborn infant is only a partial system: between the distress signal and the relief of need, there must be a mother" (p.828). Attachment theory explains our freedom to engage with ourselves and others as largely dependent on the quality of our first relationships, particularly with our primary caregiver. Appropriately, attachment theory began with infant observation, as the joint work of pioneering psychiatrist and psychoanalyst John Bowlby (1907-1990) and psychologist Mary Ainsworth (1913-1999) (Bretherton, 1992). John Bowlby studied the effect of maternal deprivation on children (Bowlby, 1951, 1965) and noted how the attachment between mother (or another significant figure) and child was crucial for the child's survival (Bowlby, 1973, 1980, 1982). In collaboration with Bowlby, Mary Ainsworth and her colleagues (Ainsworth, Blehar, Waters, & Wall, 1978) carried out elaborate studies of babies and toddlers with their mothers, and observed patterns of interactions which they named attachment styles. They particularly noticed that, upon separating from and then later reuniting with the attachment-figure, children were either capable of calming down and re-establishing connection with mother (a pattern which they named secure attachment), or demonstrated myriad difficulties to do so (insecure attachment). Research into attachment styles continued and elaborated on these findings (e.g. Hesse & Main, 2000; Main, 2000).

Attachment theory provides us with one of the basic and most persistent organizational principles of development: our personal and social identity. The mother-baby dyad is our first identity as a baby, preceding the development of our personal identity. In recognition of the primacy of this mother-baby dyad, Winnicott (1952) has famously stated that "there is no such thing as a baby" (p.99). This *mother-baby* relationship of uniting, separating, uniting again, and separating once more is the first dialogic platform for forming the unit of the self. A good attachment relationship is a fertile playground for identity formation and identity deconstruction. Secure attachment relationships provide the child with a solid *us* into which the child's *I* could surrender more easily without terror of disintegration.

While the analytic thinking of the time considered the life of an infant and child to be primarily determined by its drives and fantasy, or inner life, Bowlby argued for the importance of a real, maternal connection. In 1951, Bowlby wrote:

> *If growth is to proceed smoothly, the tissues must be exposed to the influence of the appropriate organizer at certain critical periods. In the same way, if mental development is to proceed smoothly, it would appear to be necessary for the undifferentiated psyche to be exposed during certain critical periods to the influence of the psychic organizer- the mother* (p.53).

[2] Cybernetics is an interdisciplinary field closely related to system theory that involves the study of structure of regulatory systems: i.e. examining the patterns of connections between parts of a system.
[3] (Mitchell, 1993, p.132).

Through his empirical research, Bowlby concluded that healthy growth requires that "the infant and young child should experience a warm, intimate, and continuous relationship with his mother (or permanent mother substitute) in which both find satisfaction and enjoyment" (ibid, p.13). Bowlby believed that the role of the primary caregiver was to maintain "an attuned, resonant, and appropriately responsive relational field" (Sills, 2009, p.38), to supply the child with a sense of a *secure base* – a stable environment from which its needs are met so that it can explore the world. The quality, security and stability of these attachment relationships are therefore deeply related to emotional and mental health throughout life (Bowlby, 1980; Sable, 2008). These qualities, as we all know, are primarily nonverbal, and are often translated through tactile sensations, such as with holding and using a loving touch (Turp, 1999; Winnicott, 1960b).

Object-Relations Theory

The Object-Relations movement was pioneered during the 1940's and 1950's in Great Britain, building on the Freudian theory yet rejecting Freud's emphasis on biological drives. The term *object-relations* was first coined by psychoanalyst Ronald Fairbairn, and then was later expanded as a field by other important contributors such as Melanie Klein, Donald Winnicott, and Harry Guntrip. Instead of the focus on drives, object-relations theory considered relationships to be "at the heart of what it is to be human (Gomez, 1997, p.1)."

Psychoanalyst Melanie Klein, founder of the object-relations movement, believed that we were only able to experience the outer world through our inner, subjective world. Ego strength, she believed, derived from the security of internalizing a "good" object (Klein, 1963). This subjectivity was oriented towards relationships from birth and was first noticed in bodily terms (Gomez, 1997, p.34; Klein, 1960), and experience was thus constituted from the interplay between one's own internal and external reality. This was a great leap from a biologically-based Freudian theory to a now more psychologically-based theory (Bloom, 2005 ; Greenberg & Mitchell, 1983).

The self was therefore seen as a sphere that developed within a context of relationships (Greenberg & Mitchell, 1983, p.90; Sullivan, 1940, p.10). Freud's biological and physiological explanations were not completely abandoned but rather understood as taking place within social and cultural contexts, which were considered the primary shapers of man (Fromm, 1942). Love was no longer simply perceived as sublimation of sexual drive, but instead viewed as a basic human need for relatedness, which could not and should not be described in "drive" oriented language (ibid).

If our caregivers were unable to tolerate all that we were, the very organization of our self would be threatened since we would rather compromise our integrity and cover our t*rue self* with a *false self* in order to be accepted and loved (Winnicott, 1960a). Clients who arrive with very strong, dense armoring, considered to be masochistic/compensated oral, are good examples of this phenomenon. Often, underneath an "I can do it all by myself" organization (a false self) we can discover a terrified and needy individual who does not trust in the right to need, or in their own lovability.

What Happened to the Therapeutic Relationship?

> *The resonance between the patient's and the analyst's unconscious underlies any genuine psychoanalytic understanding and forms the point of departure for eventually arriving at verbal interpretations of the material heard or otherwise perceived. The analyst, during that internal journey, in his effort to stay sane and rational is often apt to repress the very transference-countertransference resonances and responses, induced by the patient, that would give him the deepest but also most unsettling understanding of himself and the patient.* -Hans Loewald[4]

While Freudian psychoanalysis sought to separate the subject matter of inquiry (the analysand) from the scientific observer (the analyst), relational psychoanalysis sought to link the two, as it sees this organization as an interactive process similar to any other worldly relationship (Mitchell, 2005, p.7).

Sándor Ferenczi (1930), whose active techniques included physical interventions (including holding) claimed that "a rigid and cold aloofness on the analyst's part represented to the patient a continuation of his infantile struggle with authority, and the same reactions in character symptoms were repeated as formed the basis of the real neurosis (p.436)." Ferenczi shifted the analytic focus from the intrapsychic experience of the analysand to the relationship between analyst and analysand, where the meaning of the connection in the here-and-now offered grounds for both understanding and for change (Rachman, 1997, 2001, 2003).

Indeed, under the excitingly dialectic relational paradigm, the distanced view of psychoanalytic interpretation had come alive and turned into a close, relational event: one that transformed the patient, the analyst, and their relationship (Gill, 1994; Mitchell, 1988; Oremland & Gill, 1991). Both parties naturally engage in a reciprocal opening and closing to one other, deconstructing and reconstructing the influence they have on one another. The role of the analyst had now become more active, and the place of the analyst within the relationship was no longer seen as obsolete but instead viewed as central to the therapeutic process. Appropriate self-disclosure and focus on the therapist's own responses to the relationship (countertransference) became part of the analytic dialogue (Benjamin, 1990). Interestingly, as relational psychoanalysis was

[4] (Loewald, 1986, p.283).

advocating *opening to the field of relationship*, it had also become more open to external theoretical and psychotherapeutic influences. Humanistic, body-psychotherapy and transpersonal theories have all been considered within relational psychoanalysis in a way that had not been done before.

As a result of the increasing emphasis on the therapist's role and the dyadic importance, the therapeutic voyage now requires improvisation, intimacy and creativity: no longer could it remain the tightly protocol driven ballroom dance. The relational therapeutic dialogue resembles a form of art more than it does a form of science, and analytic work no longer attempts to maintain an indifferent, observant and non-interventionist ideal. Here we are, on this metaphorical dance floor, following a structure that is organized yet fluid. And we are required to maintain the frame and let go at the same time.

Mitchell (2005) wrote: "The emphasis is now on interaction, enactment, spontaneity, mutuality, and authenticity" (p.ix). Like a paradigm shift in modern physics, the scientist/observer has now become an integrated part of this field of study (ibid, p.7), and therefore neutrality, abstinence, and anonymity became irrelevant myths in the analytic domain (ibid, pp.12-13). This relational approach positions the therapists in a vulnerable place of openness to their own pain as well; of possibly sharing unprocessed reactions with their clients, disclosing their own processes, and allowing themselves to be deeply affected – treading the same uncomfortable territory they invite their clients to walk on (e.g. Bion, 1992, p.291; Borgogno, 2004; Ehrenberg, 1992; Pizer, 1997, 2003).

Transference – Counter transference

> *There can be no analysis of the person in the patient's place without concurrent scrutiny of what's going on inside the person sitting in the analyst's place, and how she may be contributing to whatever occurs in the moment. Nobody says it is easy, or even fully possible, but that is the relational effort.* -Barbara Pizer[5]

After three years of psychotherapy with my patient Jennifer, a curtain of heaviness and sadness enveloped our process, yet no content could emerge out of it. For a good few weeks, during every session with her, my stomach would churn. I would contort in pain, trying with much effort to conceal my suffering; I felt ashamed of my pain and terrified by the prospect that she might notice this. I found myself in a familiar position; a teenage boy utterly ashamed of his body, trying to conceal his fear and loneliness in the hopes that nobody would reveal him.

Interestingly, my contorted pain corresponded to Jennifer talking to me about her father. Still, my shame about the potential noise of my stomach was stronger than my willingness to explore the connections therapeutically. We pretended nothing ever happened – between us, inside me. Then one day, Jennifer asked me to touch her back and, as I crouched down, I farted; a loud and very smelly fart. We both froze.

At the time, I couldn't see anything funny in it, or harness it therapeutically; I just felt ashamed, deeply ashamed. Trying to regulate my breathing I looked at Jennifer, neither of us could deny the reality of the stench or the noise. She then told me, for the first time, that she always felt sexually threatened by her father, and that she wanted to speak about it for a while, but felt ashamed admitting it, "Because I don't know if he actually did anything." Her disclosure allowed me to restore myself, "neither of us could hold this stench in any longer," I said. After that session, our work revolved around affirming her subjective reality, and monitoring the extreme shame that accompanied such work. I was encouraged to affirm my own subjectivity, and tend to my own shamed states. The secrets were beginning to arrive and surface in the room, together.

While classical psychoanalysis sought to eliminate the analyst's emotional responses brought upon by his own life (his reactive countertransference), relational psychoanalysis views the matrix as impossible to avoid, and crucial for the therapeutic process. Loewald (1986) wrote:

> *I believe it is ill-advised, indeed impossible, to treat transference and countertransference as separate issues. They are the two faces of the same dynamic, rooted in the inextricable intertwining with others in which individual life originates and remains throughout the life of the individual in numberless elaborations, derivatives, and transformations* (p.276).

Understanding transference dynamics involves becoming familiar with other *selves* the person was once a part of, as these larger selves still constitute operant dynamics. Everything the person was once a part of is still a part of him or her, and every *self* the person was once engaged in is still alive in them. This intricate archeological work can liberate us by seeing how it can relate to having an awareness of our veils (our transferences) and hence increase our capacity to truly see another, and be seen by another[6].

The *neat* therapeutic work of the therapist interpreting the transference dynamics from outside the system begins to collapse. In relational psychoanalysis, countertransference is transformed into the psychoanalyst's "*most effective tool and organizing principle: if early conflicts could be resolved live, as it were, the result would always be more lasting than if they were merely* described" (Gomez, 1997, p.27). However, as we open to new matrices of transference dynamics, new intimacy is

[5] (Pizer, 2006, p.34).

[6] In analytic terms: relating to the other not merely as an object, but also with our subjectivities, to be an us *and* at the same time two individual subjects.

potentially introduced into the therapeutic dyad, the prospect of which evokes great hope and dread in therapists and client alike.

The transference dynamics our clients undergo touch our own transferential matrices; their forms evoke our own forms, and we have an obligation to attend to our own growth and healing in the process of supporting our clients'. True, the forms through which client and therapist participate are asymmetrical (Mitchell, 2005, p.227) and that asymmetry needs to be preserved and taken into account, but both sides are influenced, impacted and both potentially need to grow. Countertransference is inevitable. Mitchell (ibid) wrote: "*Countertransference, like the weather, continually changes, but one is never without it* (p.182)." Such a position means that the client benefits from the relationship with the therapist as much as the *therapeutic interventions* of the therapist (Weiss, 1993, p.26). Barbara Pizer (2000) humbly suggested: "All we have to offer is our listening presence, along with some tentative speculations whose signals must first originate from our own personal data bank (p.34)."

From a relational perspective, working with our countertransference and using ourselves within the dyadic interaction becomes a necessary move. The therapist is accordingly called to pay attention to himself, his client, the field created by them, and the dynamic relationship between the three. This attention needs to be a soft one, a non-grasping attention: one that can tolerate attending without knowing; one that can bear deep identity flow. It is my belief that such an attention is at its best when it starts with, and is continuously informed by, our bodily sensations. This is probably what David Paré and Mishka Lysack (2004) meant by talking about "relational attunement." It is my belief that body-awareness (particularly awareness of somatic countertransference) is the most effective vessel for relational attunement.

An example for the consequences of the relational turn concerns the therapist's disclosure. For many decades, psychoanalysis (as well as other forms of psychotherapy) took pride in the analyst refraining from self-disclosure. The analysand and analyst would enter a meaningful and intimate relationship, within which the analyst served as a reflecting mirror (or a sounding board) for the analysand's projections. The effort to eliminate the therapist's influence, in order to maintain the autonomy and integrity of the patient, had given ground to one-person psychology. The therapist's inner events (reactive transference) were deemed irrelevant to the therapeutic task at hand, and if strong enough, was an indication that the analyst was insufficiently analyzed.

Relational psychoanalysis showed that the earlier narrow view of communication was not only erroneous but also counterproductive for the therapeutic process. Since the majority of communication takes place nonverbally, it became clear that there was no such thing as an objective observer. As Kenneth Frank (1997) argued: "*virtually all of the analyst's activity, even inactivity, is expressive and continuously communicates meaning to the patient* (p.268)." Relational theory does not grant an open permission for disclosure, but has brought it back into the professional dialogue from a place that considered it a taboo. What to disclose, when to share, how much to share, and when to hold back are all questions that are being asked and explored. Also, decisions made regarding these questions as a part of the therapeutic process can perhaps also be paralleled to similar questions regarding touch in psychotherapy. In addition to this, self-disclosure is still not quite seen as an analytic (or therapeutic) *technique*. Instead, as Orange and Stolorow (1998) suggested, it should be part of practice: a result of inner and interpersonal dialogues that can be witnessed as the interplay of subjectivities.

Relational practice requires us to bring ourselves, as people, not just as therapists, more deeply into the therapeutic process. We would be wise if we used theoretical and clinical grounding to support such a clinical shift. Relational psychoanalysis can certainly provide us with exactly that: theoretical and professional grounding for encouraging our hearts to open.

A Mind of Our Own

*I become through my relation to the **Thou**; as I become **I**, I say **Thou**.* -Martin Buber[7]

Gregory Bateson was a modern image of a renaissance man: he contributed to fields as varied as cybernetics, psychiatry and anthropology. It is his theory of mind, however, that deserves special attention here. Mind, according to Bateson (1979), was a cybernetic system. It was not only intrapsychic but also the interpersonal connections (patterns that connect) that constituted the *mind*. When the therapist and client sit together, *mind* is not a personal, but a relational, intersubjective process, and when we include the two of them, they become a *wider-mind*. Mind is shared by the two and this wider-mind creates the individual minds, as well as is co-created by them.

The *self* in relational psychoanalysis is close to Bateson's perception of *mind* in three ways. First, the self is seen as a process (verb) rather than an object (noun), a principle of an organization instead of a concrete entity. Secondly, the self is de-centered: the field of self expands beyond the boundaries of skin to include connections with others. Thirdly, the relationship between personal and relational is dialectic and cybernetic: they emerge from each other and are in dialogue with one another. We create the third, wider-mind and are at the same time created by it.

The relational self is created by the dynamic tension between self as continuous and integral, and the self as multiple and discontinuous (Mitchell, 1993). Adrienne Harris (1996), for example, addressed the notion of self in her discussion of body ego. She noted: "*There is no meaningful individual body ego without the interface - the holding, looking, touching encounter of the social other* (p.371)."

[7] (Buber, 1958, p.11).

Appropriately, the self could be described in both ways: as a personal object, and as a socially organized phenomenon, paradoxically being both at the same time. This unhinging of our identity-organization and surrendering to a wider-self is the relational-field, analytic third, or intersubjectivity.

This new *form* (the us-ness) which distinguishes one-person from two-person psychology (Mitchell, 1988) instills hope in the possibility for genuine relatedness and for real change. The hope it brings could be seen as creating a new attachment relationship through which old attachment patterns could be reviewed; a newness that informs and shapes the old (ibid). At the same time, this real change requires that we are touched and changed too as therapists. Relational psychotherapy means that the therapeutic process (which is no longer done on or to the client) moves through the therapist and the therapist-client dyad (Aron, 1991). The client-therapist relationship becomes a process of weaving mutual influence, affecting one another, changing each other, and being recreated afresh in the process. This is a highly involved process, a participatory journey (Maroda, 1998, p.5) instead of the classical laboratory observation.

The practice of relational psychotherapy could therefore be regarded as one possible discipline for cultivating wider-mind connections. Rituals involving opening to relational fields devise methodological ways of increasing the chance for the emergent wider-self, and the practice of body-psychotherapy is among them. Bodily attention, resonance, and touch all attend to the *us-ness* that has been co-created with a concrete, inescapable immediacy.

The relational paradigm, in adopting a broader (and less localized) sense of mind and self, adheres to a therapeutic model that is not uncommon in tribal healing and shamanism. The premises of connection, intimacy, co-creation and (dare we say it) love that guide relational dance are in agreement with philosophies of the healing arts, perhaps more than those of traditional (psychoanalytic, but also cognitive behavioral) therapeutic ones. Psychotherapist and shaman Bradford Keeney illustrated: "*When this relational, communal, ecological mind prays in harmonic resonance, the whole system reverberates with the pulse of life. Then it is life that heals* (Keeney, 2005, p.39)." And when such a connection occurs, when our relational wider-self can include us but not be limited to us, and when that connection lives in our belly, nature sings through us and[8], whatever we do seems to be full of healing.

The notion that our *self* is not only a personal object, but also a part of a relationship is a humbling one. It enables us to think of self as fluid movement of spheres contained within larger spheres and are sustained through mutual tensions: we continuously take shape in larger selves, and the *I* that we experience shifts according to the context. I partake in different selves when I am with a client, when I work in a group setting and when I am writing, with you in mind. The resources that are available for the self, as well as the complexity of such selves, change at all times.

Intersubjectivity

The phenomenon of intersubjectivity exemplifies the validity and reality of a self that extends beyond the boundaries of the skin; a shared wider-self which is one of the richest sources of therapeutic success and growth in psychotherapy. Edward Tronick (Tronick et al., 1998) called it *expanded dyadic consciousness* (p.125). Intersubjectivity is an emergent phenomenon, primarily unconscious, which represents the way *selves* are born: through interaction with other selves, and on their own terms! (Jerome Liss elaborates on dyadic states on consciousness later in this issue) Intersubjectivity aims at dispelling what Stolorow and Atwood (1992) called "*the myth of the isolated mind* (pp.7-28)."

Psychoanalyst Thomas Ogden coined the term *intersubjective analytic third* or *analytic third* (1992a, b, 1994a, b, c, d, 1995). The term describes the third subject of analysis. This *analytic third,* which can be seen as parallel to Stephen Gilligan's (1997) *relational-field* and Gregory Bateson's (1972, 1979) *wider mind*, is in a dialectical tension with analyst and analysand as separate individuals with their own subjectivities. "*Analyst and analysand each participate in the unconscious intersubjective construction (the analytic third) but do so asymmetrically*," wrote Ogden (1996, p.884).

To fully experience our own subjectivity, or our own agency in the world, we need to be recognized by another subject. Jessica Benjamin (1990) postulated that "*the psychoanalytic process should be understood as occurring between subjects rather than within the individual* (p.184)." We have the need for recognition as well as the capacity to recognize another (ibid, p.186). The importance of acknowledging the other as a subject is not new, though. The ethical philosophy of Immanuel Kant (1781) was founded on this notion. Kant's categorical imperative required us to relate to others as holding value in themselves, not simply through their value for us. We can try to understand that while we can never fully ignore the utility of the other (their *use*), we should strive to appreciate them outside of their use for us. By expressing these ideas, as Hans-Klauss Keul (2002) highlighted, Kant was already pointing to the principle of intersubjectivity (p.254).

According to Benjamin (1995), intersubjectivity is the dialogic process of sustaining the paradoxical tension between recognition and self-assertion, acknowledging the other and negating the other (Pizer & Pizer, 2006). It is a want to belong to the wider-self, yet also a want to maintain our separate individuality and subordinate the other to our own subjectivity.

Attunement to intersubjectivity requires a focus that readily occurs in trancework, bodywork, and the healing arts, and is less commonly found in *talking* psychotherapeutic work (Ramberg, 2006). It is a focus on the quality of presence, in the here-and-now, on the edge of connection. Darlene Ehrenberg (1992) proposed that such real contact necessitates an attention to

[8] Paraphrasing Carl Rogers (1986, p.137)

"*what goes on affectively between patient and analyst* (p.13)", attending to the nonverbal moment-to-moment shifts between analyst and patient (Gerhardt, Sweetnam, & Borton, 2003).

The intersubjective position is born of deep connection: an *us* that is larger than the sum of its parts, and it holds a healing potential for those exiled aspects of us. Therapy can serve as a meaning-giving context (a wider-self) for parts of the system (the person) that are coming back from such long exiles. In the safety of therapy, the person can reorganize in an organic, gradual pace. Psychologist and psychoanalyst Daniel Stern (1985) appropriately considered intersubjectivity as a "*psychic entry into the human race*," an entry that can be facilitated through secure and attuned relationships (Wingfield, 2007, p.85).

The Relational Position and the Body

> *Nonverbal attunement creates the original space of thirdness in which the free-flowing back-and-forth does not appear as a reaction to the other's demand but as the partners' mutual creation of a dance—the first form of mutual recognition. This space later becomes that of dialogue, in which it becomes possible to create meanings that transcend those of the singular person and to analyze the interaction between two partners.* Jessica Benjamin[9]

If the self is not merely a personal entity, what happens to the body? Susie Orbach (2003), for example, paraphrased Winnicott's argument and claimed that there was no such thing as a body: "*The body is only made in relationship. It doesn't exist in any viable way outside of relationship* (p.10)."

Through relational eyes, somatic events are regarded as a language for experience and expression; a means of relating to another (Greenberg & Mitchell, 1983, p.226). Instead of talking about hierarchical relationship (within the client's body/mind, and between client and therapist), we may perceive an interactional web of influences between body, mind, and the environment (Laschinger, Purnell, Schwartz, White, & Wingfield, 2004). If the self lost its localized boundary in relational psychoanalysis, than relational body-psychotherapy adds a de-centering of the body too: we are created through a dialectic movement between somatic, linguistic and relational processes (e.g. Asheri, 2009, p.110), Our bodies acquire meaning through their coming into contact with one another.

Realizing that we cannot influence another person without impacting ourselves has been deeply influential in relational psychotherapy. The dyad – and indeed the group – can form a *larger-mind*, whereby alternative forms of feedback could be restored. As is evident from attachment research and from the excitingly emerging field of relational body-psychotherapy (e.g. Asheri, 2009; Hartley, 2009; Totton, 2005a, b, 2006), bringing embodied presence to the psychotherapeutic dialogue and opening the possibility of touch is not simply a sweet *therapeutic technique* of satisfying the needs of pre-oedipal clients (and the narcissistic wounds of their therapists), but instead is a therapeutic positioning that maintains an honest connection with both analytic thinking and body psychotherapy. In attending the body and offering the possibility of touch, we acknowledge that intersubjectivity is primarily a sensory, somatic-affective event. It may also allow for reparative attachment patterns to take place, which are more adaptive forms of relationships.

The surrender to wider-self does not take place in a void, and its context – inasmuch as we are human-beings – is always a bodily context. Our somatic existence allows us to open to re-organization, and working therapeutically in an embodied way can enhance the acuity of dancing on the edge of surrender. It is as if one is working with early, preverbal and transcendental forms of intersubjectivity that cognitive processes would easily overlook.

Attending to our own somatic reality as therapists is perhaps the most potent way of *feeling into* the larger self (the intersubjective analytic third) which was created in the therapeutic setting. We have the capacity to communicate with a part of us which is no longer ours alone, and by influencing this intersubjective third (i.e. changing ourselves from inside) to impact this intersubjective field, hence to impact the client. To reiterate: we partake in a larger-self which is both *me* and *larger-than-me* (including the other). When we open to resonate, we can feel the wider-self (larger-than-me), and influencing ourselves will lend itself to shifts in our client. Thus, the object of therapy extends beyond *the client* into the triad: client, therapist and intersubjective-third[10].

I Could Have Danced All Night?

The idea that psychotherapy can become an art-form is very comforting for me. True, the center stage is not for us therapists to take: the artist is the dyad, yet working relationally allows me to exercise humanity and creativity, to open to love and to surrender and forever grow, all the while supporting my clients. I find this utterly delightful.

Writing this paper came at a poignant time for me. After nearly eleven years of living in the United Kingdom, I have moved back to live in Israel and have taken a five-month sabbatical to complete my PhD thesis and settle in before taking on clients. This week was my first working week, and I saw five clients. I could barely sleep for excitement. One of my new clients met me in a workshop I taught two years ago, and we had a very strong connection. He drove to see me from another

[9] (Benjamin, 2000)(p.49).

[10] The fourth and last paper in this series, *Gliding on the strings that connect us*, will expand on the use of resonance in relational therapeutic practice and connect it to both its shamanistic roots and relational-psychoanalysis.

town and the only time we could find for the session was 07:30 in the morning. "I was so nervous and excited towards coming here today," he said with embarrassment, "I woke up at 05:30 this morning." I smiled, "I woke up at 05:30 too; seems you're not the only nervous person here."

I spent a great deal of my life doing my best to be as least human as I could, to feel as little as possible. It didn't work for me; I have miserably failed. Somehow, my need for connection and human companionship tortured me. Relational psychotherapy offers me a home; there is a sense of coming out for me in it – a professional permission to be human. Does it feel like home for you too?

Relationality doesn't mean that self-disclosure is the basis of the therapeutic work, nor that the therapeutic goals are forgotten, but, for me, it means that I don't have to vacate my position in order to do my work properly, to surrender to a persona and leave my person behind. Moreover, it means that by being me, by attempting to be as authentic as I can, as (flawed) human as I dare, I am actually doing my job better.

Freeing ourselves from the fantasy of non-influence does not grant thoughtless or relentless impact and manipulation. The dance is not an abandoned free-form dance. We might have taken off our tuxedos and evening dresses, but the tribe still expects us to observe the rituals: there is still a frame; a strong, if flexible, frame. We move from rhythm to rhythm, we follow the pulsating demands of our dyad and maintain safety through the theoretical, clinical and human grounding. But within this form, within those different rhythms, there is a genuine place of choice- a place of artistic expression and of an opportunity for true connection. To know that this freedom to connect from the centre of our being is also a healing experience for another person is a truly magnificent gift.

Having introduced some of the concepts and theoretical structure of relational psychoanalysis, we can now put down our fancy ballroom attire, wear some more comfortable clothes and allow ourselves to follow our body's movements. The next three papers, while still speaking of relational psychoanalysis, would lean against what we have laid here today, and liberate us to move with greater freedom. After all, it don't mean a thing if it ain't got that swing.

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Biography

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Relational Living Body Psychotherapy: From Physical Resonances to Embodied Interventions and Experiments

Julianne Appel-Opper

Abstract

Many of the concepts of body-oriented psychotherapy concentrate on therapist awareness of a client's bodily sensations. The focus of this article is the important role of the *therapist's* physical resonances. In their ongoing nonverbal communication, therapist and client co-create an embodied field in which both relate with and refer to one another. Examples from my clinical work demonstrate the way in which such resonances can be developed into embodied interventions. This "Living-Body-to-Living-Body Communication" can reach and access implicit relational knowledge, empowering both healing and change.

Keywords

Physical Resonances – Embodied Interventions – Living-Body-to-Living-Body Communication

Clients bring their pre-verbal implicit relational knowledge with them into our consulting rooms. The way a client enters the room, looks at us, sits, moves, and gestures tells us about their relational rhythms and melodies. Their bodies broadcast the stories of how they were looked at, held, and touched; whether they were comforted and supported or abused and mistreated. The living body communicates in a certain language: a still shoulder, a look away, a gasp for air, or a slight movement says something. We as therapists physically react to these embodied stories. They reach us skin-to-skin, heart to heart and muscle-to-muscle without much cognitive or reflective process involved, and unintentionally we react. We react with tiny movements: we lean back, we hold our breath, we become tense and look away, or suddenly feel cold. I firmly believe the subtle physical resonances of the therapist also broadcast something to the client. This motivated my exploration of the ongoing embodied communication between therapist and client, the main focus of which was how to bring this rich and often unnoticed communication into awareness in the therapeutic space.

What follows is a body-oriented approach to psychotherapy which I have termed "Relational Living Body Psychotherapy" (RLBP).[1] I have published several articles on this approach in Britain (Appel-Opper, 2008a, 2008b, 2009) and am pleased to have this opportunity to present it to colleagues in the U.S. Many concepts of body-oriented psychotherapy focus on awareness of bodily resonances and sensations in the client. The therapist's physical resonances, or reactions, such as subtle changes in postures, gestures, and movements are mainly used for further information on the client (Joyce & Sills, 2001), or are viewed as physical counter-transference (Soth, 2006). I believe it is not enough to bring the therapist's and/or client's physical resonances into awareness. It seems more effective to develop embodied interventions, which then act as a healing Living-Body-to-Living-Body communication. I view this non-verbal communication between therapist and client as a co-creation, in which both relate and refer to each other. The embodied stories of the client co-create bodily resonances with the therapist, which in turn co-create further resonances with the client. In RLBP, the therapist brings her/his own physical resonances into the therapeutic space, thus affirming body-to-body the stories of the client's body broadcasts. This is an important part of RLBP because it encourages the body of the client to continue to speak. The stories are confirmed in a safe and mindful step-by-step process. Embodied interventions and experiments/exercises are then co-created within this bodily field between therapist and client. By remaining receptive and present in body, the therapist can monitor how her/his interventions bodily impact the client.

The Bodily Sensations/resonances…

As a Gestalt psychotherapist, I root myself in the phenomenological method of inquiry and field theory. I make a conscious effort to slow down so that I can sense how I am in my body in the moment, trying to be aware of my own rhythm and melody so that I can clearly hear and receive my client's own rhythm and melody. It is as if I am slowly descending a staircase that leads me deeper into my body and the relational embodied communication of my client and myself. In that space I am able to listen to the stories the body of another wants and needs to tell and share. I hear the echoes and sense the shadows of related somatic patterns from contacts of the past.

Merleau-Ponty wrote that only as lived bodies are we in the world ("e*tre-en-monde"*,1945/1974). I agree with Kennedy (2003) that "the phenomenal field as the lived body is part of phenomenology and carries all the richness and promise of what we call field theory" (p.76). Schmitz (1989) focuses on milieus and atmospheres in the body and draws attention to the fact that "felt perception is not a reception of signals but a lived body communication and incorporation" (p. 13, my translation). His alphabet of the living body inspired me to explore sensations further. In one exercise, I ask participants at my workshops to look out for a "narrow" space in the body. I then ask for a "wide" space in the body. I suggest staying on a phenomenological level and not analyzing, having them simply describe in respectful and non-shaming terms. From my experience this kind of vocabulary helps the participants to widen and deepen their sensations and allows them to be impacted

and "impressed" by the stories of another body. In another exercise I ask two participants to let themselves be impressed by the "grace" of the other body as they sit together in quietness (Appel-Opper, 2008). This exercise is useful to sharpen the sensitivity of the subtle non-verbal communication between two bodies. In this connection I teach the metaphor of the anchor. I agree with the sentiment of Gilbert and Evans that therapists need to be anchored in their thinking so that they can hold onto a meta-perspective as they let themselves be deeply physically impacted and impressed by another body (2000). Examples of a bodily resonance could be cold hands, a headache, tension in the forehead or spine, holding one's breath, getting dizzy, or feeling chaos in the body.

Within the Gestalt tradition, there have been several contributions to bringing the body into the heart of psychotherapy **(**Clemmens & Bursztyn, 2003, Clemmens, 2010, Frank, R. 2004, 2005). James Kepner, one of the pioneers of physical process work in Gestalt, has introduced metaphors based on rich clinical experience (Kepner, 1987, 1995, 2003). He writes of the therapist's role in creating and holding an embodied field instead of merely talking about body experience. He has influenced authors such as Tervo (1997, 2007) who further refined and developed his work. In vignettes of her work with children and adolescents, Tervo describes how she experiences herself as an improvisational dancer, learning to listen to the "natural beat" of the child (p.78). The reader gets a sense of her bodily presence: her observation, imitating, mirroring, and staying in the embodied field, creating games which give the child the opportunity to breathe and move. This allows the child's body to structure, enliven, and defreeze.

… Are Co-created and Refer/relate to Each Other

During the years I lived and worked in Great Britain, I became fascinated with Dialogical Gestalt Psychotherapy and Relational Psychoanalysis in theory and in practice. My experiences coupled with the study of related texts opened my horizons.

Dialogical Gestalt Psychotherapists discuss what they refer to as the "between" of a healing dialogue, wherein therapist and client share meanings and phenomenology (Hycner, 1991; Yontef, 1988). Parlett (1991) points out: "through creating a mutual field each of us is helping to create other's realities" (p. 76). Personally, I wish to apply these concepts to *non-verbal* physical communication between therapist and client, as they also co-create one another's *physical reality*. For example, clients broadcast and transmit their embodied stories in the way they hold their breath and lean forward. We might not consciously notice this but our own bodies will physically respond to it. We may react by leaning forward as well, or by leaning back. At the same time our breathing rhythms can be impacted. These tiny reactions also broadcast and transmit something to the client's body: we convey to the other that we are getting a glimpse of the world the client has experienced. In this way we share *physical meaning*.

The following metaphors from psychoanalytical thinking can also apply to the living body. Bollas' (1991) metaphor of the shadow of the other also illustrates how all experienced relationships continue to live and leave shadows in our bodies. Bollas writes of an "unthought known" which I would describe as an *unsensed known*, that lives in the body waiting to be heard by "some-body". From a Living Body perspective, Tolpin's (2002) concept of the growing edge transference can also be seen as a hopeful, healthy striving of the body that one day another body will be able to listen and see the invisible.

Relational Psychoanalysts are currently developing their concepts from a stance of inter-subjectivity to a focus on two bodies in relationship. I have been inspired by authors like Aron (1998), Harris (1998) and the Boston Change Process Study Group (2008), focus on relational perspectives on the body and and bodily based communication. Also impressive are how Gestalt concepts such as Field, Gestalt, and working in the Here and Now play a role in this literature. Beebe and Lachmann (1998) conclude it is the task of the analyst to "read the non-verbal communications" (p. 501) which they view as organized self and interactive affect regulation, mutually co-constructed by therapist and client. Aron (1998), focuses on bodily communications in which "the analyst must be attuned to the nonverbal, the spirit (breath) of the session… and his or her own bodily responses" (p. 26). He adds that analysts "need to convey their visceral understanding of the patient" (p. 29). Beebe and Lachmann (1998) point out, that "subtle nonverbal communications are particularly powerful because they occur in the here and now of the interactive matrix" (p.501). For additional discussion of the significance of attending the implicit embodied communication between therapist and client, see for example Anderson, F.S. (1998, 2008), Balamuth, R. (1998), Knoblauch, S.H. (2005, 2008), Nebbiosi, G. & Federici-Nebbiosi, S. (2008), Petrucelli, J. (2008), Stern, D.N. (2004).

LaBarre (2008) provides us with a case study which includes such a nonverbal encounter between therapist and client described in minute detail in a" kinetic text". I agree with Jacobs (2008) that such articles bring gestalt therapy and contemporary psychoanalysis to points of convergence. In this connection I would like to mention Denham-Vaughan, (2005) who focuses in a recent article on the shift in gestalt to a relational aesthetically orientated approach that increasingly works with structures of ground. Such a style of developing gestalt therapy further is close to my heart.

Now that I am back in Germany I have started to read the recent German literature on body-oriented psychotherapy. I am happy to have found texts by colleagues describing how they integrate body processes into their work. I cannot quote all of these rich texts, but wish to mention the following authors with whose work I feel a certain connection: Bauer,H. (2006), Downing, G. (2008), Geißler, P. (2008), Geißler, P. & Heisterkamp, G. (2007), Korbel, L. (2008), Poettgen-Havekost, C. (2004). Thielen, M. (2009), Volz-Boers, U. (2007, 2008), Worm, G. (2008)

… And Can Be Refined Into Embodied Interventions

This next section includes some examples from my clinical work which demonstrate how I bring my physical resonances into the therapeutic space and develop embodied interventions. The spot light is not on the client alone, but on the bodily relation and referral between the client and myself. Together, therapist and client co-create a "Relational-Living-Body-to-Living-Body Communication" in which healing and change can take place.

Ants All Over the Body

I remember a female client, Mrs. S., whom I saw at a psychosomatic clinic in Germany. She started talking as soon as she walked into my room. She talked and talked; after a few minutes I felt as if I were sitting in a rhythm of chaos and anxiety. My head felt dizzy, my hands cold, and I felt as if I could not breathe. To say something I had to interrupt her, so I started to lift my right hand as a sign that I wanted to have a word. This enabled me to gradually express my sensations. I told her about my cold hands and how my body did not have enough space to breathe. I can still see her immediate glance at her hands. It seemed as if she noticed them for the first time.

In the sessions that followed, we focused on her hands and her experience that she "did not feel them". We discovered that it was hard for Mrs. S. to "focus on anything", so I asked her to touch her own hands and try to concentrate on just that. We decided that I would simultaneously touch my own hands. In one of these sessions she came up with the image of ants running all over her body, the floor, and "everywhere". As she explained the image, I noticed her shoulders had moved up slightly and her arms seemed to be hanging there lifeless. At the same time, I sensed an impulse to move my own arms. From these ongoing relational bodily communications, we gradually created an exercise utilizing this ant image, with her moving her arms and hands as if she were gathering the ants. Mrs. S. expressed her enjoyment of this exercise. It looked as if the movements unfroze her shoulders and arms while structuring them. Mrs. S. also started accompanying the movements with phrases like: "it is alright now, calm down". In the following sessions we noticed how her breathing rhythm had changed, and that she was able to gather her thoughts more. We both recognized the connection between her mother, whom she described as "pure chaos" and "all over the place", and the remaining chaos in her body.

As I reflect on the session, I note the strong reaction of raising my arm to say something, which I had never done before and have never done since. This embodied intervention had conveyed something to the client. I believe my arm had received the stories transmitted by Mrs. S's arms and had acknowledged this from her body to my body. This encouraged her body to continue to express what was unspoken.

The Pain Finds Words

Recently in Germany I worked with a client Mrs. V, 50, about my age. She came to see me because of "chronic pain and anxieties around her body". After some time we focused on her anxiety of developing breast cancer. She had just gotten her regular scan and received the good news that she did not have cancer. As I sat with her, I had a sense of tension in my chest. From the corner of my eye I could see she was hardly breathing. I asked her what her breasts had experienced in her life so far. Immediately she replied that she had not been able to breastfeed her son, and that the recent experience at the clinic had been awful, adding how the nurses in the "old GDR hospital" had been ignorant. As I listened to her experience, I sensed a tension and heaviness in my breasts. I then noticed that I wanted to hold my breasts as if they were in pain. I expressed my sensations and my need to hold my own breasts, explicitly asking her whether this would be OK to do "amongst women". Her "yes" came promptly and clearly, so I crossed my arms and cradled my breasts in my hands. I made these movements slowly so that I could monitor how my client's body would take my intervention. Seeing me like this made her cry, and I encouraged her to express herself fully. Later I told her I had felt as if her breasts had been left at this hospital. She nodded, and I asked whether it was time to take them back. The subsequent sessions revealed that she had treated her breasts as if they were still in the clinic and not really part of her body.

I agree with Soth (2006) and Landale (2002) that working with clients who have had to objectify their bodies is challenging. Landale (2002) states: "most people have complicated relationships with their own bodies" and "that embarrassment, shame and fear of the body are common" (p.120). In my workshops I teach how we can find interventions that honor the body for what it has done in terms of creative adjustment. Interventions can be self-touch and communicating to the body as in the example of my clinical work with Mrs. V.. At the same time, the bodily impact of the intervention can be monitored, and if necessary, negotiated between therapist and client. How the body is spoken to and the words we use are of great importance. From my personal experience I have gathered there is a huge difference between addressing the client's shoulder as "tense" versus "still". In workshops I use the metaphor of "a window opening". The words we use may directly reach the child who had to come up with creative adjustments, but they may also burden the client by adding to the weight that is already there. By this I mean the weight of guilt, embarrassment, self-hate, shame etc. Following is an example of how this can develop in the clinical situation.

Embodied Messages to the Forehead

I remember the following scene from one of my workshops. B., a colleague, told the group how she did "not have any relationship with her own body", and that her mother had "controlled everything". As she spoke I noticed a tension in my forehead, as if the area was under some pressure. At the same time, I saw that the skin of B.'s forehead was paler than the rest of her face. Her eyes also seemed a bit watery. She was nearly crying, but I noticed she screwed up her eyes and tried to continue to talk. I kept looking at her, feeling the pressure and tension in my own forehead. I felt like I was on thin ice. With this embodied co-created message in the field I decided on a tactic of intervention. I said something along the lines of: "as I sit with you and listen to what you are saying, I feel an impulse to touch my own forehead." As I said that I looked out for physical signs of how B. would take in what I had just said. I focused on her breathing, the tension in her body, her eye contact and the paleness of her skin. I gathered from the signs that the intervention had reached her body; the rhythm of her breathing slowed slightly and she looked at me openly. She immediately said yes, that this would be fine with her. I slowly and mindfully stroked my forehead very softly as if my hand caressed my forehead. I let my breathing flow in a regular rhythm and watched her body, especially her forehead and her eyes to see how this intervention impacted her. Immediately I saw tears form, her lips move, her mouth open a bit and a distinct presence of sadness. I watched carefully to check that she was supporting herself by breathing regularly.

B. later told me that she wanted to touch her own forehead. As she did so in a soft, gentle way she talked about how she had learned not to show feelings, as this had been "dangerous" when her mother was around. I added that it was good her forehead had been able to learn to hold these feelings inside. I noticed that she let out some big sighs, which I encouraged and joined her in doing. While we both were sighing, I started to feel more at ease as if the thin ice had turned into much more solid and trustworthy ground. She looked different than she had at the start of our work. Her skin looked less pale and her eyes were under less pressure.

We later talked a bit about what had happened. Another participant said she had felt relieved that B. had been able to let go a bit. B. shared how her regular headaches now made sense at a different level. It became clearer how B. had felt shamed by her mother. Previous experience has taught me that old patterns are often associated with feelings of shame. Sometimes there is an expectation of being shamed, which keeps the window of the body closed.

The Body under the Stone

The participants of my workshop had done an exercise in pairs. Before moving on I looked around to see how people were doing. I noticed that one of the participants, A. was looking down at the floor and that her body seemed heavy with a downwards movement. I had known her for some time, as she had already been to my workshops, and I had seen this before, but not at this intensity. A. then moved her head up and looked at me with a mixture of hope and fear. I felt drawn towards her and was full of curiosity. I inquired whether it was all right if we focused on her a bit longer. She agreed, and I sensed I was very touched by how she appeared at that moment. Somehow my head wanted to analyze and understand what had happened to her during the exercise. When I questioned how she was feeling now she answered she felt "shattered, like under a stone." I noticed her eyes looked sad and she was supporting herself by rounding her back again. I empathized with her, feeling crushed and somehow down there too. I started to sense an atmosphere of heaviness, darkness and resignation. This felt like deadening oneself. Then I thought: "this is old bullshit", and decided to risk expressing this. I felt the strong urge that somebody had to say that this was "old bullshit", and how it had been for her in the past. I remember saying this in a clear voice, trying to reach out to somebody inside her who wanted to face this creative adjustment from the past, or a young A. who had to learn to deaden herself. I kept on looking at her as if my eyes could tell her: "come on try, let us try". Moving my head slightly up I asked her whether this old bullshit had to stay or whether she wanted to create something new together with me. A. answered yes. A. was somehow imprisoned in this old creative adjustment she had developed in order to survive. Her spine was held down, her breathing shallow, her chest closed and her perception narrowed.

I asked her to lift herself a tiny bit, which she did. As she did this I noticed that my eyes wanted to look away from her. I told A. about this sensation and checked with her how it would be if I were to look at her. She told me she had trouble being looked at. My response to this was quick and clear: I told her I would close my eyes so that I could not look at her. After I had kept my eyes closed for a few minutes A. told me that she wanted to stand up. I remember that I asked her whether she was standing since I could not see her. She answered "yes" and I recognized that her voice came from a standing position. I then also lifted my head more and let my spine move up a bit. and waited. Nothing seemed to be happening, so I asked her again: "Do you want me to look at you?" and heard a quick yes in response that sounded like an automatic answer. I invited her to check with all of her A.'s available: little A, the counselor A. etc. and what the reply would then be.

There came another "yes", but this time her voice sounded much softer and younger, as though it came from a little girl. In trying to address little A. I asked her: What needs to happen so that this little A. can be looked at? She answered that she was afraid of having to leave the room, of being thrown out. With eyes still closed I asked somebody to stand in front of the closed door to make sure that nobody would be able to throw her out. I noticed how serious my voice sounded and that I gave very clear instructions. I remember that I checked that there was really somebody standing in front of the door. Then I asked her again: What needs to happen so that little A. can be looked at? Immediately she replied she was afraid that somebody

could shout at her. I took a deep breath and decided to ask another participant to stand behind her and cover A.'s ears without touching them so that these ears could not be shouted at. With my eyes still closed and not seeing what was going on I felt the need to check with A. again. She expressed she wanted somebody to hold her hand, which another participant did. At this moment A. told me I could open my eyes. When I did, I realized I had a few tears in my eyes. She noticed this and I saw her take it in. I reminded her to continue breathing and support herself through it. At the end I thanked the participants who had taken part in our work and doing what I had asked. Someone remarked I had only passed on what little A. needed from them.

In this powerful piece of work I decided to move under the stone and from there I encouraged her to move away. As I had my eyes closed I experienced how it must have felt to be under that stone; dark, lost, and alone, I could not see a thing and just heard voices, which was scary at times. I realize now that I got a felt sense of what happened to A. I felt very sad throughout my whole body as I sat there not being able to see anything.

This makes me wonder now whether A.'s mother had also felt shattered under a similar sort of "stone". My fantasy was that her mother had battled with the fact that she had left her daughter under one. I believe that A. needed to physically see with her own eyes that there was somebody standing in front of the door and that just speaking about it was not enough.

Some Thoughts at the End

I hope that these examples highlight the way I work from a Living Body perspective. In earlier articles (Appel-Opper, 2008a, 2008b, 2009) I describe other embodied interventions. In one, I wrote about how I worked with a male client whose "trauma was written into his hands". From my physical resonances of cold hands and his feeling that his hands were not his own, we developed embodied interventions. We worked out a plan that he would look at my hands for a few seconds and I would keep an eye on how his body reacted by doing so. The next intervention of moving my fingers impacted him under his skin. This opened up space to focus on his shame around his trauma, since he had not been able to do anything when he was abused. I believe these interventions allowed the physical information held in his hands to be passed on to the rest of his body: the breathing, his skin, his spine and his eye contact. Through this his whole body was involved in carrying the burden of the information held in his hands. This helped to bring back the felt sense of his hands. These clinical examples confirm for me the importance of the language of the body. Especially when working interculturally, the language of "the body can be the primary means of expression." (Möhring, 1995, p. 102, own translation)

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Note

I prefer the term "living body" to "lived body" (for example, Des Kennedy, 2003). In my mind the former captures the image of the stories and the past relationships living in the body.

Biography

Julianne Appel-Opper is a Psychological Psychotherapist (German State Registered Psychotherapist), Clinical Psychologist (German Association of Professional Psychologists), Registered Integrative Psychotherapist, Body and Gestalt Psychotherapist with the United Kingdom Council for Psychotherapy, supervisor, and trainer with twenty years' clinical experience. She is a viva examiner and visiting tutor at Metanoia Institute in London. She worked in psychosomatic clinics with a wide range of patients, both individually and in groups. For twelve years she lived and worked in various countries (France, Israel, California and the UK). Julianne is now in private practice in Berlin and also works internationally. She has developed her approach of the 'Relational Living Body Psychotherapy' which she has taught internationally. She is also particularly interested in the interface between body and culture and in intercultural communication. She has published articles on these themes. Julian*ne can be reached at julianne.ao@web.de

Stream of Consciousness: The Impact of the Positive Relationship in Contrast to Prolonged Isolation

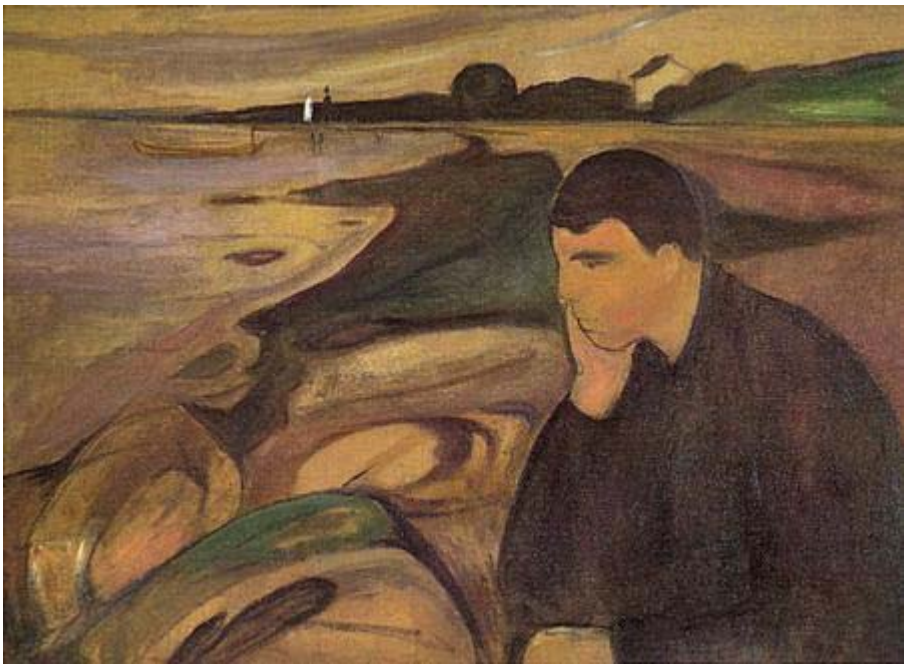
Jerome Liss, M.D.

Abstract

Our awareness of the stream of consciousness can shift our inner attention from real events experienced with others to the repetitive thoughts of those real events that occur when we are totally alone. This is called the impasse. The mind's labyrinth reinforces an unhappy event until we are desperate, anguished or even terrorized. Sometimes the Impasse experienced in solitude, and especially prolonged solitude, becomes more intense than the original event that created the disturbance. This article explains that real events with others occur during dyadic consciousness while the inner repetition of the event, the impasse, occurs during monadic consciousness. Systems theory helps account for the collapse of monadic consciousness, which can feel like "falling into a hole" or by "being pulled under by a whirlpool. What produces the impasse? The subcortical structures of the brain underlie every moment of consciousness, which is chiefly a cortical process of the brain. Our "daytime logic" of interactions with others and performing tasks is guided by the subcortical basal ganglia, while our "logic of the night" is the outcome of the subcortical limbic system that determines both our emotional states and self-other states of trust or alienation. The therapist's job is to involve the subcortical systems in the therapeutic process. Body-oriented psychotherapy does this effectively, because the patient's language flow (from Broca's area in the cortex) is always accompanied by body dynamics that engage and mobilize the subcortical basal ganglia and limbic system.

Key Words

Stream of Consciousness - Prolonged Isolation - Basal Ganglia - Limbic System - Subcortical



What is the Impasse during the Stream of Consciousness?

The Logic of Daytime creates a stream of thought that is clear and rational, guided by a strategy of action, and easily recorded and reproducible by verbal communication. This logical stream of cortical consciousness is guided by the underlying action routines regulated by the subcortical circuits of the basal ganglia.

The Logic of Night-time, in contrast, is a stream of thought that is usually less clear, less rational, pushed by emotions, more readily forgotten, or else represented by a single element that obsesses the mind, while all other components are buried out of awareness. In addition, it is difficult to reproduce this Stream of Thought with verbal language. This is our basic experience when we are alone. (See "stream of consciousness I," in Bibliography)

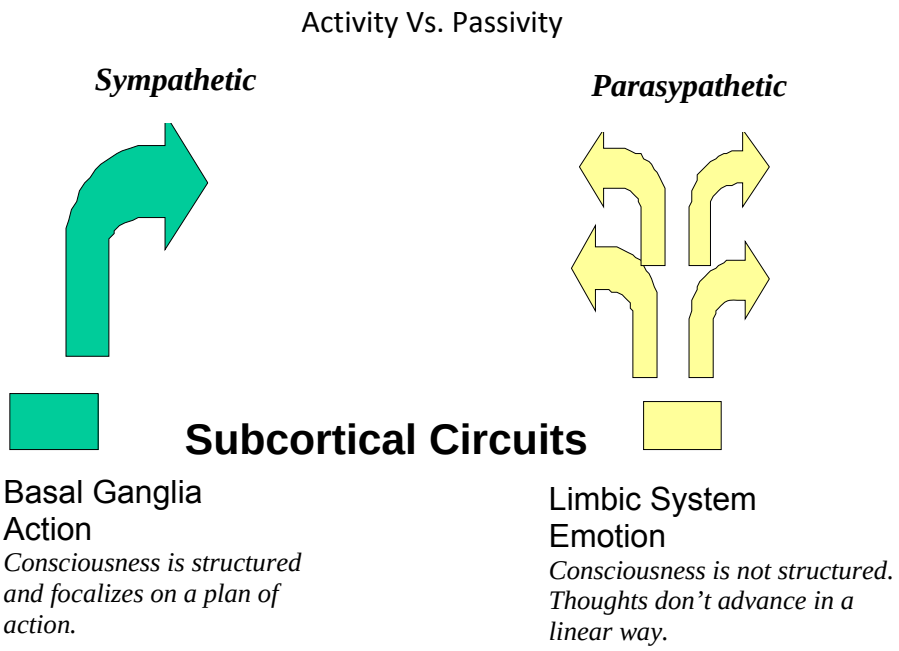
Passivity that is Not Regulated by the Genetic Code.

When does our night-time logic get stuck and become an impasse? When we are assailed by inner thoughts like, "What a mess!", "I'm just no good!", "It's like Hell!", "I'm trapped, there's no way out!" etc. This might be called our inner prison. **But how has it come about that evolution has left us in this inner dilemma that has no exit?** The reason is that

our brain has been programmed so that we can adapt to a community. **We have no genetically based adaptation to prolonged isolation.** Studies of prehistoric communities have revealed that between the period of earliest man, 200,000 years ago, and the onset of civilization, 10,000 years ago, human beings lived in tribes. When civilization began to spread itself, due to the cultivation and storage of grain, a series of difficulties began to crop up. The genetic code was not adapted to certain features of civilization, especially our living in a house with four walls and nobody there.

Prolonged Solitude.

Two factors combine to make us very unhappy, because they didn't occur in our primitive tribe life -- prolonged solitude and passivity. In primitive circumstances there was always a reason to get up and do something. There was always something to do, if just to put more wood on the fire. And a day of being alone could take place, for example, going out for the hunt all alone, or picking berries and digging up roots. But the modern combination of prolonged solitude and passivity didn't habitually happen and therefore wasn't coded for by our genes. While in this civilized life, especially in modern times when economic production depends upon the individual and no longer upon the family unit, we can come home from work, close the door, put on the microwave and spend an evening absolutely alone and with absolutely nothing to do! That's when negativity creeps into our consciousness. And with repetitions that are not interfered with by dialogue with another person, we get trapped in our impasses. Repeated impasses make us anxious and then depressed.



The Dyadic State and the Monadic State

Dyadic Consciousness Prepares Us to Adapt to Monadic Consciousness.

Prolonged solitude was studied by Rene Spitz.(1945) Children living in a situation of prolonged isolation, separated from their mothers, were found to lose their vitality, mental focus and capacity for relationships (self-other capacities).

Research by Harvard Professor Edward Tronick (2005) shows that during the self-.other relationship between the mother and the child, (called "the dyadic relationship"), the child learns the fundamental reactions necessary to maintain both physical and psychological equilibrium during "connection with the other." (see also Stern, 1985; Downing, 1997) Of great use, the equilibrium is "remembered" and continues when alone. Therefore the connected child has better resistance to short and long periods of solitude. In contrast, the isolated child does not have this formative experience; solitude wreaks its havoc. Disequilibrium, discoordination, fear, terror.

Even the strictly physiological reaction of maintaining body temperature while alone is dependent upon contact with the mother, and this as well as other psycho-physiological adaptations become extremely disturbed during prolonged solitude, concluding, in the most severe cases, in infant death. This is evidence that the adaptation by means of sufficiently complete contact with the mother penetrates to **the brain's lower subcortical circuits.** Our argument in the previous article on the Stream of Consciousness, namely, that **the Impasse in the stream of consciousness is due primarily to *subcortical circuit* dysregulation,** is further supported.

Tronick's terminology is useful. The infant in contact with the mother is in "a **dyadic** state of consciousness." The infant, when alone, is in "a **monadic** state of consciousness."

Two States of Consciousness

Dyadic State of Consciousness	Monadic State of Consciousness
	

The impasse during the stream of consciousness is the adult's major form of unhappiness and occurs during one's **monadic** state of consciousness. Solitude has been prolonged and, therefore, too long. Beyond this, insufficient contact during one's **dyadic** state of consciousness, either during infancy, or else as an adult, has produced this unhappy situation of repetitions leading us into the hole of anguish. The self-other relationship has been insufficient to keep consciousness buoyed up and above water in solitude.

What Is Missing in States of Prolonged Solitude? Contact, Expression and Elaboration.

If we look at the *praxis* of psychotherapy, we can better understand how the **dyadic** state keeps the brain in equilibrium, even when adapting to periods of aloneness, and how **the monadic state becomes vulnerable to the negative impact of solitude because there has not been sufficient preparation by means of good self-other relationships.**

Psychotherapy creates a beneficial dyadic state because of three factors:

1. **Contact** with another person with whom there is a feeling of **trust.**
2. **Saying out loud** what we are thinking and feeling.
3. **Elaborating** our thoughts so that they emerge **in sequences.**

Solitude means the opposite: The trusted other is **not present**. We don't speak to someone **out loud**. We don't develop our thoughts with their **natural sequences**.

Therefore, experience can become easily **blocked** during solitude. That's the **impasse**:

1. **Contact:** "I'm feeling so alone… Nobody understands… Nobody can help…"
2. **Expression:** "I'm thinking. Nobody to talk to."
3. **Elaboration:** "Every time I hit up against the same wall. The same thing, over and over…"

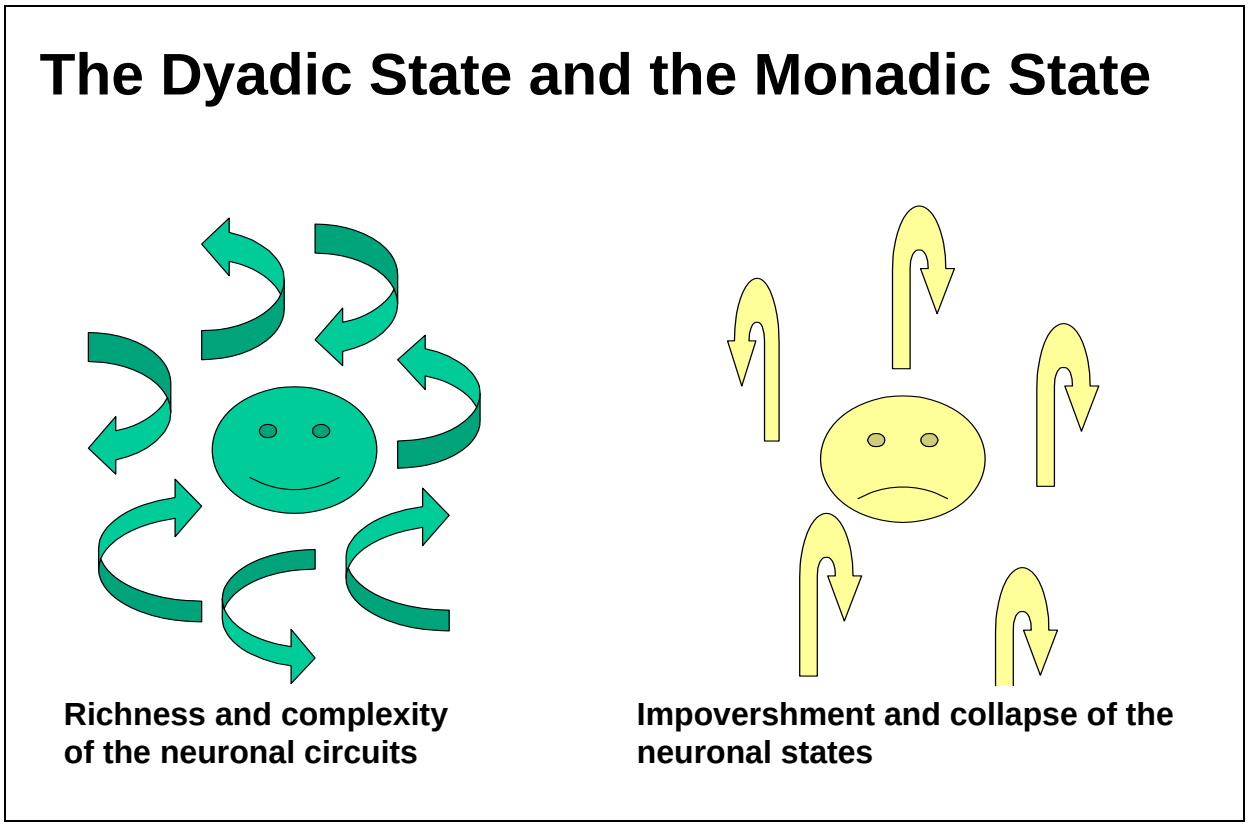
Some moments and periods of being alone are necessary for everyone, children and adults. We need to be alone and away from stimulus inputs to allow the mind to calm down. The brain needs periods of quiet to auto-regulate itself. But we are talking about something else. Our problem of the Impasse comes from excessive periods of solitude, a situation which can occur too frequently and then, in depression, that becomes self-reproducing and inescapable.

The Contribution of Systems Theory

The Mental-Neuronal Spirals Turn Around in Emptiness Until There is Exhaustion.

How can we understand that dramatic difference between positive self-other contact and prolonged isolation? In Tronick's terms, **what makes the difference,** even when we are alone, if that aloneness has been preceded by sufficiently good **dyadic contact,** or if we have been living, instead, in a state of excessive **monadic solitude**?

Let's imagine spirals that turn round and round. Our neuronal circuits work like this, turning round and round. (We are now in systems theory applied to the brain.) When we have contact with the psychotherapist and when we have satisfying contact with other people in daily life (always at issue, the self-other relationship), **the brain neuronal circuits are continuously enriched by the three factors indicated above: relationship contact, saying out loud our thoughts and developing our thought sequences.** Because the repeating circuits are continuously enriched, they maintain their equilibrium, complexity, ongoingness and energy. Beyond this, if the relationship experience is lively, trustful, intense and participative, the brain circuits of the experience are equally lively, coherent and equilibrated. **The positive regulation of the brain during its dyadic moments will carry over to maintain brain regulation in its monadic moments.** Thus, the sufficiently positive and prolonged self-other relationship protects us during our moments and periods of solitude. "I really like solitude," says the person with positive relationships. "I don't feel happy," says the person who experiences impasses during solitude. But the problem of missing positive self-other relationships may be denied. "How about spending more time with others?" asks the naive helper. "That would be even worse," says the person entrapped by impasses. The alternative of being with others doesn't seem at all attractive. That means that positive self-other relationships have not been developed, or are no longer available, and the impasse of solitude feels a relief – or so it seems at the moment – in comparison to being with others who are either "too lively" or "too depressed." The impasse of the repeating neuronal circuits makes the person feel "the world is out of tune with me," or vice versa, "I'm not in tune with the world." In a sense, this person, isolated and depressed, may be, unfortunately, right; the subcortical circuits of the Impasse make the person dissonant with normal social relationships and so there is, using Daniel Stern's term, a self-repeating cycle of continuous "disattunement."

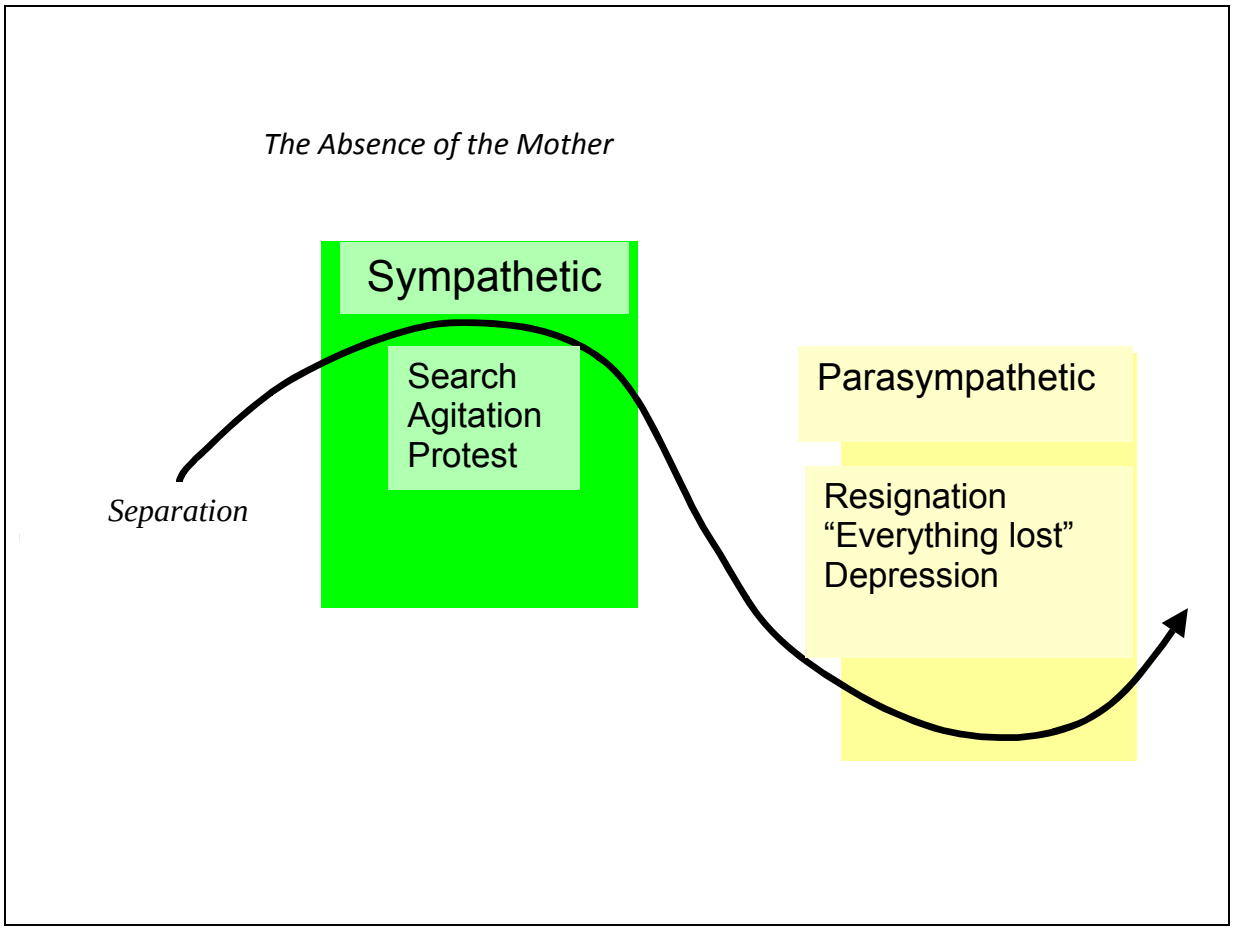


Let us look more deeply into the dynamics of the impasse in isolation. (But not only in isolation. Even when we are in the company of others, the negative thoughts and feeling of alienation could continue unrolling in the back of the mind.)

A single thought repeats itself, "I'm a loser. "I'm good for nothing." "I can't get anywhere." Spirals of thoughts running on the same obsessive rails create aridness, dryness, pessimism, closure, rigidity. The ivory tower is being built. When the external event becomes overwhelming, and traumatic, the reaction gets more vigorous and breaks out with more energy. "A disaster." "Betrayed." "Hell!" "It's impossible!"

While these self negations run through the mind, one or two images may appear as momentary "flashes": A face showing contempt, a shoulder turned away in refusal, a moving toward the person feeling rage, or the moving away from the person feeling shame. Even the sound of a criticism or of an unjust judgment echoes in the mind while the visceral sensations become turbulent and upsetting. This period of an "active reaction" against the stress does not last. After a time, there will be a fall of energy.

We see the same sequence when the child does not see the mother. Should the absence last briefly, there will be no problem. The problem is dosage. If circumstances create an absence that goes on for too long, the child's first reaction is one of activation and agitation, even desperation. Then we have the "rebound" into the phase of low energy and depression. (Bowlby, 1969) Adults live out the same energy sequence: In the first moment of stress lived in solitude, the brain is taken over by a state of agitation and desperation, while the mind turns about in every direction looking for what is missing or a way out of some sort of labyrinth. After this there is a collapse of energy and the person falls into a state of resignation, hopelessness, impotence. "Everything is lost!" or "There's no way out of this trap!" The energy and inner structures of ongoingness that were developed during dyadic relationships are completely lost. The neuronal spirals turn in the emptiness, cut off from all external resources of nourishment, and the hole in the psychic ground grows with every turning of the circle, "wish-disappointment."



How can we explain the impoverishment and the deterioration of the neuronal circuits during prolonged solitude?

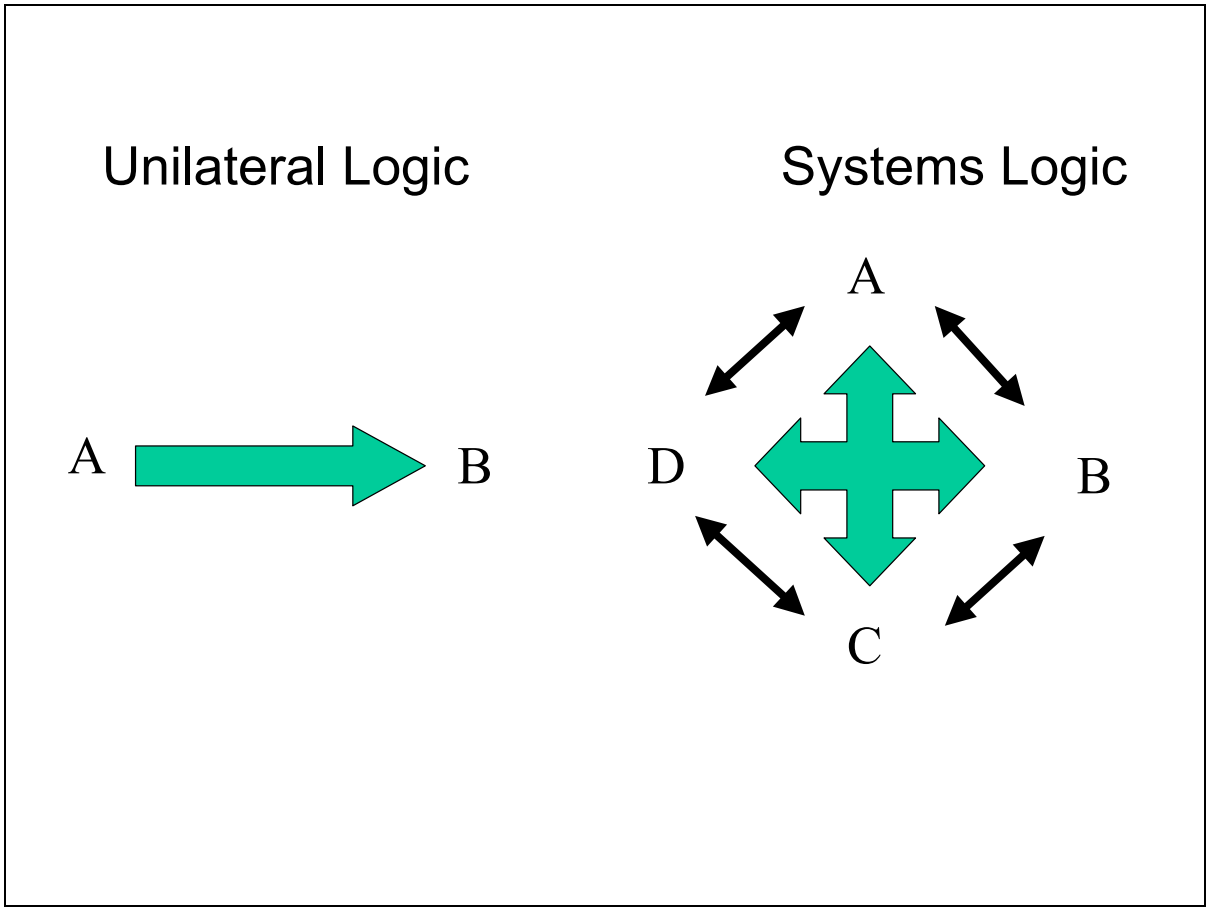
We will now turn to systems theory in order to illustrate how brain areas interact. This will clarify the richness of making good connections and the impoverishment due to excessive solitude.

Systems Dynamics: Brain Regions are "Semi-Autonomous Systems in Interaction."

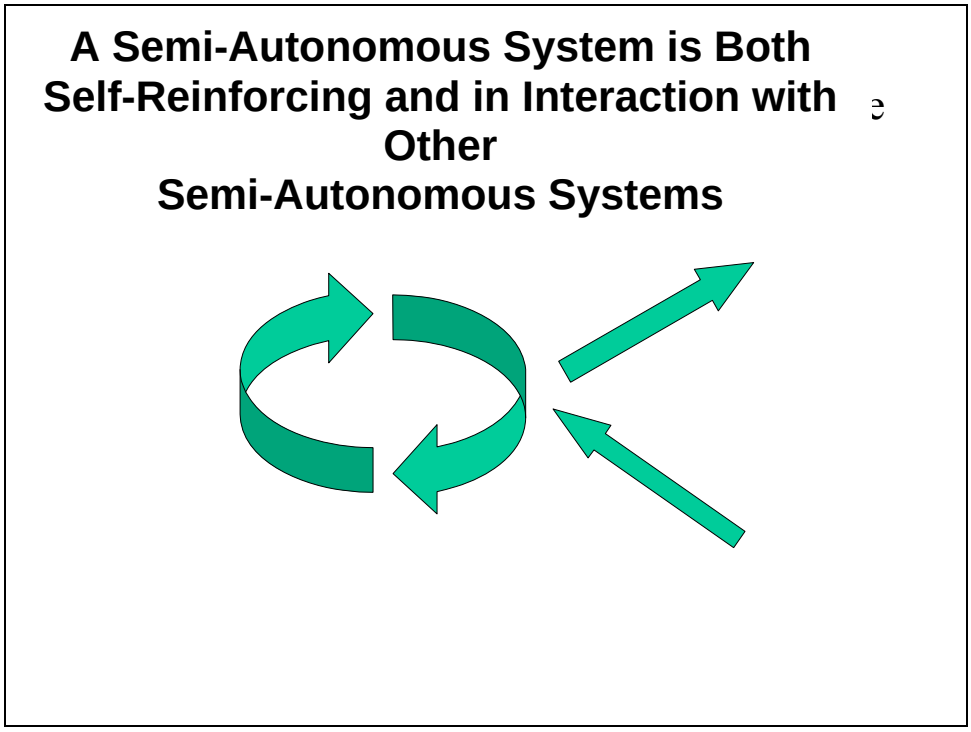
The brain is an enormous system composed of many regions. (Further on, we will emphasize differences between cortical and subcortical regions.) Every region is a subsystem. Systems theory offers tools for understanding interactions among Subsystems. (see Bertalanffy, 1981; DeRosnay, 1975; Gray et al., 1969)

The Biosystemic Method is inspired by the concepts of systems dynamics. "Bio" refers to "biology," that is, the biology of our body and mind as an underlying substrate that guides our conscious and unconscious mind. And "Systemic"? Systems theory offers maps that help understand and guide us when we are in complex territories, which is of great use when we are facing the mind-body components of any important experience or experiential sequence. (See Liss & Stupiggia, 1996)

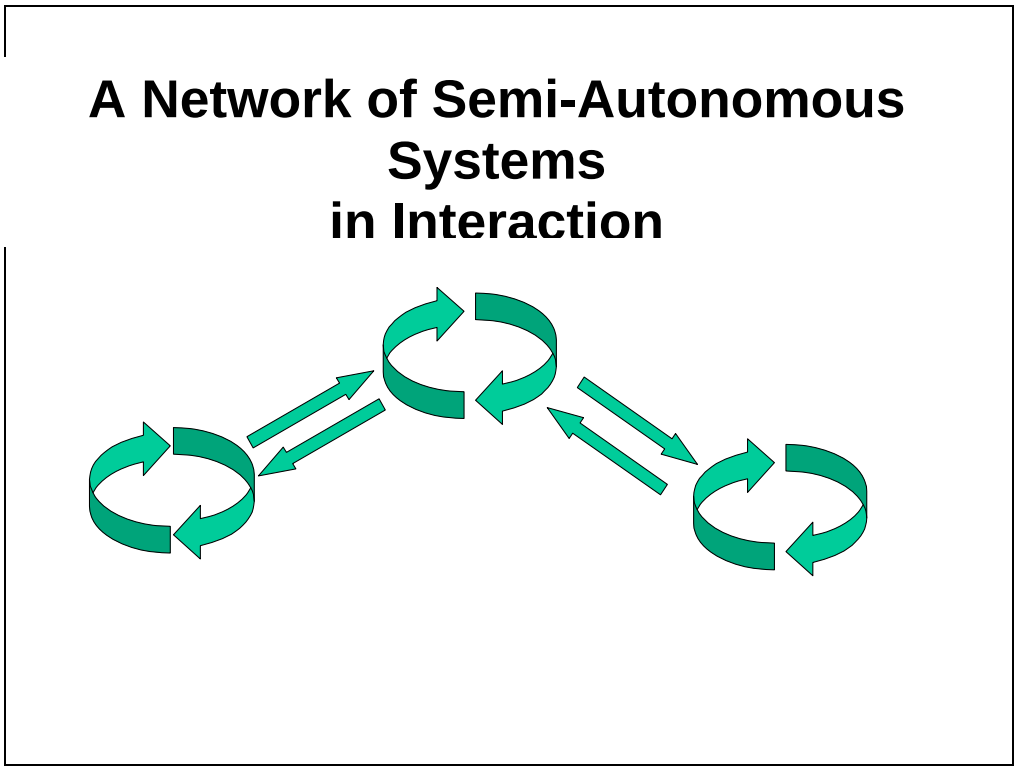
Unilateral logic and systemic logic are illustrated in the next design. Unilateral logic is like a single pathway from A to B. Systems logic starts out with a complex terrain, simplified by the regions A, B, C and D. Notice the richness of the interactions! A single pathway of A to B is a gross simplification and, thus, a misleading distortion. The illustration in the design shows that among the four regions (and the brain has many more than four sub-regions), we have six bi-directional arrows that create 12 interactions. If we take this unit or system as a whole, any state moment of four interacting regions is being caused by 12 interactions plus 1 (the "whole" as a causal unit) = 13 causalities. If we want to keep all this in the mind at one moment, we could say it is mind-boggling. So the schematic systems design helps keep the complexity in place.



One moment, please, the situation is not so simple! A brain region is not only a system in interaction with outside systems. The brain region has an inner dynamic of self-perpetuation. Brain regions are both interactive and self-reinforcing. For this reason we call brain regions and neuronal circuits "semi-autonomous systems in interaction."



Let's look at the complexity that this double action – within and with the outside – can create for any group of systems. We will reduce our figure to three brain regions with only two interactions, for the sake of simplicity.



We have 7 causalities. Three are internal; four are interactive (counting the arrows).

These simplified systems designs help us overcome the mind's tendency to search for single causality when we are looking at complex mind-body phenomena. It will help us better understand the psychology of the Impasse during the stream of consciousness. It also averts us to the epistemological dangers when schools of psychology declare, "We have found the truth!" and brandish their single-causality theories as proofs of their superiority. Rational versus emotive theories of brain function can overemphasize one region against another. In the long run, cortical and subcortical regions are in continuous interplay. "Depth psychology," at various times in its history, has declared different "basic causes," from "periods of fixation" to the Oedipal trauma, to pre-natal traumas, to the vision of the primal scene. The systems map shows that the brain has multiple causality at different levels, and this initiates our sense of adventure! This is to explore the complex territory, like going from island to island in an archipelago of a thousand islands.

Developing the Concept of "Internalization"

Do "Inner Structures" Experienced during Relationships Carry Over into Solitude?

We are now in a position to understand how prolonged solitude can deflate and collapse *the bubble of normality*. The dynamics of systems theory show that the spirals of normal experience between two people can create the sense, "I'm intact, I feel together," even when the person is later alone. In contrast, a disequilibrium resulting from insufficient relationships and excessive solitude, past or present, sets us up for the inner collapse and feeling of desperation that comes from the grip of the Impasse. The inner spirals that feel solid when we are "connected," become weak and insubstantial, and we lose our grounding. Thus the design showed the arrows of impoverishment.

Let's examine more closely the two states of consciousness: rich vs. poor. The rich state occurs with satisfactory interpersonal dynamics. On the other hand, the poor state occurs when we are alone and losing force of "inner structure," as we enter into internal dimensions, often trying to face memories of hurt from the past or fears for the future. In the rich interpersonal state, we are "connected" – the baby with the mother, the patient with the psychotherapist – and we are having rich experiences of contact and self exploration. The brain is being nourished, and the neuronal-chemical circuits are activated to create good feelings, reasonable perceptions, and active capacities for adaptation. The more "intense and profound" the therapeutic experience, the more sturdy and resistant the spirals of activation. We can call these activated circuits that can be somewhat maintained in our solitude as "internal structures."

But what happens when these "internal structures" do not sufficiently carry over during the stream of consciousness in solitude? What seemed solid and sturdy, our sense of equilibrium, can then collapse, when we return to our inner world. It may feel like a bubble that deflates or pops when our inner life (whose components and dimensions are like "inner currents,") brings us up against an impasse of doubts, uncertainties, hurts and fears, and we feel we are "up against the wall." There is a visceral feeling, it could be like a punch in the stomach or of collapsing in the desert; this has been hiding behind the curtains and suddenly springs up when we are face to face with our selves, alone…

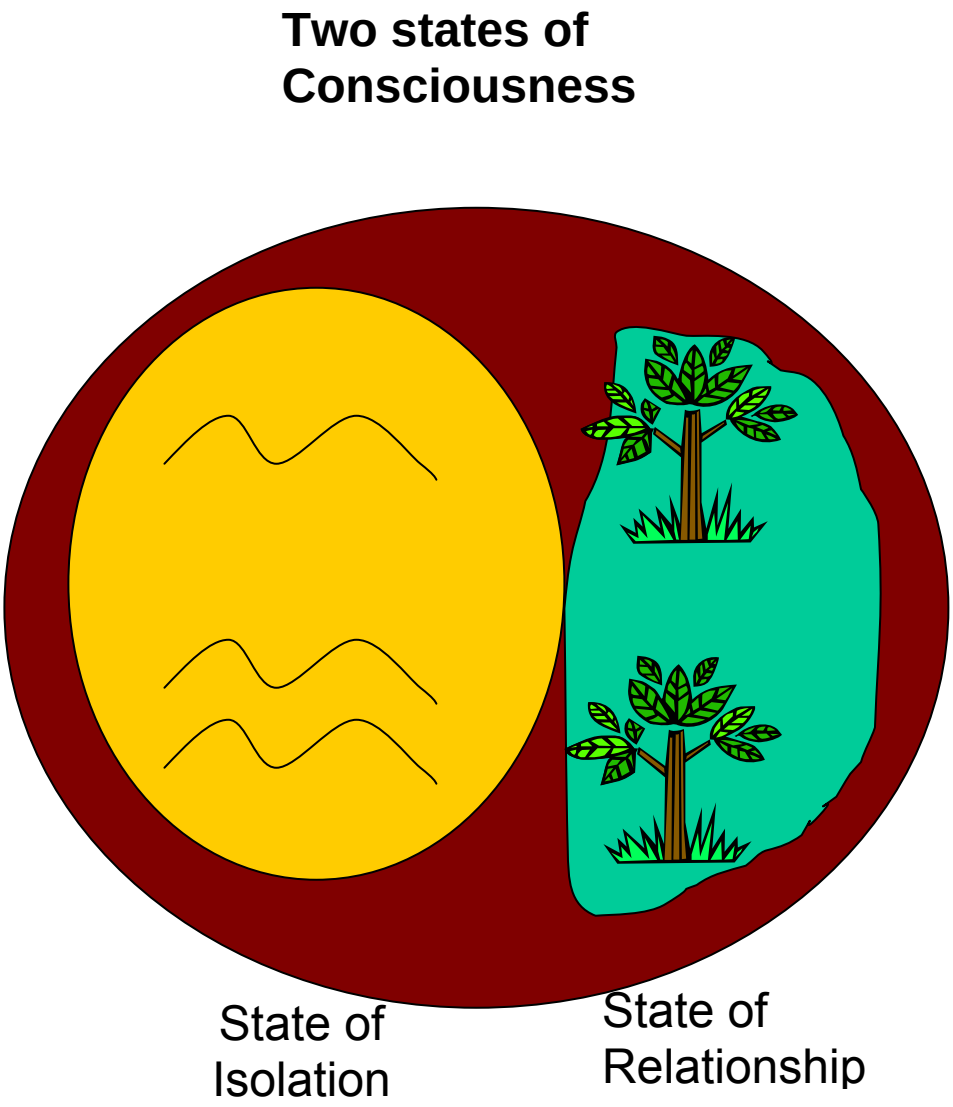
The Inner Terrain: A Growing Forest or an Enlarging Desert?

Melanie Klein offered the concept of "internalization" forty years after Freud opened the door to the unconscious. (Klein, 1952) A simple way to think of this fundamental process: "What happens when the other's presence repeats itself in solitude?" Because this is a mixed cortical-subcortical process, certain aspects are conscious – "I felt good speaking with her" – while other aspects are totally unconscious, but influence our mood – "Something feels perking in me," or "I feel I can get my scene together," or "Now I feel calm." What might occur between mother and child? The mother has just paid a brief visit in the night. After she leaves, the child moves his hands and legs, looks at the moving lights of a car on the ceiling, and laughs. And in the same way we can feel replenished and "okay inside" when we have had an experience of deep exploration, helped by our psychotherapist. If the contact was fruitful, this presupposes that there was "attunement" during the self-other interaction. (See Chapter VI and VII in Stern, The Interpersonal World of the Infant, 1985.)

Now let's look at the other side of the coin. We find ourselves alone and flooded by some painful memories: a hurt, a loss, a defeat, a disappointment. With the therapist or helpful listener present, we could elaborate it, get it off the chest, discharge the tensions and reach some kind of conclusion or "completion," at least for the moment. "Oh, well, I understand, and I see how to approach it the next time." But alone, the impoverished circuits rarely carry on the dialogue with the helpful listener in an autonomous way and with full elaboration of sequences, at least, not after a few minutes.

Losing the thought-emotion pathways experienced momentarily with the helpful listener (the Dyad), the brain circuits turn in on themselves, becoming emptied of their original richness and focusing obsessively on one or two elements (the monad). The repeated phrases of self-negation burrow more deeply into the terrain of our Self structure, and the hole is deepened. The dimensions of the problem, with no specific itinerary for evolution, expand and generalize, and the mind becomes a mined field with holes in the ground, reminding us of battlefields after a war. Sooner or later the circuits die out, the land loses its vegetation, and the terrain of the inner Self looks like a desert.

Let's imagine that we have a camera in outer space looking at our inner world. Two continents will be seen, varying in size and quality from person to person, and also changing their form and extensiveness during a single person's evolution. The camera shows one continent with forests and rich foliage, the other terrain reduced to a desert. These two continents represent two states of consciousness, either of which can dominate our mental focus when we are alone: the state of empathic dyadic consciousness or the state of prolonged isolation.

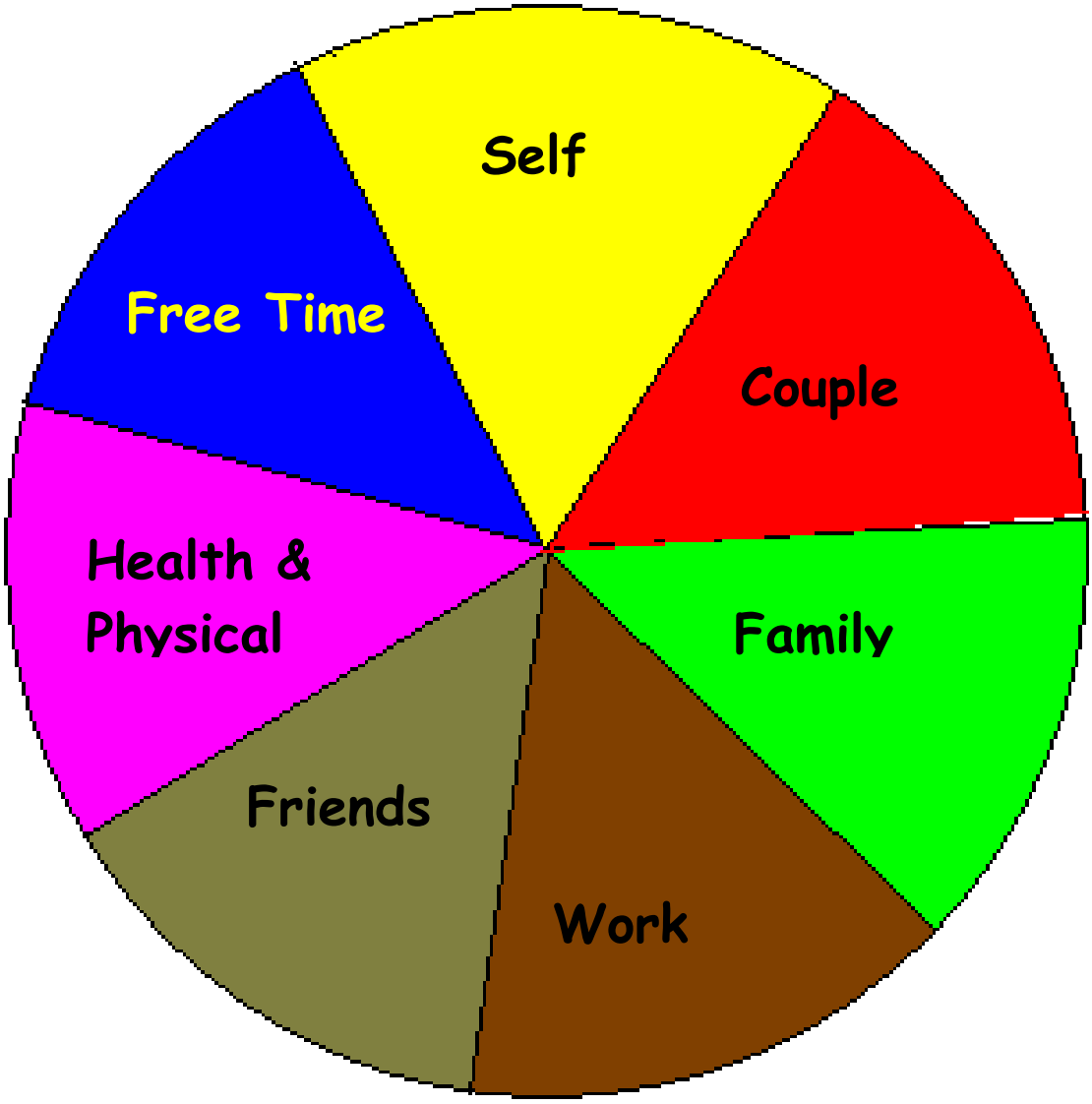


Each continent grows larger or smaller over time, depending upon the quality of the self-other relationships. Is there attunement or misattunement? Connectedness or alienation? Engagement or indifference? Intensity and interest or blandness and boredom? The waves from the dyadic consciousness, influenced by these qualities of the self-other experience, then flow over into our aloneness.

And what to do alone? "Cultivate your garden," comes the counsel of Voltaire. But alone, our intentions will often be over-ruled by deeper forces. Whether our tendency is to have a stream of consciousness that truly "cultivates our garden" and offers us rich harvests, or else experience our inner life like a dried out riverbed that is leading to desertification, depends upon these subcortical forces that rise up automatically. In conclusion, if we can at least understand the brutal fact that there are automatic unconscious subcortical impulses which become unleashed when we are alone, and more so when we are alone for a long period of time, we can better understand the helplessness of our minds when we are submerged and blocked by Impasses.

A Systems Map: "The Dimensions of Life"

We'll now return to our potential richness. There are many issues of our life that are important for us, that are ongoing, dynamically developing or blocked and stagnant, and that periodically require our attention. To summarize these countless issues, the following design, "The Dimensions of Life," attempts to picture the areas that are essential.



Looking at this diagram, we can better understand what areas are going well and which dimensions are creating problems. But it reveals another truth. When one problem is taking up our entire inner world of attention, other dimensions are not being considered. Let us imagine that we have just experienced an extremely unhappy event – a disappointment in an important relationship, a failure, a threat, a loss that happened suddenly and was not expected – and we find that this event continues to circle in the mind. If we talk about this to an untrained listener, we might find ourselves hurt and imprisoned by the comment, "You're exaggerating," said for our benefit, presumably, and therefore said with good intentions, but nevertheless stifling the inner feeling.

The impasse repeats itself because it has not been elaborated and organically transformed by means of sharing with a helper who offers deep listening. A verbal recounting from the head is insufficient. The words must embody the deeper (subcortical) feelings that are spiraling inside like an unharnessed wild stallion.

But until such a fortuitous sharing and "working it out," we are entrapped by the impasse of negative repetitions. If we look again at the diagram of "The Dimensions of Life," we can see that we are being obsessed by one particular dimension. It may last for days, months, years. The mind-body dynamic is following "the Law of Oxygen." What does that mean? It means that when oxygen is missing and we feel suffocated, we can think of nothing else! In the same way, when we have one unresolved dimension, all other life regions fade away, are taken for granted, elicit no energy, give no special satisfaction, and remain neglected by a stream of consciousness that is absorbed by its Impasse.

Many Impasses are Possible.

We can be impressed by the stupendous number of situations and problems that enter the human mind. But for each person who suffers, that particular dimension of difficulty becomes an entire world. The inner subcortical push takes up the entire cortical terrain of consciousness. One person suffers from a lack of personal esteem, another has distrust of everybody

else, another feels constantly anxious when with others, another has a constant feeling of guilt, another suffers from moments of panic and worries that any moment it can come on again, another has psychosomatic pains or asthma, another just has no desire and feels depressed. Let's go on with the panorama: A woman thinks, "If I don't have a man in my life, I'm not like the others. How can I have satisfaction if I can't share it?" A person who grew up in an *orphanage*, "I'm not normal. Everybody else has parents. I'll never be a normal person." Someone has been in *prison*. "What a disaster. What misery. And anybody who looks at me can just see that I've been in prison. What a humiliation!" *Homosexuality*, an abnormality in the body, even if unseen by others, *sexual abuse* during infancy, coming from parents who were poor or from *an "inferior" social class* and, in some cases, a person lacking a certain level of instruction and diploma. I remember a young woman who was oppressed by the following memory: "My father was a drunkard, an alcoholic, and he fell on the sidewalk in front of the house. My mother told me to go out and clean up the vomit." Shame, fear, bitterness, suppressed anger, the baggage that we can each carry around within us when we are submerged by the Impasse that blocks the flow of consciousness.

A Brain Map for the Impasse

A Brain Map to Help Understand the Variety of Impasses that Make People Suffer

Seeing this enormous variety of potential impasses, we may rightly ask ourselves, "How is it that people can suffer from such different problems?" while in each case the suffering is intense, total, tenacious and unrelenting. We gave an image previously of states of consciousness like different "islands" inside the mind, and going through our mind is like a trip through an archipelago. In fact, in different periods, a different island of suffering might appear. Nevertheless, each person probably has a limited number of such islands of vulnerability, and becomes surprised that others find no difficulty with one's type of problem, but can be vulnerable, instead, to other types of disappointments and fears.

To explain this variety and, at the same time, give some order to the complexity and variation of inner Impasses, we will return to our basic point: Each experience in the stream of consciousness is a cortical phenomenon floating at the surface of currents whose source is the subcortical unconscious.

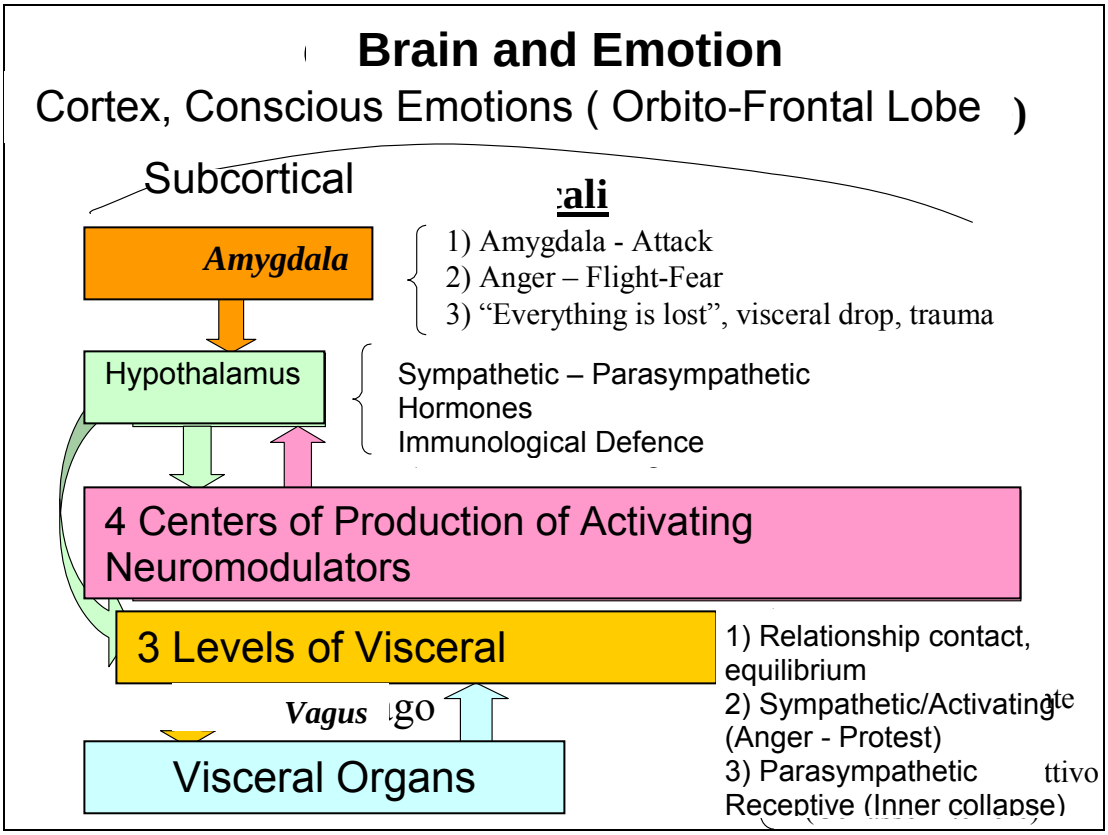
Here are some examples:

Cortical Experience of the Impasse	*Subcortical Circuits*
"I don't know… I'm always anxious that something can happen."	Fear
"If somebody offends me, I go out of my head!"	Anger
"They disappointed me. It was a betrayal! I can't trust anybody again."	Rupture of the Self-Other Relationship
"I can't do anything. I'm blocked, a piece of cement…"	Inhibition of Action
"There's nothing I want… Nothing matters… Empty."	Energy exhausted

These are merely simplified examples. They are meant to show that the nucleus of an impasse is a force that is regulated in the bottom part of the brain, the subcortical regions, and that passes upward to create dysregulation and incompleteness in the upper cortex. From the subcortical unconscious to the cortical consciousness!

While a psychiatric diagnosis will speak of "pathology," we use a more neutral term, "dysregulation." The advantage of "dysregulation" is that it presupposes that all of the forces in play are positive potentials. The only problem is that certain forces are excessively present, such as the amygdala-based emotion, while other forces are insufficiently present, such as the basal ganglia system for directing effective actions.

The next design gives a "map" of the subcortical systems that are producing the impulses that come to surface in the cortex. (This map will be modified in the coming years as research regarding states of consciousness and brain mechanisms continues to advance.) It is useful to keep in mind that no single area has total responsibility for a function. A function, such as an emotion, has many brain areas contributing to its ongoing process. The map just helps us pinpoint central functions and central areas.



Amygdala Attack – Anger, Flight-Fear, "Everything is lost," visceral drop, trauma

Each of the above subcortical areas can contribute to the experience of an impasse. That means that each subcortical area impacts on specific psychological functions, whether acting separately or with other regions. We will present a Table to show these connections among specific Impasses and their subcortical components.

Table: Typical Impasses in the Stream of Consciousness and Subcortical Regions that Create Them

Impasse	Function of the Brain Area	Subcortical Area
Anger	Emotion / Sympathetic	Amygdala and Hypothalamus
Fear	Emotion / Parasympathetic	Amygdala and Hypothalamus
Rupture of a Basic Relationship	Self-Other	Cingular Gyrus and Hippocampus
Inhibition of Action, Paralysis	Action	Basal Ganglia
Energia Used Up	General Brain Activation	Subcortical Areas in Pons (Tegmentum, Locus Coeruleus, etc.)

Our model of the connection between the experience of the impasse and its neurophysiological roots becomes clearer now. Each element of the experienced impasse, coming from the brain's cortical dynamics, and visible to us through introspection, finds its roots in specific regions of the brain's subcortex, and this is invisible, even to ourselves. To understand a particular impasse from a researcher's point of view means to understand the particular cortical – subcortical connections that drive the experience forward like a relentless train.

For the Future.

The reader familiar with recent research regarding brain neurophysiology can already see limitations of the above model. It is too simple. Several regions must be linked and activated together in creating the full blown experience. For example, the Table suggests that amygdala-based rage reactions must be connected to hypothalamus-based sympathetic processes, when the emotion is intense anger. On the other hand, the emotion of fear must involve both the amygdala and the hypothalamus-based parasympathetic processes. (The hypothalamus is the "hub" of sympathetic-parasympathetic alternation. (Gellhorn, 1972) But this is still too limited. We can now add the research contributions of Steven Porges, namely that the "visceral drop" in intense fear, loss and or disappointment, has been shown to be regulated by the dorsal-vagal visceral nuclei. (Porges, 2003)

Other research currents must be added to enlarge the mind-brain model. Gerard Edelman's hypothesis of the "dynamic core" concept adds other neural routes for the study of consciousness. (Edelman, 1989) The "dynamic core" involves the interplay between the thalamus and the cortex; the thalamus changes its attention regulation of the cortex according to whether the major input for the thalamus, at any one moment, comes from the action-oriented basal ganglia or from the emotional-oriented amygdala. This just means that as research regarding brain mechanisms and human experience advances, new doors of understanding will be opened.

Summary.

The theme is to study the dynamics of the impasse that blocks the stream of conscious. This impasse is tenacious, unrelenting and expansive, taking up the whole attentional focus of the mind when the person is alone. It cannot be easily shaken off, and the person wishing to merely "change direction of thoughts" is surprised and disappointed that his conscious efforts are to little avail.

The power of this force is the subcortical unconscious. Various areas of the subcortex contribute to the final picture of the impasse, whether it comes from a situation of loss, disappointment, betrayal, rage, fear, distrust, or loss of vitality.

The work of Tronick, Stern and Downing has brought to light how the dyadic relationship -- mother and child, or therapist and patient – can create an "introjection" of the other which lasts into periods of solitude. This dyadic relationship helps develop capacities and their corresponding cortical-subcortical brain circuits during high stimulation moments that spill over into the reduced stimulation circumstances of solitude. Thus, sufficiently developed dyadic relationships are our main protection against the suffering and unhappiness that result from the continuous impasse. In contrast, an insufficiency of positive dyadic relationships, whether present or past, can create the conditions in which the unhappy person keeps falling into the same hold of inner misery, and cannot find a way out by himself.

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Biography

Dr**.** Jerome Liss, medical psychiatrist, lives and works in Rome. He has studied medicine at the Albert Einstein College of Medicine in New York and psychiatry at Harvard University in Boston. Dr. Liss is also a consultant for the World Food Program, United Nations. He collaborated with Prof. Henri Laborit in the study of the neurophysiology of emotions. Dr. Liss is founder and director ot the Italian School of Biosystemic Therapy. He is author of various books including "Comunicazione ecologica" (ed. Meridiana), "Apprendimento attivo" (ed. Armando) and "Deep Listening" (Ed. Meridiana). He can be reached by Email: j.liss@fastwebnet.it.

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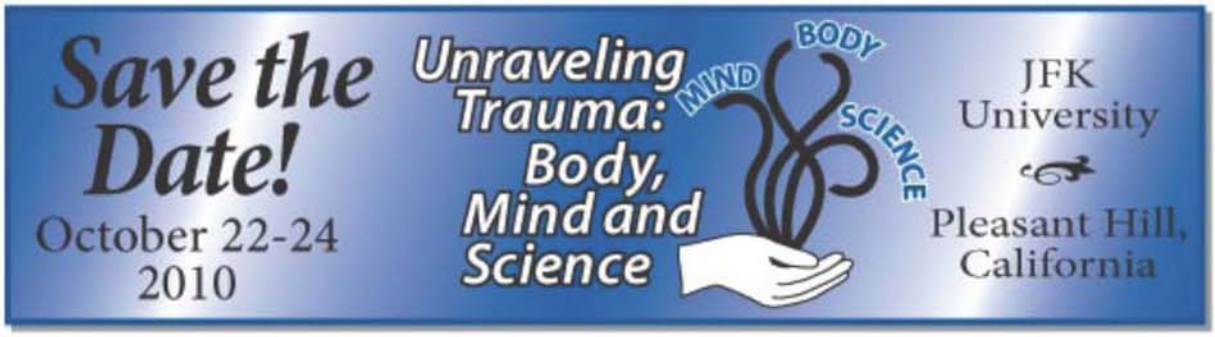

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