Bridging the Split: Integrating Psychodynamic and Body-Centered Therapies

Claire Haiman, PsyD

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Abstract

An exploratory study examining the ways in which psychotherapists trained in psychodynamic and body-centered therapies integrate, or choose not to integrate, the two theoretical traditions in their clinical work. Eleven dually trained clinicians were interviewed, all of whom integrated their work to some degree. The majority made use of assimilative integration, incorporating body-centered techniques into a psychodynamic framework. Differences and similarities are discussed with regard to transference/countertransference, conceptualization of patient experience, technical interventions, and psychoeducation of patients regarding integrated work. Concerns about touch are also briefed addressed.

Keywords: psychotherapy integration, psychodynamic psychotherapy, body-centered therapy

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Psychodynamic and body-centered therapies have historically stood apart from each other with the former traditionally privileging words and "insight" and the latter, sensation and experience (Caldwell, 1997; Pruzinsky, 1990; Smith, 1985). Once relegated to the margins, body-centered therapies are now increasingly popular (Shannon, 2002), and are supported by a growing body of neurological and biological research (particularly in the area of trauma), that demonstrates what body-centered therapy has long asserted: that the body, and bodily experience, are central to healing (Ford, 2002; Porges, 2011; Schore, 1994; Schore, 2003; Siegel, 2001; Siegel & Solomon, 2003; van der Kolk, 1996; van der Kolk 2002). Contemporary psychoanalysis makes central the patient's experientially felt sense of self (Shane, Shane & Gales, 2000), but still favors verbal expression and views bodily expressions as "acting out" associated with "borderline" and "primitive" states (Miller, 2000). Accordingly, clinicians who pursue training in both psychodynamic and body-centered therapy often find themselves with two practices, unable to straddle this professional and cultural divide (Greene, 2001; Hadar, 2001; Miller, 2000; Ogden, 1997; Ross, 2000). How do therapists trained in both models reconcile them? This article will explore how dually trained clinicians integrate or decide not to integrate their work.

Methodology

Procedures

The author developed and administered a structured interview to participants using the grounded theory approach, in which the author's assessments and impressions are an intrinsic part of the data (McCracken, 1998; Pidgeon & Henwood, 1997). Interviews were recorded

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and transcribed. Individual interviews were then compared with one another and considered against relevant literature in the field to identify common themes, in the method described by Strauss and Corbin (1990).

Participants

The participants were eleven clinicians in the New York City area who had been trained in both psychodynamic and body-centered therapies. All had received MSW or PhD degrees from psychodynamically oriented programs. Four had also obtained psychoanalytic training. Body-centered training included Bioenergetics, Core Energetics, Craniosacral Therapy, EMDR, the Hakomi Method, Pesso Boyden System Psychomotor Therapy, Rubenfeld Synergy Method, Sensorimotor Psychotherapy, and Somatic Experiencing.

Results

Critiques of Psychodynamic and Body-Centered Therapies

Nine of the eleven respondents had begun their training and practice in psychodynamic psychotherapy (PDP) and came to find it overly intellectualized and (at worst) withholding, hierarchical, and ineffective or (at best) effective but slow and inefficient at reaching psychological depth in particular preverbal places that are difficult to reach in talk therapy. Most experienced this lesser efficacy and efficiency in their own personal therapies as well as in their respective clinical practices. Further they had an intuitive sense of needing and wanting to go deeper and that the body was essential to that goal.

Two participants began with training in BCT and found it technically effective but without sufficient theoretical underpinning. They reported feeling confused and adrift when something came up in session that didn't match the technical guidelines of the BCT model. In the words of one participant, "A lot of [therapists] are guided by good intuition but need more of a compass so they don't do work with patients who are too fragile or fail to recognize the splits or personality disorders." This corroborated some of the experiences participants had as BCT patients where they got into very deep places but the therapist was not able to process or contain the experience. The participants in the study often spoke of PDP as providing the theoretical compass they needed to recognize and negotiate complicated self-states, personality disorders and the like.

Integrating Psychodynamic and Body-Centered Therapies

After receiving training in both PDP and BCT, participants combined these modalities in different ways in their respective practices. Three distinct groups emerged: those who had essentially converted from PDP to BCT, those who synthesized them, and those who maintained two separate practices—one BCT and one PDP.

Three participants fell into the first category, that of those who had rejected PDP in favor of an entirely BCT practice. These clinicians de-emphasized the importance of transference by pointing out its ubiquity as "an ever-present phenomenon" in everyday life. Furthermore, according to these "converts", the skills provided by BCT obviated the need to develop the relationship as a central vehicle of healing. Instead, they understood those patient responses that are interpreted as transference in psychodynamic work as direct communications to the therapist about what the patient needed. These clinicians described their reactions to the patient as "hunches" or "intuition," rather than as "countertransference". They did not report experiencing somatic countertransference.

Of the eleven participants, there were two who embraced both modalities but kept them separate in practice. Both conceptualized their work as psychodynamic and subscribed to traditional notions of transference and countertransference. They understood touch as destabilizing to the therapist-patient relationship. One of these two clinicians, however, spoke of her intention to move toward a more integrative practice with new referrals. She envisioned this change as allowing for a treatment where she could shift between a PDP session "where we sit and talk", a craniosacral session on the table, and a session where "we'd talk and process what came up" in the prior craniosacral session—all with same patient. This clinician also anticipated that she would refrain from going into transference "as deeply". Instead she imagined adhering to the "verbal skills" of craniosacral work which was "much more about 'There's a big wave of rage coming up through the right arm' and you name it and hold a space for it and help it clear and you're not like, 'What does this remind you of?'"

Six of the participants attempted to integrate both methods in their clinical work. Five used "assimilative integration" (Messer, 1992; Wachtel, 1991) where the techniques of one model are imported into another home-base model and translated using the latter's theoretical framework. In this instance clinicians incorporated BCT techniques into the theoretical framework of PDP and applied PDP concepts to bodily experience. For example, one clinician conceptualized

> looking at the dialogues with different parts of your body by thinking of them as self-objects.... People will have notions or feelings about their bodies or parts of their bodies that really reflect how they were nurtured or cared for, how they formed their ego structure. Freud talks about that, that the first ego is a body ego. It's the beginning of the way we understand ourselves. It's all linked...It's just that you use the body to begin to express and articulate some of the those internalized self images...[My work is] on a continuum [with psychoanalytic work.]...I do believe that this is a sort of holding environment, like Winnicott's idea, that this is literally holding, this is another step along that line.

Participants interested in synthesizing tended to work with transference and countertransference in "exactly the same way as in psychodynamic work. You talk about it...'What does it feel like when I touch you here?' or 'How do you feel about me?'" They also reported that transference was intensified in BCT, which they attributed to therapist-patient touch. These clinicians made use of somatic countertransference, listening for and interpreting their own bodily reactions as relevant to the clinical encounter. For example, one clinician reported an instance during which

> My stomach is in knots. I'm noticing that I'm not breathing. To me that could be a countertransference reaction. I ask myself, "Why is this person making me afraid? What am I tense about?" When I'm really tuned in with someone...I would say, "My right shoulder hurts. Is there something going on with your right shoulder?"

One of the six participants interested in synthesizing used affect regulation as her home-base model and assimilated PDP and BCT techniques and theories. Whether she was considering attachment or body posture, she was conceptualizing patient experience in terms of nervous system arousal and affect regulation. In her words, "both [psychodynamic therapy and Somatic Experiencing] are about tolerating and expanding affect." Whereas other clinicians tended to cite Winnicott in describing their theoretical stance, this participant mentioned Allan Schore and Dan Siegel. She described working with a patient who was very "panicky".

> A lot of the work was around trying to bring the arousal down, some through eye contact, using the attachment relationship—that was the psychodynamic piece—but some of it was, "Try to relax, feel your body, what comes up in your body." In my mind what I was saying to myself was, "She needs to bring her arousal down." What I still believe is that I, as the

> attachment figure, was the person who was going to help her regulate and then she'd see me in that way. I'd use a lot of eye contact, which is very psychodynamic in a way because you're saying it really is the relationship and the contact [that's healing], but then it's very physical—it's a somatic intervention.

This eye contact differed from that of traditional PDP in that the patient was instructed to "keep looking at me", rather than letting the patient's gaze wander while the therapist's gaze remained steady. This clinician reflected that this shift was

> the biggest development for me. Other than learning somatic techniques, the idea that I can be directive without it being intrusive...People left to their own devices will go back to their old defenses. Unless they're held in a certain place, they will go back to their old patterns. That's true with psychodynamic work too. Information about the brain has been really helpful with that and I think bodywork has a lot to offer there. I think it's really important to hold people in a space.

Commonalities Among All Participants

Regardless of whether they integrated their work or not, all participants agreed on the centrality of trauma in the development of psychopathology. They conceptualized their work as facilitating the patient's "natural healing process" and emphasized the importance of in vivo experience over insight. As one participant put it, "Insight follows healing," not the other way around. Along these lines, gratification was seen as essential to the work, rather than a possible impediment to it. One clinician summed up the view common among participants that "if [patients] were totally unsupported in childhood, they need to know what it feel like to be supported. Then life shifts. They need to know what safety would have felt like."

Even if participants did not integrate explicit techniques from BCT, all reported observing the body with a keener eye. For example, one clinician who attempted to synthesize her work said that even in "straight talk therapy", she will:

> just keep watching their body, their breathing. Instead of just talking about stuff, I'll bring it into the here and now with the body. "I notice your arms are covering your abdomen there. Can you check in with that? What does that position feel like?" Or they'll furrow their brow and I'll say, "Do that a little more. Really furrow that brow. What does that feel like?"

Participants saw interventions like this as deepening emotional experience or prompting a curiosity about why feelings are inaccessible. In the words of another clinician, if "someone's not saying much, but his or her body is crumpled up, that's what's happening, that's where the truth is at the moment. You can give them a way into themselves by looking at the body."

Several clinicians reported that adjusting their physical stance, without indicating anything to the patients, as a powerful intervention in itself. For example, one clinician (who maintained two separate practices) adopted the same physical posture in both PDP and craniosacral sessions:

> I really ground in my midline and hold as wide a perceptual field as I can so [I'm] in a much more receptive space. Especially in an analytic session where things are getting tight and disorganized I'll start going midline to midline and it's amazing how it organizes the field. Mostly I don't say anything to the patient but I'm just shifting the resonance in the room.

Another clinician who also sought to synthesize these two modalities reported about a patient who "would probably be considered alexythymic and is really very out of touch with what he's feeling and thinks a lot". She had suggested using BCT but he rejected it, saying "Every time you ask me about what I feel in my body, it's really annoying to me, I don't feel anything. I want you to stop asking me." Even though she stopped explicit focus on his body, she

> was very careful to use all his nonverbal cues—I'd mimic his body gestures or I'd attune my tone of voice to his so I became really aware of his body signals and trying to regulate his body. So I felt like I was still doing somatic work even though he was so insistent that he didn't want it.

Synthesizing Techniques: Containing vs. Activating

In addition to emphasizing bodily focus and awareness, participants who actively integrated PDP with BCT identified two central BCT technical intentions: containing intense experience and evoking intense experience. Containing techniques (also referred to as "cooling") included relaxation techniques such as deep breathing, "grounding" techniques such as feeling the weight of the body in the chair, and boundary creation/boundary awareness techniques. One participant described her use of a containing technique with a female patient where

> the anger was bursting out all over the place and getting in the way of her interpersonal relationships, but...she was also sort of afraid of it. I had her move into hitting and then [pause and] hold it and let her sense the aggression in herself and see how her body can hold it and that she has some control over it...[and that] we can work with choosing to express it.

Similarly, when working with someone who "needs structure-building to tell the difference between you and me" another clinician emphasized the importance of being "really concrete". He would put his hand on someone's arm and ask, "Can you hear me talk? Can you feel the ground? Can you feel me touching you?" Most participants, however, eschewed therapist-patient touch, or approached it very cautiously, when the patient's boundaries were diffuse or reality-testing was poor. This did not mean there was no contact. Rather, clinicians might have patients hold themselves, or touch their own skin to become aware of the physical boundary there.

Activating techniques (also referred to as "heating" techniques) are designed to arouse feeling and intensify patient's contact with feeling. One participant of this study described working with issues of "closeness and distance" as an activation technique by

> starting close to them [the clients] and have them tell me where to move and check with them about how the distance feels, what the connection feels like. I'll go further back, then they'll say, "No. I've lost the connection now." I want you to come one step forward. And then another step forward. Then we'll try what it's like to come really close. What does it feel like when the connection is too close? Where do they feel it in their body?

Another clinician described "the hand on the back experiment" as an example of an activating technique:

> I say, "Be in touch with your spine. Become aware of it. Is there any place where I could put my hand on your spine that would feel OK?" It's a mindful experiment. This woman wasn't sure. "I'll put it in the middle to start with and then we'll move it around." I saw her flinch as I moved toward her back. I called her attention to it. "I'm starting to get memories now of being hit in the back", she said.

Although all clinicians who tried to synthesize these modalities agreed that containing/cooling and activating/heating were essential and basic techniques of their practice, most noted that a technique could be experienced as either heating or cooling depending on context. For example, one clinician described her use of eye contact in working with a patient who was "hyper-aroused, panicky, with a preoccupied attachment style." For the first few months of treatment the focus was around establishing a secure attachment.

> We spent a lot of time in eye contact. "What comes up for you as you're looking at me?" She'd say, "This is too much for you. You don't like me anymore." I was able to tell her what I was actually feeling. Fortunately I really liked her a lot. Then [the eye contact] became a resource so when she was uncomfortable she would look at me and it felt like the practicing phase where she'd look back to me and make sure everything was alright [as she explored more activating issues].

Here, eye contact shifted from being an activating to a containing technique through the development of the therapist-patient bond. Therapist-patient touch was seen as a similarly context-specific intervention. While there was general agreement among participants that touch was "heating", leading to an intensified transference, there were some instances where therapist-patient touch could be experienced as containing or soothing, and others where it was clearly used to evoke powerful feelings.

Who Gets What?: Factors Determining Practice Among Therapists Seeking to Synthesize Their Work

For participants who did blend their work, there were several significant factors that influenced the modality (PDP or BCT) and technique they drew from in the clinical encounter. These factors were: the results of the psychodynamic assessment, existence of a trauma or abuse history, fears of litigation, and patient expectations of treatment.

Psychodynamic assessment. Clinicians often relied on PDP assessment to determine whether to use containing or activating techniques. Containing techniques were deemed most appropriate in working with people in psychotic, borderline, dissociative and oral states (or stages)—in other words, states of hyper-arousal. In the words of one participant,

> I'd be very very careful [working with someone who was psychotic]. I would never try to raise their energy or emotional level. That's what you do with people who aren't experiencing much. I would just work physically with what they are already feeling. They already have contact with depths of feelings they don't know what to do with. I'm just helping them do something with those feelings rather than get them more amped up.

Participants reported that activating techniques were well suited to overly bounded individuals, those organized at the neurotic level and those tending to be disconnected from emotions. This state was described as one of "hypo-arousal" by one clinician, and "being in the anal stage", by another. Clinicians cited success using activating techniques with people who were alexythymic, obsessive, schizoid, or had Aspergers.

One participant who synthesized her work addressed a tricky paradox: sometimes a patients can come across as intellectualized and cut off (i.e., in need of an activating technique) when actually they are so over-aroused that they are in a freeze response, and thus in need of containment to access some of the activation. This clinician described her work with a patient who "would be considered avoidant…over-regulating, hypo-aroused, talking in a cut-off intellectual way". Starting with relaxation and deep breathing, this therapist had the patient focus on internal sensation, prompting with cues like "as you talk, is it possible to put your mind's eye on your body?" After establishing this baseline, the clinician was able to use more activating techniques.

As mentioned previously, participants relied heavily on their countertransference (including somatic countertransference) in choosing their interventions. As one participant reported, "I'm checking, 'Am I pulling away or am I having to exert a lot of effort not to get pulled into a pattern in their body?'"

Trauma/Abuse history. In working with people who had unresolved trauma from prior abuse, clinicians made use of a variety of containing techniques to address boundary ruptures and ambivalent feelings about touch and intimacy. For example, one clinician who "converted" to BCT reported working in a group Psychomotor structure with a patient who was revisiting previous abuse:

> You see the rage on [the patient's] face and hurt, but their legs are opening and they're leaning toward [the abusing father]…That has to be stopped. So I tell them what just happened so the pilot [a witness figure in Psychomotor] can see it and they can work with it. A "limit figure" is then enlisted to contain the patient's desire to reenact the abuse, by holding their legs together. [The patient] can try very very hard to open. You need someone very strong to hold their legs together, and at the same time, benign: accepting the energy. "It's ok to have all that energy. I won't let you open for abuse." It helps it get rechanneled so it's okay to open up for an appropriate partner. It's a limit on opening in the face of abuse.

These clinicians tended to have multiple and seemingly contradictory views about how to use touch in integrated body-centered work with survivors of sexual abuse. All but one participant felt that survivors experienced touch as threatening and dangerous. However, they tended to feel that touch was necessary for complete resolution of the trauma. All participants spoke of the need to move slowly and with the patient's explicit permission and guidance when using therapist-patient touch. One clinician captured the sentiment common to all participants that, when it comes to touch, patients "call the shots...they are in control. That's a ground rule." To this end, one participant described working with a woman who'd been sexually abused as a child. Some of the treatment was

> working with her in exercises that involve pelvic movement. This is not particularly with touch. The patient can do this herself, and then I'd be next to her. At some point she'd say, "Ok. I want you to put your hand here [on her stomach]. And I want you to take it away." She had control over it. There would be touch that could be safe or ok that she had control over.

Fear of litigation. Most participants reported that they modified their work with regard to touch because of fears of litigation. One clinician routinely referred patients to a group where touch happened with other members within the Psychomotor Structure. Others figured out ways patients could approximate the experience of being touched (e.g., wrapping themselves tightly in a blanket to provide containment) when it was not appropriate for the therapist to touch them. Some obtained explicit informed consent that the work would include touch, in an effort to head off any future problems that might arise, but most reported "being very lax about that sort of thing." All relied on their ability to accurately read patients, emphasizing the importance of countertransference, in deciding who to touch and how they would touch.

Patient expectation. Some patients arrived at treatment specifically seeking PDP, some seeking BCT as an adjunctive therapy or for the treatment of a specific trauma, and a significant, but ever-growing number (usually veterans of long-term PDP) arrived seeking another approach, one that was more body-focused and experiential. By and large, patients got what they expected. In instances where clinicians felt another modality or a blended approach was more appropriate, they varied in how they went about introducing the concept. One participant who synthesized these modalities reported working with a patient who specifically sought her out for PDP and explicitly stated:

> "I don't want any of this body energy stuff. I'm here because I heard you're a really good therapist. Don't bother me with this other stuff." So I said, "Fine." We started to work and she started to get headaches frequently during her sessions...Finally one day she was getting a headache in the middle of the session so I said, "Look, I can help you with this, but you said clearly at the beginning that you did not want to deal with this. I'm really respecting that but I'm sitting here with a lot of ambivalence because I think this could be helpful." She said she'd think about it. The next time she came back and it happened she said, "OK, try whatever it is"...The headache would develop around things that were coming up that she wouldn't let herself feel. It was really simple. I just put some pressure at the base of her skull. It allowed her to cry and to feel things she needed to feel. We went on in an integrated sort of way.

This same clinician reported working with another patient with a long history of PDP treatment who sought her out for BCT because she "had a lot of difficulty experiencing her feelings." The therapist used some BCT techniques, mostly focused on breathing and bodily awareness,

> and she just sort of spaced out...I think she probably dissociated. It wasn't helpful. What ultimately happened was I stopped trying to do that with her and worked with her psychodynamically. It took two to three years. Her issue was basically interpersonal trust or she needed to really experience me caring about her….Maybe I would try some of the physical work again, now with more trust.

In instances where patients were not aware of the different modalities, there was a coming-out process of sorts in which the clinician disclosed their approach. Two participants (both of whom had converted from a PDP to a BCT practice) addressed the modality issue directly from the outset of treatment, regardless of what therapy the patient was seeking. For example, one clinician after doing a full trauma-sensitive intake, would introduce EMDR saying: "For the past five years I've been using a tool that I find far more effective than just talk therapy." Then she said she would introduce Shapiro and "her story about walking in the park and how bilateral stimulation makes a difference… it's not a magic bullet but it does allow us to go faster."

Another participant took the other extreme and said nothing at all. Instead, this clinician left clues around the office and figured that if people were interested they would inquire. For example, when she was seeing someone referred for PDP, she left her massage table (used in her Rubenfeld Synergy Work) assembled in her office, knowing that she was,

> introducing something. With all of [my patients] I made the decision to keep the table up because I wanted them to know who I am and what I do and also I think with each of them this work could be an adjunct to what I do. So I've kept it up and people have asked me, "So what do you do with the table?" This in-her-head woman came in and said, "What do you do on that table?" So that's the way that we start. They ask me. The one that's been very very sexually abused never asked me about the table…Their curiosity is usually an indication of them edging toward being more interested in it. Other patients might see my Synergy certificate on the wall and they might ask about it.

Most participants, however, provided patients with a gentle introduction to their blended work with more to follow as it emerged in the treatment. In describing her approach, one clinician left it "somewhat vague. I'm very careful when people don't have a background in [BCT] to lay a gentle foundation because I think people can find it a bit odd." At the outset of treatment she would tell patients,

> Sometimes I might ask you what's happening in your body, in other words, what sensations are you feeling in your body, or I'll ask you to associate to sensations you're having in your body in terms of thoughts, images, because I find that it helps move the work along and there are sometimes things you have access to as you focus on your body that you don't necessarily [have] when you're just thinking about what you're feeling.

Another clinician introduced body-centered work by telling patients that the truth is in the body and the body is a repository for unconscious emotion. If you tune into your body, and I help you tune into your body—because it's not like I'm the expert and you're just sitting there—we may learn something about yourself because there's a piece of your being that might not be conscious and your body might have this information.

Conclusion

Of the eleven participants who had sought training in both psychodynamic (PDP) and body-centered therapies (BCT), about half (six participants) actively sought to integrate PDP and BCT in their clinical work. Two clinicians maintained distinct practices—one devoted to PDP and another devoted to BCT—and three clinicians were "converts" who had left PDP behind and practiced BCT exclusively. Regardless of how they conceptualized their stance, all the clinicians in this sample saw trauma as central to psychopathology, and used a treatment approach of identifying unmet needs (particularly the need to be safe) and gratifying them, so as to create a "corrective emotional experience" as first described by Alexander (1961). It would be more accurate, perhaps, to say they were striving for a corrective physiological experience, as these clinicians emphasized the centrality of sensation and bodily experience in pathology and healing. A successful treatment, in essence, allowed patients to process trauma held in the body so they could revert to a physiological baseline that allowed for experiencing a wider range of feelings (both emotions and sensations) without lapsing into states of hypo- or hyper-arousal.

While bodily experience was central to all treatments, specific interventions ranged from the very overt, incorporating therapist-patient touch, to the very covert, in which the therapist simply focused on his/her own bodily state in an effort to change the level of activation in the room. Cooling/containing techniques were deemed most appropriate for hyper-arousal, dissociation, psychosis and the like. Heating/activating techniques were best-suited for hypo-arousal, intellectualization, obsessionality, or compartmentalization. However, all techniques were context-specific so something, like eye-contact, could be activating in one treatment, or even in one phase of treatment, and then containing in another. Method and technique were also guided by patient's expectations so that patients seeking either PDP or BCT more or less received it, though clinicians often introduced their blended approach, either gently and somewhat vaguely at the outset of treatment or more explicitly as it became relevant in the treatment. Of note, several clinicians described a growing number of patients who were veterans from PDP seeking BCT or blended PDP-BCT to facilitate a more experiential process.

Discussion

The critique of psychodynamic theory and practice which emerged among participants seemed, unwittingly, to mirror developments in the field of contemporary psychoanalysis.

These notions—that the patient's experience was real, as was the relationship between therapist and patient, that transference was an explicit communication from the patient to the therapist about what was needed, rather than a veiled communication from the unconscious, and that feeling, rather than insight, was the motor of treatment are in fact the cornerstones of intersubjective psychoanalysis (Aron, 1996; Biurski & Haglund, 2001; Stolorow & Atwood as cited in Biurski & Haglund, 2001). Moving away from the psychodynamic community may have made participants unaware of these advances in the psychoanalytic world. Indeed, clinicians in my sample who were most vehement in their denunciation of psychoanalysis also tended to be most out of touch with these developments. Conversely, the more these clinicians knew about attachment theory and models of autonomic nervous system arousal, the more comfort and ease they had integrating these approaches.

It seems that the integration between psychodynamic and body-centered therapies is perhaps following a pattern similar to the integration that occurred between PDP and behavior therapies. In that instance, an initial antagonism gave way to a movement toward the center from both camps. Psychodynamic work increasingly addressed patients' coping mechanisms and the impact of external experience; behavior therapy increasingly incorporated cognitive models of understanding and intervention (Arkowitz, 1997). Similarly, in this sample we see participants utilizing BCT methods to balance out PDP that felt too intellectualized and making use of PDP theory and methodology to ground BCT work that felt too freeform and unmoored. The integration of psychodynamic and behavior therapies ultimately led to the establishment of formal structures celebrating this blending, such as the Society for the Exploration of Psychotherapy Integration (SEPI) and the Journal for Psychotherapy Integration (Arkowitz, 1997). The creation of the USA Body Psychotherapy Journal in 2002 and the advent of the International Body Psychotherapy Journal now may herald a similar sort of institutionalized dialogue between body and psycho-therapies. Similarly, the Board of the Sensorimotor Psychotherapy Institute includes psychoanalysts Phillip Bromberg, Martha Stark, and Beatrice Beebe, as well as Continuum Movement founder, Emilie Conrad, and the recently deceased founder of the Hakomi Method, Ron Kurtz.

BIOGRAPHY

Claire Haiman, PsyD is a clinical psychologist and Somatic Experiencing Practitioner. She has also completed Kathy Kain's Touch Skills Training for Trauma. Claire is in private practice in New York City.
Email: claire.haiman@gmail.com

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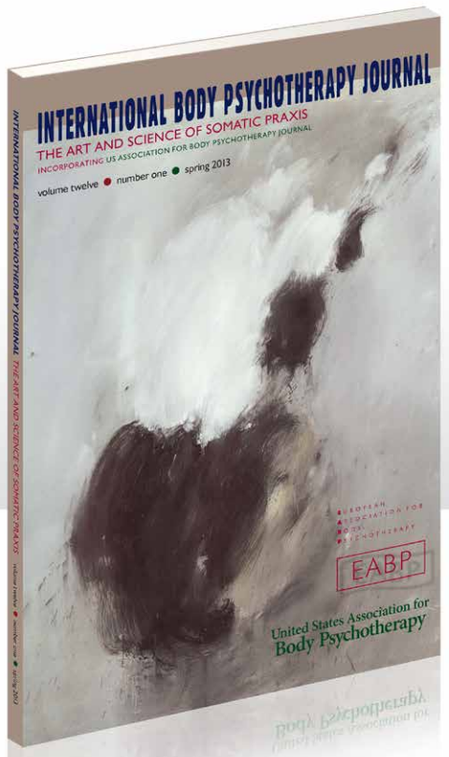

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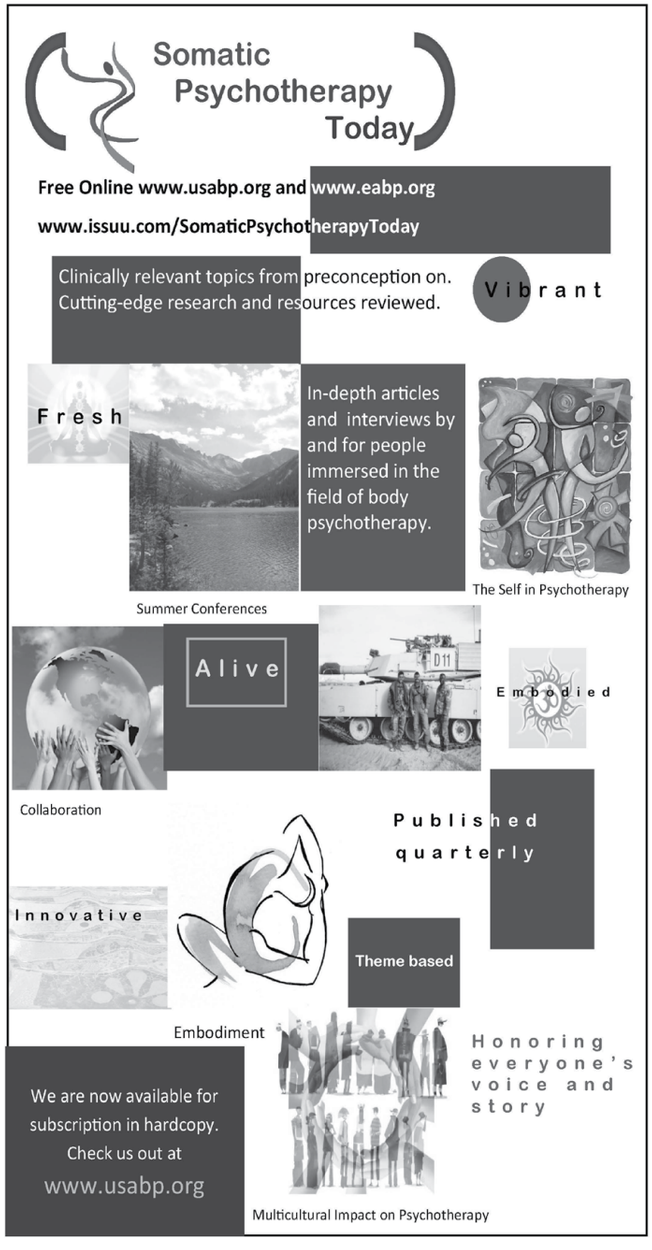

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