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PANTA REI
The image on the cover is an oil painting by Eugène Brands, entitled 'Everything Streams'. It refers to 'Panta rei', the principle that everything moves, changes and transforms all the time (Heraclitus, Plato, Aristotle).

Editorial
Volume 12, No. 1, 2013

The title of the last USABP national conference was "The Body in Psychotherapy: The Pioneers of the Past, the Wave of the Future". In our last two issues, we honored many of the pioneers of the past and will certainly continue to do so in subsequent issues. But, the themes of this issue represent some waves of the future, the expansion of the parameters of body psychotherapy itself and its integration with other fields of psychology and other branches of scientific endeavor.

Having just reached the age of 70, I shall invoke the elder's privilege and begin this editorial on a personal note that transports us back a few decades… almost half a century.

It was my 25th birthday and I was heartbroken: I had recently moved to New York from Boston and had neither a PhD nor a baby. My loving husband, who had been my childhood sweetheart, was deeply involved in his PhD program in physiological psychology, so it was easy to hide from him that something was dreadfully wrong. Whenever he was gone, I went to bed.

It was that simple. I spent most of the time in bed. When I couldn't stand the boredom anymore, I confessed what was really going on, and I heard my husband on the phone to my best friend trying to figure out what to do with me. She told him about a kind of psychotherapy in which you took off all your clothes and screamed into a pillow. This was a more intriguing option than the drugs then circulating (mostly pot and LSD) that scared me and the alcohol that just didn't do it for me either. It sounded weird, but having participated in one of Al Pesso's early groups at the Charles Street Meeting House in Boston, it also made more visceral sense to me than just talking to someone.

So, once a week my husband dragged me out of bed and took me to a Reichian therapist who looked into my eyes and told me at the first meeting that I had been terrified all my life. And, he did indeed plop me on a couch with pillows, force me to breathe more deeply than I ever had before, and kick my legs and scream into a pillow while he (sometimes painfully) massaged hypertonic musculature. Six months later I was no longer clinically depressed and, interestingly (for the quantitative, evidence-based folks), my score went up 100 points on a retake of the Graduate Record Exams, with no prior preparation. But I was far from finished. I began studying Martha Graham technique intensely and, trying to figure out what I would study in graduate school, with a BA in history and a couple of years of study/research in International Studies at MIT.

I was beginning to be interested in psychology, but Columbia's psychology PhD program didn't seem to be about people so I enrolled in a program in sociology and Middle East Studies (in the meantime I had learned Turkish at a Princeton-NYU summer institute). One day, after I had passed my orals and language exams and was making plans to go off to Istanbul to hole myself up in a library and analyze Ottoman novels, I received an intriguing call from the director of a program at Columbia's College of Physicians and Surgeons for psychiatrists and social scientists to learn each other's disciplines and collaborate on research. I asked if it carried a stipend. It did. Istanbul plan nixed, I joined the program. Its director, a psychoanalytically oriented psychiatrist, soon pointed out to me that I was far more interested in the patients than any of the young psychiatrists in the program, who mostly wanted to figure out what medication to prescribe for them. He opened doors for me to take all the classes with the residents in psychiatry and then to participate in Columbia's psychoanalytic training clinic as a research fellow.

In the meantime, I was discussing all this with my Reichian therapist, also an MD, who agreed to train and supervise me privately while I sought certification from a postgraduate psychoanalytic institute that trained PhD's and MSW's. I formulated a dissertation topic at Columbia to reflect my interest in Reich's work but not betray my personal interest in the topic. Investigating Reich's ideas on child rearing allowed me to interview his wife, translator's wife, and many of the senior Orgonomists without entering into any of the sociopolitical issues surrounding his work and eventual death in a U.S. prison. In the course of these extended interviews, I was interested to find out that I was not the only PhD candidate being privately trained (instructed and supervised) by an Orgonomist.

Illustrating how far our field has come, we open this Spring 2012 issue with a penetrating contribution to the training of body psychotherapists by Sibylle Huerta Krefft entitled "Sense and Sensibility in Supervision". Relying on neuroscientific research, she describes relational, embodied supervision focusing on emotional resonance to enhance the learning process. She also sees it through the eyes of chaos theory relevant to non-linear self-organizing systems. In that light the responsibility of the supervisor becomes to introduce just the right amount of perturbation to allow the self- organization of the supervisee to briefly enter a period of chaos followed, hopefully, by re-organization at a higher level of complexity. Quoting Will Davis she reminds us to ask "How?" rather than "Why?" as she explores embodied tutelage in this context. She emphasizes that learning takes place optimally in a relationship which includes both bodies and emotions: learning, thinking, language and the body are inseparable. If, as she states, "relationship shapes communication and vice versa, and non-verbal communication comprises 70%-80% of communication", the language in which we communicate the remaining 20% - 30% loses its heretofore enormous importance.

In the late 60's and early 70's much of body psychotherapy seemed to have "thrown out the baby with the bath water", ignoring advances in the wider psychotherapeutic community and hunkering down into competing training institutes which were considered and considered themselves countercultural, New Age, or one of the many other epithets that frequently characterized them. That was certainly my experience. I never told psychoanalytic or academic colleagues of my personal or clinical interest in Reich (the only book of his in the Columbia Psychoanalytic Clinic library at that time was Character Analysis), and my Reichian colleagues, I knew, thought that just talking with somebody was of no help at all. So, for more than 20 years, I kept my professional life housed in two separate castles, the walls of which were only breached in my private practice, in which they were seamlessly combined.

Claire Haiman takes on this issue in "Bridging the Split: Integrating the Psychodynamic and Body-Centered Therapies" utilizing a grounded theory approach (exciting to me as this

was not on the horizon when I was structuring a qualitative dissertation myself). Structured interviews with 11 New York City area therapists who were trained in both body-centered psychotherapy and psychodynamic psychotherapy produced three different ways of handling the bridge/split. All were initially trained in psychodynamic psychotherapy, but one group left that training and moved almost exclusively into body-centered work while a second group integrated the two, and a third group maintained two separate practices, one body-centered and one psychodynamic. She provides quotations from them illustrating each of these three positions as each therapist uniquely practiced it. This is the richness of contemporary qualitative methodology.

Moving into the challenges of clinical practice, Morit Heitzler brings to our attention the boundaries that are front and center in the body psychotherapy community as well as the larger psychotherapeutic community of trauma therapists with her thought-provoking article "Broken Boundaries, Invaded Territories: The Challenges of Containment in Trauma Work". She explores the paradoxical nature of boundaries and containment as they are and must be played out in the relationship between therapist and client. As an introduction, she analyzes an awkward initial exchange with a client that occurred prior to her sophisticated and nuanced understanding of both internal and external boundaries. Utilizing her work with this challenging client, she demonstrates in two vignettes the complexity of working with the invaded boundaries that are an inevitable part of early trauma. Her riveting description of the client's attempts at seduction with money and power, accompanied by rage, leads ultimately to a pivotal embodied enactment. The therapist was able to sense through her own body both what the client experienced and how she herself had "the capacity to lose and regain my sense of self" in order to guide their mutual journey.

As illustrated in Dr. Haiman's article, body psychotherapy, along with acupuncture, homeopathy, naturopathy, etc., has long been considered, even by many of its practitioners, "alternative", or "complementary". Body/somatic psychogtherapy was not part of psychology curricula nor was it given a place in medical schools. Just as mainstream medical schools are now beginning to teach Integrative Medicine, mainstream psychology has begun to integrate approaches that would formerly have been considered outside of acceptable standards of practice. Integration is the guiding paradigm of "Yoga Based Body Psychotherapy: A Yoga Based and Body Centered Approach to Counseling", in which the author, Livia Shapiro, strives to integrate on a theoretical level two approaches to the body, the outcome of which she calls Yoga Based Body Psychotherapy. She marries Susan Aposhyan's developmental movement sequence, the Five Fundamental Actions with Anushara Hatha Yoga's Universal Principles of Alignment. She describes each system in detail and shows how the introduction of yoga postures within the framework of the Interaction Cycle supports change and transformation, thus broadening the scope of body psychotherapy's already eclectic stance.

Another jurisdiction considered with ambivalence by some even within body psychotherapy has been the realm of energy work. Just what do we mean by "energy" anyway? Debra Greene explores this question in "Expanding the Dialogue: Exploring Contributions from Energy Medicine." Many of us, especially in the Reichian tradition, have worked with concepts and techniques of energy all our professional lives. But, in recent years, a whole field has grown along beside us, usually referred to as energy medicine. Its abundant literature is exemplified in my own library, which devotes more than two shelves to housing the outpouring of books in this field. Dr. Green outlines a clear, multidimensional model focusing on five principles of the etheric body (the power supply, the replica effect, the blueprint effect, the interface effect, and the internal senses), discussing areas of overlap with and application to body psychotherapy in hopes of forming an energetic bridge between energy medicine and body psychotherapy and simultaneously opening a mutually beneficial dialogue.

Noemi Csaszar and Joszef Vas explore yet another dimension in their article entitled "Tandem Hypnotherapy" (THT). Tandem Hypnotherapy is practiced in groups. A therapist and co-therapist work together with each participant singly. The co-therapist goes into trance with the patient while the main therapist holds the space and attends to the group as a whole. A mutual attunement evolves during THT. The authors believe that by using THT the symptoms of pre/perinatal traumas can be replaced with an associative mode of prenatal experiencing which includes acceptance and love. The essence of THT is viewed as an integration of touch, trance, and transference. Three case vignettes are presented to illustrate how THT works.

The ramparts of both castles (psychoanalysis on the one hand and body psychotherapies on the other) were being slowly dismantled in the 90's by neuroscientific research, especially that involving fMRIs. And, many body psychotherapists, certainly including me, were tiring of their narrow, physiological focus. Many body psychotherapists embraced relational psychoanalysis and integrated it into their work, acknowledging the effect of language on the body as well as of the body. The people who had straddled both worlds all along were publishing their views and our field was more and more interested in listening. The EABP had been in existence for several years, and the turn of the century saw the inauguration of the USABP. Both organizations have grown steadily and produced well-attended conferences in alternate years. The USABP Journal started as a very small, desperate effort to increase communication within our field and has grown into the jointly sponsored, professional journal you hold in your hand or read on your computer (or iPhone or iPad) today. Graduate schools are teaching somatic psychology, and modalities such as Somatic Experiencing and Sensorimotor Processing are incorporating the latest findings of neuroscience into their curricula, which are in turn being accepted for credit by undergraduate and graduate programs. It's an exciting moment for education and innovation in the field of body psychotherapy; old, new, and the once occult are all making their way into the fold. We celebrate this broadening and widening with a brief but relevant poem from poet and psychotherapist Salita Bryant, entitled "A spacious life" reflecting the value of mindful spaciousness in our work and in our lives.

Jacqueline A. Carleton, Ph.D.
New York City
March, 2013

Sense and Sensibility in Supervision

By Sibylle Huerta Krefft[1] MA, ECP

Submitted 21 March 2012; accepted August 2012

Abstract

This article addresses enhancing supervisory knowledge and skills through the dimension of body psychotherapy, which has received decisive support for its empirical and theoretical approach through recent neurobiological findings. Learning, including learning under supervision, is related to the structure of the relationship between the parties involved and is most effective when the body and emotions are engaged. Learning is a bodily process and can be described neuroscientifically. Stress in the short term reduces learning potential and long-term performance anxiety leads to burnout. Utilization of the pulsation model of body psychotherapy can also, on the career level, help to alleviate exaggerated expectations. Critical instability, in fact, is necessary for change. The goal of this paper is to clearly outline the relevance of body psychotherapy for supervision and at the same time to caution against an all too great simplification. In view of the continual rise in stress-related illnesses, this approach is becoming increasingly important.

Keywords: supervision, body psychotherapy, neurobiology, learning, unlearning, work- and stress-related illness, burnout.

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Through developments in neurobiological research, the body has reclaimed its role in the process of learning. It is no longer possible even for the natural sciences to ignore the connection of the senses to making sense of learning. Learning is experiencing. Whether the head, which is ostensibly the primary learning apparatus, is just a part of the body or whether it should be viewed separately is an ongoing preoccupation within neuroscience research. Neurobiologists still argue about the location of the mind, of free will or even of the soul. The neurobiologist Antonio Damasio reaches the conclusion: "that (…) the mind arises from or in a brain, situated within a body-proper with which it interacts; that due to the mediation of the brain, the mind is grounded in the body-proper; (…) and that the mind arises from or in biological tissue—nerve cells—that share the same characteristics that define other living tissues in the body-proper" (2003, p. 222). At this critical juncture where neuroscience research finds itself to be largely interdisciplinary, encompassing not only educational science and psychology but also laying claim to areas of philosophy, and where supervisors are finding themselves open to widening their horizons, I would like to try to interweave the knowledge about learning that is supported by these various disciplines.

[1] First published in German in issue 1/2009 of the journal SUPERVISION by the Beltz Publishing Group, Weinheim, BRD. Translated from the German by Elizabeth Marshall

Including the Body and the Emotions

For decades, body psychotherapists and psychosomatic practitioners have had at their disposal useful skills for working with the relationship between learning and the body. In the field of supervision, too, including the body and the emotions in the learning process is nothing all that new. Satyr, Fallner, Levold, Lambelet et al. have addressed the subject in various ways (body language, energetic dynamics of systems, interventions on the body level in supervision, affective communication in supervision). A study of supervision as practiced by body psychotherapists (Huerta Krefft, 2006) showed that supervisees also highly valued a holistic approach. Bulling's dissertation (1999) on the development of a concept of supervision for teachers on the basis of body-oriented humanistic psychology confirms the positive effects of this approach. Now, through neurobiology, we are confronted anew with the question of the integration of body knowledge and its practical applications for the supervisor.

The whole field of learning is large and difficult to evaluate. While neuroscience research teaches us that we learn best information that we are able to connect to already familiar parameters and yet still presents a slight challenge, I will show how the knowledge of neurobiology combined with a body-oriented attitude could lead to the further development of supervisory skills. This paper is intended as an impetus for further thought and should make the reader curious—a valuable illustration, as the brain, research tells us, doesn't care to learn things that don't interest it.

Learning in Relationships

As we know from our own experience and now find corroborated by brain research, learning depends to a great extent on the relationship between the parties involved. Grawe and Donati (1994) attribute 50% of the enduring and positive effects of therapy to the structuring of the relationship in the therapeutic setting. Certainly this figure can't be entirely transferred to supervision, although it is mirrored in the efforts of the supervisor to establish connectivity and resonance. We could find a neurobiological correlate of the relationship level in the activity of the mirror neurons. This discovery by Italian neurobiologist Giacomo Rizzolatti (Bauer, 2005) supports the supervisory paradigm of observational learning (modeling). Through an accidental observation during an experiment with apes, Rizzolatti's team discovered a neural system that mirrors bodily sensations and emotions that arise exclusively from the observation of actions performed by others. The mirror neurons of the observer—and this has been confirmed in experiments with human beings—are activated and "firing" through the observation (Bauer, 2005). Beneath consciousness, the relevant motoric action schemata of one's own mirror neurons are being mobilized. This activation makes it possible for individuals to move in tandem in situations that demand highly complicated coordination, such as in a crowded pedestrian precinct, without mishap. These actions are coordinated beneath conscious awareness, on a basal motoric level (Bauer, 2005). On the sensation level, the mere observation of bodily pain in someone else triggers the activity of one's own pain sensation mirror neurons. Thus, intuitive understanding occurs before any conscious reflection. Resonance happens of its own accord and belongs to the basic human configuration. If it is missing then something is already wrong. Stress inhibits mirroring activity and thus impedes one level of the interpersonal learning process (Bauer, 2005). We could also take the activity of mirror neurons as being correlated with intuition.

It seems to me helpful, if not at this point indispensable, to bring in the concept of the "inner construction" as used in supervision (something like an inner road map which everybody develops and which guides one's information processing in a very personal way) to prevent mirroring activity from being perceived as a one-to-one process. This makes it clearer that neural mirroring works as if it is the same thing, but that it really is—and can only ever be—similar. In view of this, we must be careful and always seek feedback. In body psychotherapy, the concept of "vegetative identification" described for many years a similar phenomenon. About vegetative identification, Knapp-Diedrichs elucidated the following: "a condition in which the body perception of the therapist serves as an indication of the organismic processes of the client. The reason for this is the orgonotic interaction of both systems, that of the therapist and that of the client" (1992, p. 94). The dangers of handling this without a certain level of awareness are well known (Boadella, 1991) and training in the attentive and painstaking use of vegetative identification is therefore an integral part of body psychotherapy educational curricula. For supervisors, additional problems arise from this. How can we protect ourselves from unwanted mirroring processes (identification with the client system on a basal level)? What happens to people who are excluded from mirroring processes (e.g. as a result of unemployment), or who are involved in only negatively connotated mirroring processes (e.g. bullying or harassment)? Aware as we are in supervision of the basal mirroring occurring in the client system, how can we help to transfer this process of mirroring more to the conscious level? *What are we learning without realizing it?* Does the supervisor's self-care, solution-oriented acting, emphatic empathy and ability to assert boundaries influence the client system because, whether one means it to or not, it will be mirrored and learned on a basal level by the client system?

Learning as a Bodily Process

Relationship shapes communication and vice versa. A recurrent phenomenon in communication training is the emphasis on the outstanding importance of the analogue content of communication (the relational content which includes all non-verbal aspects of communication) which comprises percentages of between 70% and 80% of the communicated content. After such a preamble, the focus is then on the meaning and the shaping of the remaining 20% to 30%, the language. The analogue content is defined as the non-verbal and packed away in the chest of techniques. But this doesn't work, because defining the analogue content as thus and castrating it only hardens the apparent dichotomy of the verbal and "the rest" (the so-called non-verbal). Furthermore, such a definition contains a fallacy: language follows on, is grounded in and always connects with the rest of communication, this non-verbal portion. To focus communication on language is backwards—the non-verbal part of communication should not be contained within a negative contour in relation to language. This remainder contains everything beyond the word itself. This is not only what we call body language. The analogue content is more than just a bit of body language, which only represents the consciously perceived aspect of a cascade of communicative processes. Let's take a look at communication as a holistic process. "The permanent interplay between a system and relevant environmental aspects applies on all sub-system levels; so it is also between cells and organs in the body, between organs and the organism, as well as on the psychic and the social system level. In turn, the different system levels represent for each other environmental aspects", writes psychosomatician and student of Thuere von Uexkuell, Werner Geigges (n.d., p. 248). We

must claim this for communication and learning, too. Communication takes place and has its effect in interpersonal space and, as neurobiology demonstrates, in intrapersonal space also. As in interpersonal space, this doesn't happen intraorganismically like a neuronal one-man show from the brain to the rest of the body, but according to the principle of circularity within the whole organism. With his concept of "somatic markers", Damasio (2003) shows this interweaving of body sensations, emotions and thoughts. He postulates that congruent with certain bodily states, there develops associatively a marking of the relevant object in the memory. Thus, body sensations, emotions and thoughts are linked together and these links are reinforced by constant repetition. We all know this well enough from day to day situations, in which, for example, a smell or a sound can trigger a whole sequence of feelings or thoughts. Thereby the principle of "use it or lose it" is operative.

Unlearning is also a deeply human characteristic. Regarded from a supervisory point of view, this means that one cannot overemphasize repeated, sensorially accentuated reflection. This would indicate support, for example, for structured case conferences, which include dramatization and role playing. According to Damasio (2003) feelings can of themselves strengthen or weaken thought processes, and it should not come as a surprise that feelings of happiness are beneficial for one's cognitive powers.

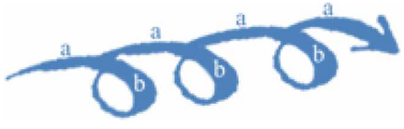
Learning, thinking, language and the body are in this sense inseparable from each other. Learning can no longer be clearly divided, located, deduced. Learning takes place simultaneously on many levels of the organism. We learn mostly without being aware of it. And if we had to access what we know through knowledge, we would be lost. We would be just too slow!

The spoken language as a medium of information for communication and learning is in itself a form of expression of the organism, as on a purely physical level it is dependent on the body's constitution. For instance, a certain openness in the cervical and oral segments of the body plays an important role in the creation of a sonorous and well-modulated voice. In addition, full breathing and a relaxed diaphragm make an indispensable basis for speech, because the diaphragm acts as a kind of bellows for the vocal chords. When somebody "loses" their voice, this means in a figurative manner that it takes their breath away—they cannot breathe out and in this way produce sounds. Paying attention to breathing and dealing with it respectfully has often had the effect of helping those I supervise untie some tangled expression.

Let us now turn to body language. This comprises learned and culturally differentiated gestures and a certain globally comprehensive expression of feelings and sensations. It develops through experience. Where body language has been adapted by spoken language, the emotional content is immediately obvious: "my colleague stabbed me in the back!" Also, gestures can be extremely explicit: a throwaway movement of the hand, a shaking or scratching of the head. Precisely because it seems so simple and comprehensible, it is essential to ask for feedback to really understand body language. I can only then, as a supervisor, develop trust in my observations and interpretations through asking and then learning to differentiate between observation and interpretation. As a supervisee, I can only learn to open up to new levels of communication without anxiety through this sort of non-judgmental feedback. Together, we must learn to communicate in a differentiated way and to distinguish between sensation, interpretation and expression. This is particularly essential in intercultural communication. In conclusion, I warn against interpreting body language literally, word for word, so to speak; we humans are not trivial machines, but organisms in dynamic and energetic motion.

Learning in Motion

Neurobiology has, with all intents and purposes, proved that movement stimulates blood circulation in the brain and therefore facilitates thinking. While only 40% of our energy potential is converted into movement, the blood supply to the brain is increased by 25% (Schule, 2006). It has also been shown that the process of neural interconnecting with the already known and the final anchoring in the brain can only take place in non-movement phases, when resting or sleeping. If input follows input then one loses what one has learned (Kistler, 2004). If we take this information seriously, then it could be a good idea to organize supervision as an evening stroll. From a neurobiological viewpoint it is important that development occurs in phases. In body psychotherapy, we find a parallel in the concept of the non-linear movement of the human organism on the basis of the observation of the pulsatory processes in the human body (sleep-wake cycle, heart rhythm, digestion, life phases, etc) and in nature (changing of the seasons, day and night, etc). Pulsatory development takes place only through the continuous process of gathering (b = inward movement) and the following outward movement (a) and vice versa (see figure below).



(Huerta Krefft, 2005)

Therefore, development needs both embodiment and expression. To put it more figuratively, if you are trying to get a car out of a snowdrift, you need to do more than just hit the gas. It is well-known what happens if you should try—you dig yourself in even further. Instead, one needs to alternate between accelerating and rolling back, so that one can work up the right momentum to roll out of the drift (this wonderful analogy is from Will Davis). This image has proved useful in supervision. It links up to a sensory memory that many people have: getting out of the snowdrift has strongly positive connotations. Shifting the focus like this on professional setbacks or phases of low achievement can be used for a re-evaluation of the situation. If in supervision we first establish the principle of a good balance between the phases of inward and outward movement and if we value self-regulation as beneficial both for health and for learning, this makes it easier for clients to deal with such periods at work less judgmentally and to recognize that they too are necessary. From practical experience, I see how relieved and reassured many clients are when they realize that they need not be permanently in a state of expansion and optimization to have a sense of meaningfulness in their professional development. As I have already shown, in the alleviation of stress lies the chance for creative solutions, which would otherwise have been blocked by anxiety. This shift in attitude for clients under supervision who are trapped in narrow thinking has proven very helpful. The reevaluation outlined above offers a profound change of perspective.

The so-called *transitional phenomena* in the process of organismic self-organization are another significant aspect of the same process. This manifests in the interplay of states of order and states of disorder. Out of apparent chaos, a new order already begins to

form. This is well illustrated in the famous image of a glass of water in which sand has been stirred up. American psychotherapist Will Davis (1990) sees in the transitions from order to disorder and vice versa the prerequisite for growth. According to him, constant equilibrium would lead to stagnation.

Here, body psychotherapy meets research on transitional phenomena from the field of synergy, which describes the need for "critical instability" between exploring the new and protecting the status quo. This is as true for physical health (e.g. heart amplitude) as it is for neural learning processes. The *variability* of the organism in relation to the environment becomes the touchstone for mental and physical health. "Psychologically as well as physically, life appears to be a cascade of adaptive order-order transitions" (Schmid-Schoenbein et al, 2003, 296). Instability thus becomes an expression of incipient change. Supervisors can readily translate this into the concept of "inducing disorder in the system", which is necessary to facilitate change. Movement out of the motivational equilibrium becomes a precondition for self-organization and learning and, thus, for change. Interestingly, the supervisor Helmuth Bulling (1999) points out in his dissertation the special significance CHANGE has for the teachers involved—they saw precisely therein the most positive effect of group supervision.

Conclusion

The functional approach of body psychotherapy with its emphasis on the question "How does the organism organize its energy? Not why, but how?" (Davis, 1991), converges on supervisory thinking and creates space for synergy. It can be very helpful when considering systems to look at the system of the body. Otherwise the bodies of those in supervision can only come in through the back door, so to speak, in the form of illness, which is at least in part work-related. At the moment it seems that the bodies of working people are learning to say "no" to the system, but not to say "yes" to themselves. The issue of burnout is just the tip of the iceberg.

Neurobiological learning research supports much that body psychotherapists already knew and utilized, which, usefully, can help us to formulate good arguments for what we do. In a working environment that is becoming progressively more and more alienated from the senses, supervisees can learn to appreciate their bodies as a source of insight and wisdom. Sensibility would at the very least give birth to making sense, which would perhaps bring new light to the old Marxist axiom that "being determines consciousness".

BIOGRAPHY

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Bridging the Split: Integrating Psychodynamic and Body-Centered Therapies

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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

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

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INTERNATIONAL BODY PSYCHOTHERAPY JOURNAL THE ART AND SCIENCE OF SOMATIC PRAXIS

A spacious life
Salita S. Bryant, PhD., MFA

Learn the lessons of heron ancestors:

Pilgrimage to cool mud
Wait for a sign
Wait for spring
Wait for the full pulse of sun

Pause:

A still white heron
Pause one legged
In the shallow waters of lake Obi
Learn not to eat the fish at my knees

Pause Again:

Try not to fly south when
The nights begin to freeze
And dew forms crystals
On the surface of clear still water

Find stillness in a measure of breath:

When there is only emptiness
When there is no thought
No unbearable longing for freedom
There is freedom

Be:

A single white heron
In a still blue lake
Learning to fly
By standing still

BIOGRAPHY

Salita S. Bryant holds a Ph.D. in literature, an M.Ed. in Clinical Counseling, and an MFA in poetry. She is Assistant Professor of English at Lehman College and author of *Addie Bundren is Dead.* She has won The Midwest Writing Center's *Off Channel* Contest, Connecticut Poetry Society's Award, *Boulevard's* Emerging Poet's Award, *Spoon River Poetry Review* Editors' Prize, *Iron Horse* Discovered Voices and nominated for three Pushcarts. She has published in *Alimentum, The South Carolina Review, Agenda, Nimrod, Snake Nation Review, Third Coast, Dogwood, and The North American Review,* among others. She lives in NYC and is a psychoanalytic candidate with Harlem Family Institute.
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Broken Boundaries, Invaded Territories: The Challenges of Containment in Trauma Work

Morit Heitzler, MSc

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Abstract

One of the most excruciating aspects of trauma is the invasion or collapse of boundaries, not just as experienced in the moment of trauma, but also as experienced as lasting damage. Traumatised clients usually bring to therapy an ongoing background feeling of threat: both to physical and emotional survival and to their sense of identity. Not knowing where "I" end and the "Other" begins creates chaos and confusion in the client's inner world, which echoes strongly in the therapeutic relationship. Therefore, most methods of trauma therapy are highly concerned with re-building and establishing safe, containing boundaries as the foundation of any therapeutic work. However, is it really possible to by-pass the client's embodied experience of shattered safety by introducing safe therapeutic boundaries? Can we, as therapists, contain the impact of trauma without engaging with chaos, confusion and vulnerability in the consulting room? This paper will explore the paradoxical nature of boundaries and containment and their role in trauma therapy.

Keywords: complex trauma work, boundaries, containment, re-enactment, projective identification, relational

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What would you say to a client who tells you, "I want to get under your skin; I want to hold your heart in my hand; I want to be part of you so that you can never go anywhere without me!"

The first time I was on the receiving end of such a declaration, I was a young therapist, struggling to grow up fast enough to become what I now see was my own idealised version of a "real, proper" therapist. I felt invaded and scared out of my wits. The intensity and naked honesty of the client's statement threw me off balance – a balance which was pretty precarious anyway. In my distress, I clung to the first firm landmark available in my psychological professional landscape: BOUNDARIES!

This client has no boundaries! We can NOT do therapy without first establishing the therapeutic boundaries! Oh, thank God - now I know what to do: I will make sure that she gets the right idea about her boundaries and mine!

Thus, with a great sense of purpose and self-righteousness, I embarked on lecturing the client on the issue, explaining in my soft yet determined voice how important it is that we will learn to see each other as two separate individuals, each of us with her unique qualities and strengths, each of us with her own personal space, which we need to appreciate and respect, space which is defined by clear boundaries, which we will now be VERY clear about, as it is this clarity that will help us to maintain these boundaries, and it is this maintaining of our clear,

defined boundaries that will make therapy a safe, fruitful journey, and this is what we are here for, isn't it?

Oh dear, what an embarrassment. To this day, I still cringe when I remember those moments, although I also feel compassion and love towards that younger version of myself, braving her first steps into the vast stormy ocean of the "human psyche", armed with so little other than high ideals and passion.

No wonder she needed something to hold onto when the waves grew higher. And what is there to hold onto if not the firm rules we all learn in year 1 of any psychotherapy training—boundaries! *The* holy cow of the therapeutic field.

Now, a good few years later, I—like that young therapist I once was—*do* believe that boundaries form one of the basic, crucial principles of therapy generally and trauma therapy in particular. However, I would like to think that my ability to work with boundaries—or lack of boundaries—in the therapeutic relationship has grown a bit with time and is less inspired by fear and more anchored in acceptance of vulnerability—mine as well as the client's.

Boundaries and Trauma

Trauma, almost by definition, breaches people's normal boundaries. It is as if life was driving a bulldozer over people's normal sense of protection, sense of safety and sense of self. This has a significant impact not just during the traumatic event itself, but also carries lasting effects on the psychological organisation of traumatised people. Those who suffer from PTSD live in emergency mode, constantly ready to flee or fight. Their experience has told them that the world is not a safe place and that people are not to be trusted. They oscillate between extreme levels of hyper-arousal and dissociation, as the ability to self-regulate is impaired. At the same time as they have heightened responses, they also shut down a great deal so that many of their normal responses to life and to other people are not accessible to them. Those who suffer from developmental trauma and Complex PTSD (Heitzler 2009, p. 179) carry life-long relational scars, as the people whom they were meant to trust and rely on most have been the very ones who have invaded and abused them. This creates such a confusing, chaotic model of relating that the only way to somehow manage the presence of others is by controlling, manipulating and keeping them at bay. In this case, boundaries are either non-existent or rigidly maintained, but their main function is to avoid any possibility of real intimacy in which two people can attempt a close, trusting and respectful connection.

Boundaries in psychotherapy practice are established to create a safe, reliable and useful framework for the work to take place. The boundaries create 'the container' (Heitzler 2009, P.179) for the intensity of the shared therapeutic journey. If the container is safe, solid, consistent and defined, it provides a secure space in which both client and therapist can brave the unpredictability of their emerging feelings and impulses. If the boundaries are safe, both client and therapist can embark on what at times feels like a very dangerous adventure: that of disintegration and renewal.

Much of our therapeutic work takes place around boundaries. Clients express conscious and unconscious resistance, submission, anger, love, mistrust and many other aspects of their inner world through their reaction to the boundaries we set. Exploring and attending to the client's sense of the boundaries is one of the ways in which the therapist can attune to the client's childhood scenario. The early implicit and explicit messages which were internalised around self and relational boundaries are crucial, as they form the blueprint of the client's sense of self

as well as setting the foundation for her relational patterns.

In trauma work, the client's suspicion and alertness around boundaries is heightened as it is the transgression of boundaries that led to the collapse of all that was known to be safe and trustworthy. More than communicating in various ways the experience of her own broken boundaries, the client is constantly busy checking the therapist's personal and professional confines. The natural impulse of the child/adolescent to test the parent's boundaries in order to feel contained and to define the emerging separate self here acquires a different twist: the client, who feels overwhelmed by her trauma and only able to deal with the magnitude of it by dissociating and fragmenting, tends to believe that nobody can survive and bear what was and still is unbearable for her. She is torn between conflicting impulses: to share the intolerable fear and pain with a loving, understanding adult on the one hand, and to protect herself and others from the relentless impact of the re-traumatisation on the other. Because more often than not her experience has led her to conclude that there is no reliable adult out there for her, it is very hard for her to believe that the therapist can be genuinely and whole-heartedly available to explore with her those chambers of hell known to her only in isolation. Thus, testing the therapist's boundaries is almost a prerequisite for any possible therapeutic process, and consists of testing the therapist's physical, emotional and mental capacity to withstand the impact of the trauma, as well as testing her willingness to engage with it.

I will present a vignette of my work that will illustrate this stage in the process with one of my clients.

Vignette 1 (from the beginning of the therapy)

Clara was 45 years old when she first stormed into my consulting room. She was 15 minutes late for her first session and was still at the tail-end of a phone call: "I can get you fired in no time and you know that!" I heard her saying. "You better get your act together before I really get annoyed!" She turned her phone off and surveyed me and the room through her large black eyes. "Do you have a bathroom here?" she demanded. "Yes," I said, "it's over here". I welcomed the opportunity to be alone for a moment and to collect myself. "What an entrance!" I thought. "Is she going to get ME fired in no time?"

In fact, this became an increasingly likely possibility as Clara proceeded to tell me of her past therapeutic endeavours, which ended mostly with her "chucking" yet another useless therapist. Clara's first therapy began when her daughter, Lisa, turned 10 years old and their relationship deteriorated from bad to worse. More or less at the same time, Clara developed a painful stomach ulcer. Now, three years later, her daughter was withdrawn, incommunicative and suffered from recurring panic attacks. Clara was at her wits' end after trying "all sorts of family therapy, child psychotherapy and everything under the sun", as she put it. The one thing she took from all these therapies was that perhaps her own attitude towards her daughter might contribute to Lisa's difficulty and she was willing, reluctantly, to entertain this idea. However, previous therapists who suggested a more understanding, loving approach towards Lisa were dismissed as "lovey-dovey softies". Clara wanted some practical solutions as to how to get her daughter back on track. She was also concerned about the persisting symptoms of her ulcer, as it had an impact on her working life. Clara was a senior partner in a prestigious advertising company, running a big office with many people working under her. She resented having to take breaks to eat properly, as well as not being able to be at work when the ulcer flared up and the pain was beyond ignoring. Clara was married to a successful businessman who was

often away on work trips. He was a powerful, charismatic person, who often "had too much to drink". They had a son, whom Clara adored, who was then 9 years old. In her uncompromising way, Clara made it clear from the first session that she was not in therapy to work with her issues. No, the problem was clearly Lisa, and she came to get some guidance as to how to handle her. However, she was aware that I was a body psychotherapist and worked with psychosomatic symptoms, so she expressed some hope that I could sort out her ulcer at the same time.

The message I was getting was quite clear: "Stay away from me and my inner world! You may have some access to my intestine, as long as it does not involve me. You can do your business, but I am not going to be part of it." There were also some implicit themes, among them incompetent therapists, a mother struggling to help her daughter, impatience and intolerance towards vulnerability of any kind and a general sense of threat: "If you will not do what I expect you to do, you're out. No second chance."

I agreed to work with Clara, which she, herself, seemed to have taken for granted. My condition was that she must come to therapy weekly, at a regular time. As soon as I presented it, the first boundary was attacked. "I cannot do that. I am very busy and run a large office, surely you can not expect me to cancel everything just to be here every week!" I responded calmly by saying: "I understand your situation. I am a busy woman myself and run a busy practice. It is not always easy to juggle all the responsibilities in a woman's life, but we can choose our priorities. If you choose to work with me, I will expect the same level of commitment that I am able to offer, which is a weekly regular session." I saw a glimmer of appreciation in Clara's eyes. She had met her match. After some negotiation we agreed on a regular time and so began our shared journey.

Clara's tests of my boundaries grew from straightforward, obvious attacks to more sophisticated, subtle attempts. She offered me extra money when she had had what she considered a good session. "Why can I tip my hair-dresser or masseuse and I cannot tip you? You did a good job today and you deserve some extra for it!" She often wrote the wrong figure on her cheque, always paying more then she was supposed to, waiting to see my reaction - would I forget to deduct the extra sum of money from her next payment? Then she "forgot" her chequebook three sessions in a row, patently looking for any signs of hesitance or awkwardness on my part that might "give away" my reluctance to insist on being paid.

Clara also tried to be "helpful". She offered me her expertise in advertising my practice and tried to convince me that I could climb higher on the professional ladder if I got myself a proper publicity campaign. I would be able to help more people, she argued, rather then waste away my talent stuck in a small consulting room in West Oxford. She sent some colleagues and work acquaintances, some of them semi-famous figures in the entertainment world, to see me as possible clients. Her "attack" on my narcissistic shadow was relentless. I had to remind myself again and again that THIS—these tests and temptations and boundary challenges—this was the therapy, as it seemed that not much else was happening during sessions.

The main charge was invested in trying to get to me, trying to seduce me or break my boundaries. As much as I tried to remain clear, grounded and focused within myself, maintaining my own sense of my boundaries, I was shocked one morning when I woke up from a long dream in which I was giving a therapy session to the late Princess Diana. In the dream, my consulting room was located in a large castle surrounded by a deep, stormy river. The only way to cross the water was by a small row boat. Would you like to guess who was the person in the dream in charge of rowing princess Diana over to see me? Yes, Clara did find her way into my psyche, when I was not expecting it—she had gotten under my skin, under my defences.

I noticed my countertransference feelings as well as the unconscious reaction to the seductive manipulation of my grandiosity. "What is being communicated here?" I wondered, "Who is being seduced by whom? Whose inflated ego had to surrender? Who crossed the protective yet isolating margin and managed to get into the castle?"

Things begun to make more sense as Clara's life story was slowly revealed.

When Clara was 6 years old, her charismatic, successful father had finally managed to divorce his depressed wife, Clara's mother. Taking with him the larger part of their shared assets and Clara, their only daughter, he moved back to England, his country of origin. Clara's mother was left in Italy, her homeland, and was committed soon after to a psychiatric ward following several suicide attempts. From then on, Clara saw her mother only once a year, and her visits were marked by the mother's uncontrollable tears, howling and clinging onto her daughter. Clara resented those visits and, as she grew older, did all she could to avoid them. She felt disgusted by her mother's open display of weakness and rejected all connections to her, as did her father. Soon after moving back to England, her father married a younger woman, a Romanian student, who got pregnant within a few months of moving in with father and Clara. Clara, 7 years of age then, used to help her young stepmother in completing various application forms and official documents as well as translating conversations with neighbours and workmen. After her younger brother was born, Clara's outbursts of rage and violence started. She was a good, motivated student at school and rather popular amongst her peer group, but at home she was out of control and ruled the household with her temper tantrums. Her father was often away on business trips and her stepmother was sinking deeper and deeper into a postpartum depression. On return from his travels, her father would congratulate Clara on her command over the household and say to her stepmother: "Clara is MY daughter, she's got some of her Italian temper from her mother, but her motivation, determination and strength she got from me. Wait until she gets older—she will rule the world!" He used to shower Clara with gifts that were not suitable for her young age, like expensive perfumes and sexy underwear.

When Clara turned 10 years old, her stepmother went back to her country, taking her young son, Clara's half-brother, with her. The father declared legal warfare on her, trying to get his son back, and Clara was introduced to a succession of nannies who were supposed to look after her but got "chucked" one by one as none of them could stand up to the little tyrant Clara had become. During that time, I later learned, Clara's father started drinking heavily and regularly abused her sexually when he came back from his travels. She often witnessed him having sex with young drunk women he picked up in bars, and he used to reassure her by saying: "They don't mean anything. It's you and me, darling. You and I are alike. Only the two of us can understand each other. We are stronger and better than anybody else."

At the age of 12, Clara was sent to boarding school where she became a star pupil. The sexual abuse carried on well into her 14th year, when she began menstruating. Her father withdrew his "special attention", but supported Clara's wish to continue her academic studies in the field of economics and business. In her 20's, Clara joined the company she was now running and early in her 30's, to her father's great delight, she married one of his business associates who was 15 years older than she was. She resented her first pregnancy but was persuaded to carry the baby to term by her father who wanted a grandchild. Clara's relationship with her daughter was rather distant and grew even colder when she gave birth to her son, who became the main source of her pleasure and joy.

This story was conveyed to me by Clara in a nonchalant, matter-of-fact way. It helped

me to make sense of her: her body, her manners, her choice of partners and career, her relational stance, her symptoms, but it left me wondering: where do we begin?

Discussion of Vignette 1

In terms of trauma, it might look like an easy task to define the point in time at which Clara's boundaries were breached: when she was 10 years old and her father began to sexually abuse her. However, if we consider the developmental processes and ask ourselves how and when boundaries are initially created, the picture becomes more complex.

As a central aspect of our 'sense of self', the sense also of our physical, emotional and psychic boundaries develops in the interaction with our first attachment figure, typically the mother. It is in the individuation stage (Johnson, 1994), or what Mahler (1975), following Klein, calls the 'separation-individuation' process, that the child's healthy impulses lead towards exploring her and the other's boundaries. And from a relational and feminist perspective, Benjamin (1998) has elaborated the origins of the child's sense of self in the intersubjective dialogue of mutual recognition developing with the mother.

Typically, developmental models locate the crucial phase for the establishment of self-other boundaries around 2 years of age. Nevertheless, recent research into neuroscience and infant observation confirms (Stern, 1985) that attachment patterns begin to shape and impact the ability to relate to self and others from much earlier stages of life, starting right at birth or even before (Schore, 1994; 2003).

I came to think of Clara's attachment style as insecure-ambivalent: "The mother of the infant who develops insecure-ambivalent attachment patterns is inconsistent and unpredictable in her response to the infant," explains Pat Ogden (2006, p.50). "Because the caregiver is inconsistent in her availability, sometimes allowing and encouraging proximity and sometimes not, the child is unsure of the reliability of the caregiver response to his or her somatic and affective communication" (Ogden, 2006, p. 50).

She continues: "These infants characteristically appear irritable, have difficulty recovering from stress, show poor impulse control, fear abandonment and engage in acting-out behaviour… Their physical movement may be uncontained, geared more towards discharge of high arousal than towards the purposeful achievement of a specific goal" (Ogden, 2006, p.50-51).

Clara's mother was a loving, warm woman. When she felt well within herself, she was fully available to interact with her daughter, but as her depression grew deeper, the shifts in her moods and energetic presence grew more and more confusing for her child. Clara coped by being strong, physically and emotionally. She developed a growing contempt towards her mother as the roles reversed and her mother became more dependent on her. In our sessions, Clara often recalled her mother saying: "You are the only one who can make me get out of bed, my dear child, it is only you who makes me go on living." The combination of this unmanageable responsibility, the lack of attendance to her own needs and the fear of vulnerability that might lead to a total collapse pushed Clara to turn towards her father, who was often absent but still the only powerful adult in her vicinity. In order to please him, she had to be like him, which led to a total rejection of the weak, collapsed feminine and to the adoption of a masculine façade. Underneath this façade, Clara was plagued by her unfulfilled attachment needs, her fear of abandonment and her rage. This led to her temper tantrums and to an enmeshment with her father that was thinly disguised as a celebration of independence—an enmeshment encouraged by the father's narcissistic view of their relationship.

Clara's sense of self appeared strong and determined on the surface, but her hidden, inner reality was a pervasive sense of panic, arising from a desperate impulse to try and stop her father from abandoning her as he had abandoned her weak mother.

Her confusion around her boundaries was fanned by implicit and explicit messages from both parents. In her attempt to deal with this inner chaos, Clara developed a harsh, controlling and rejecting relational style, which perpetuated her abandonment fantasy, a fantasy that was re-enacted over and over again by "chucking" people.

In insisting on a regular commitment to therapy and explicitly stating my availability and commitment, I took my first significant step in relating to Clara's unconscious fear of abandonment. Moreover, by standing my ground right at the beginning of our interaction, I placed myself in the camp of the "strong people", like her and—more importantly—her father, thus gaining her respect.

Clara needed to check how strong I really was and whether my claim to a seat on that desirable pedestal of glory was indeed justified. She attacked my boundaries, repeating what was done to her, and in her style of attack she unconsciously communicated to me some fragments (Soth, 2005) of her own life story.

I have written elsewhere (Heitzler, 2011) about the central role which projective identification plays in the client-therapist interaction and in the processing of trauma. In this case, Clara made me feel (rather than merely understand) the irresistible seduction of narcissistic grandiosity.

In dreaming about Clara facilitating my position as Princess Diana's therapist, I, like her, surrendered to the need to be big and powerful. Moreover, I knew now what it felt like to have somebody get under my skin, not respecting my "no's" and manipulating my infantile needs. This first-hand knowledge was crucial in understanding Clara's inner world, and it was communicated only once my own boundary was invaded by the dream. I was now more "like" her and her father, and, as Clara sensed this, she was more than ready to enmesh with me. The next stage of therapy was unfolding.

Vignette 2 (from a later phase of the therapy)

About a year later, Clara and I were deeply immersed in our chaotic dynamic. The outer boundaries of therapy survived several attacks and it was through withstanding this buffeting and those blows that a greater appreciation and respect towards their containing function had been gained. Clara relaxed into our weekly rhythm, trusting at least to some degree that I was going to be there, even if she could not bribe me with money or fame. I also relaxed into the firm hold of the familiar therapeutic frame. However, as the sense of safety and trust in the outer container grew, the process took us further towards unknown, at times breathtakingly scary, edges. Clara had come to realise that underneath the rigid relational boundaries she had erected in order to protect herself, she actually did not have a clear sense of herself at all.

Who was Clara? What was it she really wanted? What was good or bad in her eyes? What was her life all about? Clara was struggling with those existential questions for the first time and nothing in her life had prepared her for that quest. She always did what Daddy wanted, she was always the girl that Daddy adored. It was very hard and confusing for her to consider herself as anything other than her father's extension, an extra limb of his physical and energetic body. Carla had no sense of her internal boundaries. This was played out in her relationship with me. If I was not to be "chucked", I was to be merged with.

Clara was working very hard, explicitly, to prove to me that we were "the same": we were both strong women, both in our late 40's, who were living in a foreign land. We both had

successful careers and had people depending on us and needing us. Neither of us needed anybody else, she argued, as we were powerful and independent. We were both able to think "out of the box" and this was the key to our success. How could I argue with this?

I tried at times to bring some of *my* reality into the room, by saying that there were people in my life that I did depend upon, but Clara rejected this, saying that she did not feel my dependency, therefore, she could not imagine it. She might agree on a conceptual level and respected what I was disclosing about myself, but she continued to experience me almost exclusively as independent and strong. "Fair enough," I thought to myself. My own vulnerability and neediness has indeed been well concealed, a legacy of my own generational trauma and cultural imprints. I have worked hard in years of therapy to enable that hidden, delicate part of myself to emerge but still, it did not come easy to me, definitely not in my role as a therapist.

In my relationship with Clara up to that moment, I felt I had had to be strong; I had to display my power—otherwise I would lose her respect and I would be "chucked". I did not now want to display my vulnerability in order to show her how wonderfully I could integrate all aspects of my personality, with no splitting at all. This would be just another proof confirming what an amazing, wholesome and generally perfect person I was, in every way. So, in effect, I was trapped, just like Clara was, locked into a one-dimensional image— "strong as Daddy".

Whilst this was happening between us explicitly, on an implicit level Clara was busy merging with me and doing her best to please whatever she imagined my unvoiced wishes to be.

She placed great emphasis on being a "good client", producing meaningful memories, deep dreams, brilliant insights. Her compassion towards her daughter grew, as we interpreted her impatience towards the daughter's needs and fears as her rejection of her own vulnerability. Clara was able to maintain some boundaries with her father, rejecting his incessant demands for her time and attention. Meanwhile, she was happily basking in the warm rays of my approving, positive feedback. She was making progress, she was being "good".

But some clouds were gathering on the horizon, threatening the blue sky of our self-congratulatory "progress": my holiday—four weeks of summer break—and our first long separation. Although I had announced it a long time in advance, Clara grew restless as the time of our last session before the break drew near.

She could not openly show her fear of abandonment and firmly maintained that she did not have any sense that I was abandoning her at all, as we had a clear date for my return and she knew, she said, that I would come back.

Still, as the break was approaching, she grew somewhat cold and distant. But as she could not really afford to abandon me, her distress went more unconscious and the only outlet for her growing rage, fear, confusion and need was somatisation. The physical symptoms that had calmed down noticeably since we had begun our work together now flared up again, and in addition to more frequent ulcer attacks she also developed a red, inflamed rash on both arms.

It was four weeks before the impending date of my holiday; Clara and I were working with her physical symptoms. Clara was sitting on the mattress in my consulting room, exploring the sensations in her arms. She noticed some feeling of agitation in her lower arms, and when I invited her to actually sense and then describe it, she said she could feel some kind of harsh, cutting energy in her arms.

In spite of that localised agitation, I had the impression that, on the whole, her arms were actually hanging rather weakly from her body, limp and as if disconnected at the joints. On the basis of that impression I then drew her attention to her shoulder blades and she reported not being able to feel them at all. When I then suggested she breathe into that part of her body

—my words were "into the place where her arms come from" —surprisingly, her sensations changed, she felt soft, weepy and very young.

When I asked her to allow some expression towards me from her arms, Clara's was a verbal expression. Her arms wanted to say to me: "Go away." I then asked her to connect to the soft place between her shoulder blades and allow an expression. The words that emerged were: "Come here."

Clara looked confused—for her, attending to conflicting messages within herself was an entirely unfamiliar experience. "It's confusing, isn't it? "I said. "Your body wants two opposite things. Which one are you going to go with?" We were now in unfamiliar territory, and Clara was invited to relinquish control and spontaneously explore the unpredictable domain of her body. I held my breath, waiting for her response. Could she do it? Could she trust me enough to follow my lead?

Clara drew a deep breath, sensing into her body. "Go away", she commanded. I took in her cold, harsh voice, her angry eyes; as I moved away, my heart sank. "She does not like me anymore", I found myself thinking. I drew further away, feeling rather miserable. "Stop", she said. There was some urgency in her voice and I felt my heart beating faster with hope: she does want me after all! I stopped and we looked at each other, assessing the situation.

In this moment, we were quite far apart; Clara's face was blank, not conveying any emotions. I felt hurt, rejected, scared, trying to hold on to that slither of hope which had been evoked when she said "stop". It was painful; I did not like being in that space. I was glad to have my turn. "Come here", I commanded. Clara moved towards me. "Stop," I barked almost immediately.

In the silence that followed I sensed a sinister, dark satisfaction rising within me: "I have the power now; I will show you what you get when you reject me! I am going to play with you!" I was shocked and upset to realise what I was experiencing. I noticed that I was so focused on myself and my reactions to her rejection that I was no longer really seeing Clara. I looked at her: surprisingly, she seemed relieved. She even smiled. "Perhaps it is easier on her", I thought to myself, "Now I am embodying the confusing rejecting-inviting mother, as well as the sadistically powerful father. Now she can be 'the Child'."

I felt the warmth coming back to my body. I was myself again and I looked at Clara. She looked noticeably younger. "Come here", she said. Her voice was pleading. Following the sensations in my body, I stepped towards her. I had a strong impulse to take her in my arms and hold her tight against my chest, but I stopped myself, wanting to give her the space to explore her own impulses in this charged moment. "Closer", her voice was almost pleading. I took a couple more steps. "Closer", she whispered. I drew closer; we were now standing very close to each other. I could see her face turning red as her breath grew rapid and shallow. She was obviously struggling. I could feel myself holding my breath, my head empty of all thoughts, my body tingling with the energetic charge of the moment.

"Closer", she was openly crying now, as I took her in my arms and held her, her body leaning against mine, her head resting on my shoulder. I felt a warm wave of love rising from my belly to my chest, warm love flowing through my arms, embracing me and her in a soft, motherly cocoon.

My body relaxed, but then... "Closer", I heard her whisper in my ear and my blood froze. More than the sexual fantasy darting through my mind, I felt invaded by fear. She wanted us to merge, to be one. I was about to disappear! Confusingly, it had a certain appeal at that moment, that forever unattainable image of total intimacy, yet it felt as if it was going to be the end of me: I was going to be sacrificed, to be swallowed whole into an amorphous "us" and disappear forever.

"This is what it feels like", I thought to myself. "This has been her internal reality all this time. She has no sense of where she ends and I begin. It is either this amorphous, merged 'us' she had with her father, or the confusing rejection-closeness she had with her mother. None of these was ever enough. She always wanted more, like her father who wanted more and more of her. That is what it feels like to be simultaneously enslaved by the longing for love and sacrificed on the altar of complete enmeshment. How can we find together another territory, another existence?"

"I cannot come any closer," I said softly to Clara, still holding her firmly in my arms. "This is where you end and I begin. This is you and this is me."

Clara turned to me, her face contorted. That was the moment when I was faced again with the statement I quoted at the beginning of this paper, as with rage and despair Clara said: "I want to get under your skin; I want to hold your heart in my hand; I want to be part of you so that you can never go anywhere without me!"

I felt the world stopping around me. Do you know those moments when you feel that this is THE moment you have been waiting for all your life? That everything is falling into place and everything now depends on the next move you take? I certainly felt that this was a moment that Clara's psyche had been waiting for for a long time and that everything depended on my next move. I closed my eyes and opened my heart. I connected to that realm in which Clara and I were one, where all beings are one, and nobody is really separated. I had an image of myself as a little bubble, floating inside the large vein of the Universe. Next to me was Clara, also a small bubble, floating happily by my side. We were holding hands, letting the steady rhythm of the universal bloodstream carry us who-knows-where; we did not need to know where. We were alive, surrounded by many more bubble-like people; we were all together in that same huge vein, and it felt good. It felt like the best place to be. I opened my eyes. Only a few seconds had passed. Clara's angry, despairing statement still echoed in the room.

"I don't want you to get under my skin," I said calmly. "I will not be able to love you then." Clara drew a deep breath. I continued: "You know what it's like when somebody gets under your skin and holds your heart in their hand. You've lived like that all your life. Is that really the love you want from me?" Clara was visibly moved and we stood there quietly for some time as she was searching for words.

"I don't know what kind of love I want. I don't know what love is. I don't even know who I am. Will you help me to find out?"

And so began the next stage of our journey, in which Clara was looking, for the first time, for herself.

Discussion of Vignette 2

I have described this session in some detail, as it illustrates some of the key dynamics and principles underlying my work with trauma survivors, especially in terms of addressing their sense of internal boundaries.

At the heart of my work lies the understanding that the child who was abused by her father cannot afford to let go of her attachment to him. Often, as in Clara's case, in families that breed abusive dynamics, the mother is a weak, submissive and child-like figure, who often has herself been physically abused and/or sadistically humiliated and degraded by the father. More often than not, that mother is aware of the abuse taking place, but is too afraid, weak or depressed to protect her daughter and therefore abandons her to the father's lawless power. The child, sensing her mother's betrayal, turns to the only other available parental figure—

the father—and identifies with him. In this way, she is attempting to keep her bond with him as well as rejecting her experience of herself as helpless and victimised. The identification with the abuser helps her feel empowered and as a consequence she develops a way of dealing with her feelings of vulnerability and terror based on projecting them onto others around her. Clara, whose identification with her charismatic father was encouraged by his narcissistic use of her, projected all her vulnerability onto her mother, her nannies and, later on, her daughter: all feminine figures whom she rejected. It is interesting to note that Lisa, Clara's daughter, continued the line of abuse, accepting her mother's unconsciously projected vulnerability, so taking on herself the role of the rejected weak female and protecting her mother's inflated power position. This was the only safe relational position Clara ever knew: *identifying with the abuser, the child further loses connection with a sense of her own Self.*

She exists as a sexual object, as a narcissistic mirror or as an extension of the omnipotent father. Her rage, terror and disgust are suppressed and often somatised (in Clara's case manifesting in her ulcer) or turned into self-harm. Her dependency on the abuser leads her to maintain their secret bond, for which she feels hugely responsible and guilty. Her internal sense of self, then, consists of being essentially bad, which exacerbates her fear of being abandoned. The contradicting impulses, on the one hand to reject the abuser in order to protect herself, and on the other to merge with him in order to secure the attachment bond, lead to a chaotic and uncontained inner reality in which the line between perpetrator and victim is blurred, and nothing ever feels safe or solid.

This conflict was the main driving force behind Clara's feelings towards me during that phase of her process I have outlined above. Having successfully projected her powerful, omnipotent father onto me, she re-enacted the enmeshment dynamic by wanting me to be like her, wanting her to be like me. Her suppressed dependency manifested at the beginning of our process in Clara's attempts to "bribe" me with money and fame as a way of securing her place in my life and as an attempt to re-create the "special" relationship she had had with her father. Once she felt secure and reassured by my commitment, her dependency went underground and was rejected by Clara. She then took the familiar role of the "good girl", being her daddy's pleasing object and became a "star client", doing her utmost to please me.

However, this relentless conflict had to be re-enacted between us, as it is the re-enactment within the safety of the therapeutic relationship that holds the potential for transformation (Heitzler, 2011).

Moreover, as our relationship matured and stabilised, the impulse to enmesh with me in order to re-find the lost sense of herself grew stronger, and with it, unavoidably, the other side of the conflict emerged: the underlying rage and fear, the need to reject and protest against the abusive father. All this was brewing under the surface for some time and it was our looming separation that intensified the unconscious dynamic until it erupted and captured us both, as I have just described.

In that session, Clara openly displayed her need to control and reject me, as well as her primal urge to get under my skin and become one with me, assembling together in an unconscious way the essential fragments of her blueprint for the experience of love. The shifts between too-rigid internal boundaries on the one hand and non-existent boundaries on the other were fully expressed in her whole bodymind. This, in my view, is an important therapeutic moment; it needs to happen so that the primal conflict can be fully experienced, addressed and held, in all its intensity, by and within the therapeutic dyad. What I think would be useful for us to think about is how that charged moment impacted me, the therapist, as inevitably I too felt that my internal boundaries got lost.

I have written elsewhere: "More than the insight into first-hand unconscious information, I see projective identification and re-enactment as a call to the therapist to experience, contain and hold self-parts that the client is not yet ready to integrate into consciousness." (Heitzler, 2011).

In losing myself and becoming the rejected child and then the sadistically powerful father, I gained a somatic, implicit understanding of Clara's inner dynamic, including a detailed embodied sense of the characters who inhabit her psyche, those parts of herself—or dissociated self-states—that constitute the fragmented, shifting torrents of her inner chaos.

Up until that moment, I had been able to think about and analyse the relational matrix, but it was through the dream I shared with you previously and through the feelings, sensations and images that took over my bodymind as Clara and I were grappling with her "come here—go away" urges, that I really "got" it. In that "here & now" instant, I gained a non-verbal understanding of what it was like to be Clara (what Lyons-Ruth (1998) calls 'implicit relational knowing', communicated subliminally and pre-reflexively body-to-body). It was at that significant moment of fear that I understood deeply just what it was that Clara had had to sacrifice on the altar of merging with her father: her own sense of herself as a living organism, defined by its boundaries.

As I survived within myself those moments of horror, that edge of disintegration, as I understood in my bones the primal dynamics invading Clara's psyche, I was able to hold and contain her in a way that had not been possible until then. From that place, I was able to really see her: to see her separateness AND to see our oneness. This then enabled me to address the past dynamic as it manifested in the present, and to say: "I don't want you to get under my skin; I will not be able to love you then."

I do believe that it was by stating my regained boundaries whilst expressing my commitment to her desperate need to be loved, that I allowed Clara to get in touch with the fragility of her own boundaries as well as with a new concept and feeling of love. This prompted her to wonder who she really was, what her sense of self was and to question her beliefs and assumptions about being loved.

Being a body psychotherapist, I am often asked about maintaining therapeutic boundaries whilst working with the body. "Don't you fear crossing the client's boundaries when you offer touch?" "What about the erotic dynamics—how do you hold the boundaries when you work with the client's body and yours?"

These are important questions which deserve thorough exploration. In this paper, however, I would like to think about working with the body to *create* boundaries, rather then endangering them. More than assuring safety, the "somatic sense of boundaries" (Ogden, 2006, p.226) serves as a container, providing the concrete, physical shell where the amorphous "self" can reside.

Often when we feel ungrounded, dissociated, shocked or over-tired we turn—without even thinking—to our bodies to regain a sense of reality and grounding: a sense of ourselves. We pinch ourselves, rub our eyes or arms, jump up and down or unconsciously stroke and hold ourselves. It is this felt sense of our physical existence that brings us back to reality and into direct contact with ourselves. Many people who have been traumatised have lost access to their body and with that have lost a sense of their physical container. Dissociating and fragmenting on a daily basis, they live in exile, dis-embodied, not able to find their way back home, to themselves.

Working with the physical boundaries of the body can re-establish and strengthen the felt sense of the container, leading to a newly gained connection and appreciation of the self. In my work with Clara, we focused on working with skin-boundaries (Rothschild, 2000, p.143)

muscle tensing (Rothschild, 2000, p.135) and visual boundaries (Rothschild, 2000, p.146).

Later on, as Clara's sense of self grew, we worked with interpersonal boundaries, and Clara was able to define her personal space by indicating her felt sense of distance and closeness to me. Our work at that stage was more physical than verbal and involved sensing subtle body sensations and mindfully following signs of expansion and contraction in the body. Within a few months, Clara was able to inhabit her body in a very new way, no longer as an object or tool of power to seduce and control others, but as a resource, an ally, a reliable guide on her journey towards herself.

Conclusion

When first coming to therapy, the traumatised person finds it impossible to convey to the therapist this multi-layered tormented reality. With most of it being unconscious and split off in an attempt by the organism to preserve its sanity, the conscious tip of the iceberg is often too shameful or vulnerable-making to express. Therefore, the main means of communication are non-verbal. Clients re-enact fragments of the abusive dynamic in the safety of the therapeutic environment in the unconscious hope that the therapist will get a visceral sense of their invaded, confusing inner reality (Heitzler, 2011).

As invasion of boundaries was at the core of the abusive relationship, the client will re-enact this dynamic by trying to invade the therapist's boundaries. More than aiming to demolish the external boundaries, it is the unconscious attack on the therapist's internal boundaries, her own sense of self, that forms the battleground in which the therapeutic dyad is struggling to bear and make sense of the madness of the incestuous entanglement.

As much as the external boundaries of the therapeutic frame need to be held and preserved—as an indispensable pre-condition for any process to take place—I believe that it is the work with the *internal* boundaries of therapist and client alike that determines the success or failure of the healing process. It is through the therapist's availability to the ebbs and flows, to the rupture-and-repair process of losing her internal boundaries and regaining them again, that she is able to step into the client's reality and embody new ways of surviving it.

Therapists who for their own reasons need to cling to the security of what they know and what is known, to their familiar defined sense of self, are unlikely to be sufficiently available for the requisite intensity of feelings of invasion, confusion and despair. They are, therefore, not available to be sufficiently affected by the trauma on those layers of the psyche that hold the keys to transformation. However, I do believe that for many of us who are fascinated by the mystery of the human psyche and committed to the exploration of its untamed terrains, the experience of disintegration is not a foreign one. If we allow ourselves to go to those edges in our own journey, to lose our own internal boundaries and regain them afresh, we then carry in our own bodies a felt sense of who we really are.

It was this capacity to lose and re-gain my sense of self that resourced me during the tests and trials in my work with Clara. This is what enabled me to become enmeshed, confused and lost, as I knew, in my own embodied being—that ultimately I would always be able to find my way home.

BIOGRAPHY

Morit Heitzler is an experienced therapist, supervisor and trainer with a private practice in Oxford, U.K. She offers both short- and long-term work with a wide range of clients from diverse backgrounds. Morit specialises in trauma work, and has developed her own integrative approach, incorporating—within an overall relational perspective—Somatic Trauma Therapy, Body Psychotherapy, attachment theory, sensori-motor, EMDR, modern neuroscience and Family Constellations.

In a wide range of contexts both in the UK and in Israel, including at the Traumatic Stress Service of the Maudsley Hospital, London, and at the Oxford Stress and Trauma Centre, Morit has gained a wealth of experience in working with traumatised clients, which include refugees and asylum seekers, suffering from a wide variety of PTSD symptoms.

She has been making a contribution to the profession by teaching on various training courses in the UK and in Israel and she regularly leads workshops and groups.

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Yoga Based Body Psychotherapy: A Yoga Based and Body Centered Approach to Counseling

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Abstract

This paper presents Yoga Based Body Psychotherapy, a five-stage approach to counseling high-functioning adult clients. This approach utilizes yoga postures and developmental movement patterning to assess, identify and support the processes of growth and change in clients by expanding their developmental edge. Yoga Based Body Psychotherapy pairs yoga principles called the Universal Principles of Alignment with the developmental movement pattern known as the Five Fundamental Actions, within a framework for counseling called the Interaction Cycle. The aim of this approach is twofold: to overtly bring yoga postures into the context of body psychotherapy to support further development of body-centered ways of counseling, and to afford a new lens for the practice of yoga postures by making their inherently therapeutic nature overt in the context of a psychotherapy session so that eliciting emotional material becomes a potentially viable content for healing, growth and change. A brief review of the literature covering yoga therapy, yoga in psychotherapy and yoga in body psychotherapy is offered with outlines of the Universal Principles of Alignment, the Five Fundamental Actions and the Interaction Cycle. Yoga Based Body Psychotherapy is then explicated and examples for application are provided. Further considerations exploring where this approach might go in the future and limitations conclude this paper.

Keywords: yoga, developmental movement, Five Fundamental Actions, Interaction Cycle, Universal Principles of Alignment

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This paper presents Yoga Based Body Psychotherapy, a pairing of yoga principles called the Universal Principles of Alignment (Friend, 2008), and a developmental movement sequence called the Five Fundamental Actions (Aposhyan, 1999). The aim of Yoga Based Body Psychotherapy is to support growth and change in clients using this pairing in combination with Susan Aposhyan's framework, known in body psychotherapy as the Interaction Cycle. Yoga Based Body Psychotherapy uses yoga postures paired with natural movement patterning to observe, identify, and support the process of change in psychotherapy. While yoga asana practice is not psychotherapy, it has been shown to be inherently therapeutic (Milligan, 2006). Yoga practiced as a routine over time seems to facilitate not only a physical adeptness, but also a mind-body connection in which awareness of one's subtle body and energetic movements is felt, fostered, and understood (Lohman, 1999). Similar to yoga practice, the Five Fundamental Actions as understood by Aposhyan may not be overtly psychotherapeutic but, when presented as stages of human development with an inherently therapeutic nature, may be considered

helpful to one's psychosocial- and spiritual growth. Yoga Based Body Psychotherapy makes the inherent process of emotional and psychological awareness encouraged in the practice of yoga overt within the context of the psychotherapeutic container by utilizing yoga postures paired with the psychotherapeutic support from the Five Fundamental Actions and the Interaction Cycle.

Body psychotherapies use a broad spectrum of movement-based and body-centered techniques to assess and treat psychological distress and support the process of change and transformation. The pairing of the organic movements of developmental life and the controlled movements of yoga postures inside the safety of the relationship of therapist and client provides a strong framework for holistic healing at the levels of body, mind and spirit.

The Five Fundamental Actions is a developmental motor sequence derived from studies of early motor development in humans and the evolutionary origins of movement. The sequence, Yield, Push, Reach, Grasp, Pull, demonstrates how human beings learn to engage with the world through giving and receiving in satisfying ways (Aposhyan, 1999). Aposhyan's work in this area is strongly influenced by Bonnie Bainbridge Cohen's work, which is known as Body Mind Centering. Aposhyan has further developed Body Mind Centering into a psychotherapeutic application with the Five Fundamental Actions in the Interaction Cycle (Aposhyan, 2004). The psychotherapeutic application of developmental movement patterning has also been pioneered by Ruella Frank, whose work, encapsulated in six fundamental movements, utilizes early motor patterning within the framework of Gestalt therapy as a form of body psychotherapy (Frank, 2001).

The Interaction Cycle is a psychotherapeutic exploration of the relationship of early motor patterning and an individual's relationship with what they want, the goals they are interested in developing in psychotherapy and in their lives. The Interaction Cycle contextualizes a client's progress in an individual psychotherapy session as well as the path of psychotherapeutic work over time. Four steps comprise the Interaction Cycle; Embodiment, Desire, Awareness and Feedback, and Process (Aposhyan, 2004). These four steps are similar to the progression of the Universal Principles of Alignment (Friend, 1998) in providing the sequence to construct a yoga posture, organize the progression of a yoga class and in how a yoga teacher might provide feedback or adjust a yoga posture. Yoga Based Body Psychotherapy pairs the Five Fundamental Actions with the Universal Principles of Alignment within the framework of the Interaction Cycle.

The practice of yoga postures known as Hatha Yoga is a physical discipline that creates friction and heat in the body and the mind through increasing awareness and physical capacity. Yoga is a Sanskrit term from the root "yuj" literally meaning "to yoke" or "to unite". Hatha means "to strike", as in striking a match. The practice of yoga postures literally creates union through friction as the muscles and bones work together and in opposing directions (Iyengar, 1989). B.K.S. Iyengar, one of the foremost practitioners, scholars and teachers of yoga who facilitated Hatha yoga's development in the west, describes yoga as "the union of the soul with the Universal Spirit". He goes on to say that despite this seemingly abstract notion, "the science of yoga helps us to keep the body as a temple…Yogic practices help to develop the body to the level of the vibrant mind, so that the body and the mind, having both become vibrant, are drawn towards the light of the soul" (Iyengar, 3). John Friend, who capitalized on principles of movement common to the understanding of yoga postures, and developed a succinct style of yoga known for its anatomical principles and emotional process, founded Anusara Yoga, a style of Hatha yoga (Friend, 1998).

Hatha yoga has historically focused on controlling and in many ways manipulating one's body and breath into shapes and forms based on energetic lines in the body (Walsh, 2007). Yoga as a discipline utilizes controlled movements, often restrictive in nature, to create the union or joining alluded to in its definition. Body psychotherapy supports natural organic movement by privileging the inherent intelligence of the body. Yoga derives its benefit in part from the client trying on the shape of the posture and receiving its benefits whereas, on the other hand, natural movement patterning derives its benefit from the process of the client experiencing their movement as it sequences through their body. Psychotherapy clients often come to therapy with impairment in their capacities to express themselves or experience their world. Therefore the intention of pairing yoga with the Five Fundamental Actions in the framework of body psychotherapy's Interaction Cycle is to offer the possibility that sequencing organic movement processes inside the structure and boundaries inherent in yoga postures may lead to a satisfying relationship with expression, motivation, giving and receiving. Natural movement sequencing may facilitate a sense of spontaneity, a natural expression, and a quality of freedom. Yoga postures can facilitate a sense of boundary and containment, supportive for exploring new relational and behavioral options safely. The practice of yoga in the psychotherapeutic context gives clients more intentional options to explore their body in motion and track how doing so affects their sense of self. The Interaction Cycle in combination with yoga postures also allows for the witnessing attention of the therapist, which supports the client's ability to eventually witness themselves and heal core emotional wounds, a phenomenon that does not occur overtly in yoga posture practice alone.

Yoga Therapy

Yoga Therapy is defined by the International Association of Yoga Therapists as "the process of empowering individuals to progress toward improved health and wellbeing through the application of the philosophy and practice of Yoga". This model asserts that Yoga stands on its own as a therapeutic modality for physical and psychological issues. Yoga Therapy uses yoga postures as well as the theory of Ayurveda, the science of yoga and subtle anatomy, to alleviate physical and psychological symptoms (Iyengar, 1989). The current literature on Yoga Therapy focuses on the use of yoga for physical and psychological conditions including back pain, heart disease, anxiety, depression, and eating disorders. In these cases, a protocol of yoga postures is often prescribed along with breathing techniques and meditation in combination with postures (Shapiro, 2007; Walsh, 2008; Vera, 2009). The idea is that an inclusive yoga practice will on its own be therapeutic and healing for the discomfort the client is experiencing.

Yoga in Psychotherapy

Yoga has a growing presence in the literature as a potentially viable intervention due to its capacity to increase mind-body awareness. In 1970, Fisher proposed that one's perception of their body strongly influenced their life (Fisher, 1970). Clance and Mitchell showed in 1980 that body awareness in children and positive body image were increased through yoga practice (Clance & Mitchel, 1980). A study in 2007 found that yoga has potential as a complimentary treatment for depressed patients taking anti-depressants (Shapiro, Cook, Davydov, Ottaviani, Luchter, & Abrams 2007). In 2008 a study by Fernros, Furhoff, and Wandell illustrated the benefits in overall health of mind-body therapies including body movement, breath therapy, guided imagery, and mindfulness meditation (Fernros, Furhoff, Wandell, 2008). These studies

seem to support the notion that yoga practice is indeed therapeutic. Turner and Turner in 2010 indicated that yoga practice is beneficial to mental health in its reduction of anxiety and depression via self-report measures, and indicated its effectiveness in easing anxiety and stress which in turn impact other mental and physical health problems (Turner & Turner, 2010).

Research also shows the benefits of yoga in creating an experience of mindfulness for both the clinician and the client (Davis, Daphne M. & Hayes, Jeffrey, A., 2011). Mindfulness as healing and therapeutic especially in combination with medical treatment and psychotherapy was made popular through the Mindfulness Meditation movement and Jon Kabat-Zinn (Kabat-Zinn, 1996). Currently there is research illustrating that yoga and meditation support practitioners in their own self-care regimens to avoid burnout and fatigue. Several studies point toward the benefits of psychotherapists' utilization of mindfulness-based stress reduction, yoga, and meditative disciplines to mitigate the stress impacts of being in the healthcare field (Shapiro, Astin, Bishop & Cordova, 2005; Bruce, Manber, Shapiro & Constantino, 2010; Davis & Hayes, 2010; Walsh & Shapiro, 2006; Christopher & Maris, 2010).

Yoga in Body Psychotherapy

Little research exists on the pairing of Hatha yoga practice and body psychotherapy specifically, perhaps because yoga is often considered to be its own body-centered technique. The literature on using yoga-based interventions in the context of psychotherapy primarily focuses on the application of Iyengar yoga, an alignment-oriented style of Hatha yoga (Brammer & Ingram, 2010; Monk, Elizabeth & Turner, Charlie, 2010; Khumar, Kaur & Kaur, 1993). One of the applied programs offered through Bonnie Bainbridge Cohen's School for Body-Mind Centering directly pairs yoga posture practice with the principles of Body-Mind Centering. In this approach, yoga practice as well as anatomy study are explored through the lens of "…how the body systems and developmental movement patterns support and initiate movement" (Bainbridge Cohen, 2008, p. 193). This approach does not designate itself as a psychotherapeutic application or intervention, but it does describe how to practice yoga postures in a gentle organic process supported by evolutionary movement and the systems of the body, rather than in the classical restrictive style.

Five Fundamental Actions

Susan Aposhyan explains in Body-Mind Psychotherapy (2004) that in order to have a satisfying relationship with need, want, expression, giving and receiving, one must develop a relationship with the Five Fundamental Actions: Yield, Push, Reach, Grasp, Pull. There are myriad ways these essential actions might become truncated, such as trauma, early attachment wounding, or life situations in which one learns maladaptive ways to meet their needs in the world. They are progressive, each action building upon the one before (Aposhyan, 1999). Each action has both a physical movement and a psychological quality that supports simultaneous growth of the physical capacity of the body and the social-emotional growth of the whole being.

Yield, the first action, refers to a dynamic pulsation in the body, a relaxed state without collapse. One is in contact with the ground that supports them as well as their internal, fluid state of wakefulness. Yield is full of engagement, marked by alertness and openness to receive impulses. Yield relaxes one's body and nervous system and is thought to be the state in which as a baby, one rested in the womb. Receiving support in a relaxed but alert way, with awareness, is the primary goal of Yield. (Aposhyan, 1999).

The second action, Push, organizes the muscles of the body toward movement and often reflects the client's orientation toward their motivating source. The action of the body is to press down into the ground, which rebounds as a counter-push rising up the spine, providing tone in the body. The muscles of the body create tone and support dynamic oscillation between the extremities and the core of the body. It is initiatory as well as organizing and provides the backdrop for going out and taking action in the world (Aposhyan, 1999).

Push makes the body toned, alert and strong enough for the third action, Reach. In Reach, one extends out toward a stimulus with the tone created from Push. Reach is about moving toward what one wants and acting on what one knows to be true. Reach extends from the core of the body out to the extremities (Aposhyan, 1990). It provides the capacity for one to extend oneself beyond one's personal kinesphere into one's interpersonal field where there is potential for interconnectedness.

Once Reach has extended thoroughly to grab hold of the stimulus, the fourth action, Grasp, follows. Grasp is the stage in which one takes hold of what one wants. This action facilitates one's capacity to hold onto and take in what one wants. This action requires one to grab hold of one's desired stimulus with their endpoints such as hands or feet. To Grasp is to risk engaging with the outside world and take the world in toward oneself. Through this action, one learns one can take hold of what one wants or needs (Aposhyan, 1990).

Grasp is followed by the action, Pull, in which the desired stimulus is pulled into one's personal kinesphere. Pull is how one's needs and desires ultimately get met with one's own effort. It helps to facilitate the dynamic relationship between self and the world outside as dynamic and co-participatory. Pull brings the outside world into one's personal world out of choice (Aposhyan, 1999). It is how one learns one is capable of getting what one wants with effort, strength, and will power.

Interaction Cycle

The Interaction Cycle is "a four-step cycle that joins both clients' and therapists' awareness of how clients' developmental processes are manifesting in the clients' bodies at a particular moment" (Aposhyan, 2004, p. 86). The four steps of the Interaction Cycle are Embodiment, Desire, Awareness and Feedback, and Process. The psychotherapeutic focus of the Interaction Cycle is a client's developmental edge, which Aposhyan explains as "the border between our strengths and our challenges…identified as a place in the body, or more behaviorally as the limit of our current abilities, or as the distinction between behaviors that are mastered and behaviors that are untried" (Aposhyan, 2004, p. 86). The experience of the developmental edge happens quite naturally in the practice of yoga postures. The shapes of the postures lend themselves to understanding one's physical limits and boundaries. They challenge one's bodily range of motion and flexibility and highlight growing edges in internal and external movement awareness and boundaries. The Interaction Cycle in combination with the Five Fundamental Actions explores a client's developmental edge by asking questions around motivation, desire, giving and receiving in the world. "What does the client want? How and where is she or he motivated? What is alive?" (2004, 1999, 87-8).

The first step, Embodiment, focuses on therapists' grounded relationship to themselves as cultivated through self-awareness and presence. The fullness of the therapists' aliveness and presence creates the ground for spontaneity and creativity in the session. It is the root of a healing psychotherapeutic environment. A steady yoga practice, as the literature mentioned above illustrates, facilitates the therapist's Embodiment. The client focuses on increasing awareness within the session by noticing and identifying sensations or taking deep breaths (Aposhyan, 2004). This kind of centering in awareness may look similar to the beginning of a yoga session.

The second step, Desire, focuses on understanding the client's wants and motivations. When a client identifies his/her desire, he/she accesses understanding of his/her Developmental Edge. As a client builds his/her sense of embodiment, he/she learns where he/she is in space and in reference to him/herself. As he/she understands his/her desire or motivation, he/she begins to understand his/her relationship to that desire. Aposhyan notes that when a client identifies his/her desire and motivation, his/her vulnerability increases as he/she comes to see how realistic it is, or how long it has been buried inside him/her, or the reasons around what is limiting him/her (Aposhyan, 2004).

The third step, Awareness and Feedback, focuses on making the client's identified desire into a bodily-understood reality. The interventions used to explore where and how desire appears in the body or moves within the body are broad. Feedback is offered in Awareness and Feedback by the therapist as an open-ended question, a focused question, within a menu of options, through being descriptive, or by offering an interpretation (Aposhyan, 2004). This kind of feedback can be utilized not only for organic natural movement sequences but also for the practice of yoga postures in session. Yoga Based Body Psychotherapy contributes yoga postures specific to each action and step to fully explore how a certain desire feels in one's body by practicing a posture that illuminates the developing edge. This may offer understanding of where a client is in relationship to his/her desire and his/her developmental edge at a somatic level.

The fourth step, Process, asks the client to stay with the awareness and sensations of his/her physical and emotional process with the help of the therapist. The client is supported by gentle structure from the therapist in guiding his/her emerging experience. The therapist supports the movement in the client's body to express fully through his/her endpoints, mouth, hands, heart, pelvis and feet, so that a complete sequence of movement is experienced. This is facilitated through gentle feedback and suggestions as the client moves (Aposhyan, 2004). In so doing, the client meets his/her Developmental Edge, where patterned ways of moving expand toward a new range of motion and emotion, physiologically and psychologically.

Universal Principles of Alignment

The Universal Principles of Alignment (Friend, 2008), encapsulated in Anusara Yoga have deep roots in Iyengar yoga. Each of these principles has a physical expression as an action in the body that helps to organize both the outer construction of each yoga posture as well as create a psychological or emotional effect inside the body and experience of the yoga posture (Friend, 2008). The Universal Principles of Alignment act much like the Five Fundamental Actions in that they are a developmental sequence of movement patterns. They are: Open to Grace, Muscle Energy, Inner Spiral, Outer Spiral, and Organic Energy.

As a result of being in physical bodies, Anusara principles posit, human beings arrive in their bodies and minds already contracted, or prohibited in movement and self-awareness. In addition, it is assumed that one may have already experienced trauma that hinders not only the actual movement required of yoga postures, but the capacity to fully experience one's life. The universal Principles of Alignment, then, are designed to support liberation, integration,

transformation and experience of living into one's fullest potential. Toward that goal, Open to Grace is the first stage of opening and grounding. During Open To Grace, one softens one's skin, feels the weight of one's bones and releases tension in one's musculoskeletal system (Friend, 2008). This is intended to be physically settling and deactivating for the nervous system. It creates a space in which to practice yoga that is open yet alert and welcoming of possibility, change and growth. Open to Grace is about receiving, being and allowing for support as a human being in the world. It shows up as the quality with which one is present, felt energetically as well as seen visibly in the one's posture when there is ease and comfort emanating from it.

Muscle Energy is the second stage, centered on gathering strength and power physically, energetically and emotionally. From the rooted, grounded and open place of Open to Grace comes steady muscle power that creates the organization toward action in the body. Muscle Energy gives power and purpose not only to the muscles and bones but also to one's mind and emotions (Friend, 2008). Feelings of an internal locus of control are increased as one literally engages oneself into action to produce a result. Self-chosen action yields the psychological benefit of willpower, purpose and strength. One's body literally becomes stronger and more integrated as one's muscles engage and pull in from one's endpoints to one's core. The stability of the bones and muscles afford a sense of containment and inner stability for the mind and emotions.

The third stage, Inner Spiral, widens the body from the center outward. It begins at the feet and rises up the legs and torso, expanding the width of the body in a side-to-side broadening action (Friend, 2008). Inner Spiral moves one's thighs backwards and turns one's inner thighs slightly inward and wide to counteract the very common over-external leg rotation that human beings develop by walking. Inner Spiral creates a sense of deepening, a sense of accommodation, a sense of width and breadth from the inside out. The rooting of the thighs backward into one's body facilitates the alignment of the psoas muscles as well, which tends to calm the nervous system (Friend, 2008). There is also a sense of receptivity, sensuality and access to creativity associated with this phase. Inner Spiral is connected to both one's creative nature in the world and learning how to accommodate oneself and others.

The fourth stage, Outer Spiral, energetically moves from one's waistline down the body to one's feet, countering and complimenting Inner Spiral. The waistline contracts, the lower belly lifts, the tailbone lengthens, and a tone to the curve in the spine is created (Friend, 2008). The energy of one's body is directed down and out as one's whole body tones, preparing for outward directionality or extension. Outer Spiral increases one's sense of purpose and determination, facilitates willpower and supports decision-making. It allows one to root not only into the power of one's own effort, but into one's own knowing—into one's desires and unique ways of being. Outer Spiral sets the stage for differentiating and becoming oneself in the world.

Organic Energy is the final Universal Principle of Alignment. The bones of one's body extend fully in dynamic balance from the core out through peripheral extremities and endpoints such as the hands, feet, head and tailbone (Friend, 2008). Organic Energy fosters a sense of being oneself in the world without pretense or apology. Organic Energy is intended to be a satisfying completion to the yoga posture, as well as to afford awareness and the opportunity for one to make an offering from oneself out into one's world. Outer Spiral turns the yoga posture into an emanation—a non-verbal gesture of internal experience.

Yoga Based Body Psychotherapy

Yoga Based Body Psychotherapy utilizes a series of five stages, *Sense, Initiate, Form, Experience* and *Receive,* conceptualized within the broad framework of the Interaction Cycle. Although these stages fit together sequentially and can resolve in the course of one session, each stage may also be practiced individually. A therapist may spend entire sessions in one stage, and the arc of therapy may also be viewed as following the sequence over time.

Sense

Sense centralizes on active receptivity within both client and therapist. This stage combines Open to Grace and Yielding in the context of a psychotherapy session that utilizes yoga. Much like the step of Embodiment, *Sense* is the initial stage of a session, of assessment, and of any intervention and of the arc of therapy. The therapist is first highly spacious in order to receive the client and is open to the experience of both the client and themselves. In *Sense*, the therapist helps the client ground by being present in his or her own body. *Sense* is not only the stage in which the client and therapist attune to one another; it is the stage in which clients first attune to themselves. The client is encouraged in *Sense* to feel his/her skin and notice his/her breathing, allowing him/herself to arrive in his/her body. This is similar to the beginning of most yoga sessions as well as the first moment in which a yoga posture is practiced.

Initiate

The second stage, *Initiate*, further supports embodiment and creates containment in the therapeutic relationship, the therapy session, and in the client. *Initiate* joins Muscle Energy and Push and is the way in which a client's body orients to engage his/her muscles and bones to make the shape of a yoga posture. *Initiate* is felt in the body through cultivating proper tone of the muscles. Ideally the muscles are toned, not too tight, not too loose, in order to support the body to create specific actions needed to do the yoga postures and basic actions. *Initiate* also sets a sense of boundaries between therapist and client, which cultivates a safe and productive therapeutic relationship. This stage is the preparatory place for a client to begin exploring his/her wants and motivations, like with the step of Desire. *Initiate* introduces the notion of developmental edge. It is the place and space in which a client begins to see where he/she is inside him/herself and what he/she wants in relationship to his/her world.

Form

The third stage, *Form*, combines Inner Spiral and Reach within the context of deciphering the client's Desire. This stage marks where the therapist gathers information from the client as the session progresses. In essence, the therapist reaches toward the client, while the client reaches into himself or herself. As experience is shared, emotions may begin to expand. It is here that potential core material might be accessed as the foundation of grounding and safe boundaries have already been set. In this way, there is a reaching or stretching into experience and emotion as well as an extension into the therapeutic relationship.

Experience

The fourth stage, *Experience*, pairs Outer Spiral and Grasp in the context of Awareness and Feedback. A decisive quality characterizes *Experience* in which the client and therapist co-participate in defining viable content, goals and motivations for therapeutic work. The session

has a certain momentum and the therapist and client are in co-creation. In the body, *Experience* is a toning and integrating of the body much like *Initiate*, except now with a greater directional quality of either outward or inward direction through the endpoints (mouth, hands, heart, pelvis, feet) of the client's body. This helps to root the tailbone toward empowered action when doing a yoga posture or basic action. *Experience* supports resting into a yoga posture and the immediate experience. This stage tests the client's capacity to stay with what is happening, to stay with the posture, to collect new information regarding the immediate experience and to navigate the developmental edge. A focused attention on delineating experience, clarifying experience, and working through experience is present in this stage.

Receive

The fifth stage, *Receive*, pairs Organic Energy and Pull inside the framework of Process. Like the Process step of the Interaction Cycle, *Receive* in Yoga Based Body Psychotherapy focuses on the integration of psychotherapeutic material, experience, and awareness. *Receive* denotes how the awareness and witness of the client supports their own insight. This awareness can come via feedback from the therapist, or through the client's experience of their own practice of yoga postures and basic actions. The equal giving and receiving of dynamic action in a yoga posture mirrors the dynamic understanding of oneself in relationship to self and other. The sustained effort required in a yoga posture helps a client learn how to stay in his/her emotional experience. Integration and insight are often visible in a yoga posture when the posture itself becomes a kind of offering, infused with the client's emotional content.

Application

The following application includes brief case examples with general themes and clinical issues tending to occur in high-functioning adult clients. Specific yoga postures are outlined for use with these clients in each stage of Yoga Based Body Psychotherapy and their relationship to the Interaction Cycle as a psychotherapeutic approach.

Sense

Deepening one's embodiment is the ground from which desire and motivation can be felt, identified and understood—this is the main psychotherapeutic theme of *Sense*. This stage asks, "Can I settle into this moment? How do I feel in this moment?" As the literature of mindfulness indicates, grounding and embodiment techniques are therapeutic and support the context of psychotherapy. *Sense* is the ultimate example of Yield as it stands in the Five Fundamental Actions as both client and therapist feel the present moment inside themselves and between each other. This is how the session itself begins to develop its embodiment.

Sense can be practiced in both active and passive postures. *"Xavier appeared more passive in his stance with a dominant parasympathetic nervous system response. I practiced Sense in a mobilized active way with Xavier to help him learn that Sense is not a collapse or abdication of the inner or outer structures of their body. Rather, a dynamic aliveness inside yields receptiveness and wakefulness outside. Using dynamic standing postures including lunges and symmetrical standing poses seemed to provide an understanding of* Sense *as active."* These poses require the client to practice staying present and engaged in their body and yet relaxed and easeful in their feet. *"Yamit appeared rigid and in her sympathetic nervous system. I utilized postures requiring settling in a passive manner to afford health. Supine postures requiring Yamit's legs to be active granted understanding of softening into the support of the ground."* Without this kind of grounding and support, the client may be too loose in his/her body to create strong activation of the muscles or over- grip when they engage their muscles.

Initiate

Initiate asks, "Where am I in relation to myself and to others?" *Initiate* is the beginning of identifying the client's desire as it helps cultivate the container for him/her to safely identify and work toward what motivates them. Practicing Muscle Energy and Push through yoga postures as a means to identify self and self in relationship to other affords a greater embodied understanding of boundaries and begins to delineate developmental edge at its most basic source. This physically creates the container for knowing clearly what the client desires.

When working with high-functioning adults, one of the key goals in therapy often is exploring their Developmental Edge regarding differentiation. Clients working on this goal are often learning how to have productive and positive relationships with both self and other. The high-functioning adult client can ascertain the right amount of engagement in their body necessary for a yoga posture by engaging Muscle Energy or practicing the basic action Push. This can cultivate the understanding of how much engagement they might need in relationship. *"Alan has a tendency to fuse with others. I used asymmetrical standing postures to support an understanding of the muscular engagement and self-assertion needed in different degrees. In these postures Alan's legs work together, but not in the same amount. Thus the complexity of action mirrors the holding of multiple perspectives in life. Alan also has difficulty engaging his muscles and pushing through his legs, as observed in his postures thus far. I utilized single-leg balancing postures to build strength, and asymmetrical standing poses to foster how he could potentially engage himself. I found progress in Alan's process of differentiation and cultivation of sense of self in practicing these postures."*

Form

Form asks, "What do I want and how am I in relationship to it?" Here the client clearly identifies his/her desire or motivation and begins to understand his/her developmental edge in relationship to that desire. In the high-functioning adult working on relationships, the client may want a healthier relationship with his/her partner. The use of yoga postures in *Form* are intended to help the client embody the identification of his/her desire by helping him/her open the body from the inside out and construct the yoga posture into its basic form. *"I supported Beth in doing her yoga postures with openness in order to facilitate the realization of the depth of fusion Beth has with her partner. Beth reported that her relationship to her yoga postures is similar to the way she relates to her partner."*

Postures where the client's legs are wide and their hips can move freely allow natural opening in the pelvis and legs and are relatively simple in construction. Wide-legged symmetrical standing postures and wide-legged seated postures require the maintenance of this kind of opening. These postures also require actions similar to Inner Spiral in which their thighs are moving back and wide, their low back is deepening into its curve and their waist line is expanding laterally as well as moving backward. This expansion is similar to Reach and can broaden a client's awareness and surface emotional content. Widening the back of the body, such as in forward bends, can lend an understanding similar to Reach in which the client is extending out from his/her center into his/her world. Inviting clients to practice this quality of reaching from the inside out to extend themselves is beneficial not only for stretching their body in the yoga posture; it yields the capacity to access *Form* in life, which may be as simple as allowing themselves to have a desire at all.

Experience

This stage asks, "Where am I in relationship to my desire?" Postures accessing movement of the client's tailbone facilitate *Experience* and teaching a client to stand up for what it is that motivates him/her even when challenged by the outer shape of a posture or life. As the client executes a posture, he/she comes to find how close or far away he/she is from his/her desire or goal.

Often in back bending, for example, if the tailbone is not extended down toward the feet, the lower back will compress and cause pain, serving as immediate feedback that there is misalignment. Rooting through one's tailbone in an active and decisive way cultivates inner strength, presence, and sense of self. *"Wendy has little self-identity. I have observed Wendy do her backbends in such a way that her low back is exploited in over flexibility and accommodation. I find this similar to an underdeveloped Grasp in the Five Fundamental Actions. We worked on developing appropriate tailbone action so the backbends became an expression and experience of Wendy's sense of self rather than an abandonment of herself. This seemed to teach Wendy that she can be in relationship to self and other simultaneously."* The backbends also open the heart region, often stimulating emotional release as well as bringing up fear, which is similar to the emotional component inherent in Grasp and Outer Spiral.

Receiving

Receive asks, "Can I be fully in relationship with my desire? Can my desire be met?" The way a posture is executed increases or decreases the capacity of *Receive* both in a yoga pose and in life. *Receive* is increased when attention is brought to the endpoints of hands, fingers, feet, toes, mouth and pelvis. It is where the developmental edge is tested and expanded. The discomfort it takes to hold a posture is the discomfort it takes to stretch into new kinds of movement patterns in one's body and new ways of being in relationship in the world. Coaching a client to do a yoga posture and point his/her fingers in a clear line from shoulder, through arm, to wrist, and out supports extending more energy through the arm and creates an opportunity for the expression of energy to move in a way that is more satisfying and fluid.

With high-functioning adults, it may be that in sustaining the posture they come to realize how vital their needs in relationship to their partner actually are. *" I observed Carry's hands and feet limp as she extends her arms and legs in her postures. I wondered if this could indicate a lack of fully sequenced embodiment in Carry's identified desire within therapy. This seems to be her developmental edge. I invited Carry to explore extending and expressing herself fully through her endpoints in her postures. This appeared to engage the rest of her limbs more fully. I observed movement and Carry's emotion fully sequence through her whole system."* This kind of full extension and expression potentially create radical change in how the client experiences him/herself in relationship to his/her desire to be in a healthy relationship. The client is essentially expanding his/her developmental edge, just like Organic Energy offers the final expression of a yoga posture. *Receive* has an energetic quality of satisfaction found in Pull and in Organic energy that can be noted in the full expression of hands and feet, fingers and toes and the quality of the expression on the client's face. The full completion of this stage moves right back into another wave of *Sense*—whether it is in another yoga posture, or another session altogether.

Further Considerations and Limitations

Yoga Based Body Psychotherapy is simple in its following of a developmental order like natural movement pattering, and is complex in that the therapist must learn which yoga

postures lend themselves to particular stages. In this way the clinician requires training in both body psychotherapy and yoga. This kind of training may not necessarily require the same skills needed for one to teach yoga. A skill set including the appropriateness of various yoga poses as applied to the understanding of natural movement patterning is necessary. The clinician should also be able to assess movement patterns by observing a client move in yoga postures as well as be able to articulate feedback.

The application provided in this paper is based on the high-functioning client. This is not to say Yoga Based Body Psychotherapy is inappropriate for clients in extreme states such as psychosis, experiencing active symptoms of post-traumatic stress disorder, or severe characteroligcal issues. However, the method might look different in that it would most likely move more slowly over the course of therapy.

The movements required to execute yoga postures will perhaps easily activate clients with severe trauma. Thus the majority of time will most likely be spent in the earlier phases of the sequence. Touch may also be challenging for some of these clients, meaning that verbal feedback would be the primary mirroring capacity for the therapist to offer the client. Furthermore, Yoga Based Body Psychotherapy is somewhat dependent on the capacity for the individual client to grow in his/her witness capacity. There may be other methods of psychotherapy that involve mindfulness techniques better-suited to facilitating the growth of a healthy witness function in clients experiencing extreme states.

Conclusion

The teachings and practice of Hatha yoga, though ancient in many ways, in their modern configuration play a significant role in the development of mind-body holism and understanding. Similarly, body psychotherapy is pioneering new concepts and interventions for the assessment and treatment of psychological distress. There is ample opportunity in the marriage of natural movement patterning as understood by body psychotherapy and Hatha yoga practice as understood by skilled teachers and scholars to support change and transformation. The pairing within the psychotherapeutic approach of the Interaction Cycle invites more organicity into the highly structured nature of yoga practice so that it can be in service to healing psychological distress in an authentic, natural way. Introducing yoga postures overtly into the psychotherapeutic context provides body psychotherapy with another mode of movement analysis and structural intervention to explore with clients, thus broadening the scope of the field. This paper is part of a rich and growing conversation in which both yoga and body psychotherapy are contributing to and expanding the ways we conceptualize health and disease in modern times.

BIOGRAPHY

Livia Shapiro is graduating from Naropa University in May of 2013 with a master's degree in Somatic Counseling Psychology. She has extensive training in Hatha Yoga and has been teaching yoga since 2004. She works primarily teaching yoga and providing educational programs for yoga teachers about important elements of body psychotherapy to improve their teaching skills and support their continual emerging processes. Christine Caldwell and Leah D'Abate from Naropa University supported the writing of this paper.
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Expanding the Dialogue: Exploring Contributions from Energy Medicine

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Abstract

This paper presents a model and concepts from energy medicine and explores their relevance to body psychotherapy. The multidimensional model, a key model in energy medicine, is used as a starting point. Focusing on five principles of the etheric body—the power supply, the replica effect, the blueprint effect, the interface effect, and the internal senses--areas of overlap and application to body psychotherapy are discussed.

Keywords: energy medicine, multidimensional model, subtle energy bodies, homeodynamics, etheric body

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According to Einstein's famous formula, $E=MC^2$, energy and matter are interchangeable, different forms of the same thing. Matter can be converted into energy and energy into matter. Indeed, when physicists probed deeply into matter to find what we are made of, they discovered that matter is not solid. It consists of subatomic particles that are comprised of mostly empty space. In turn, when they looked into the "empty space", physicists determined that it was not so empty after all. It was teeming, effervescing with energy, a quantum froth. This energy is omnipresent in everything that is in existence--including us.

Energy is the common denominator uniting all aspects of life. As such, it holds potential for creating a unified bridge from the spiritual and scientific to the physical and pragmatic. In his rigorous contributions toward establishing a new paradigm of energy medicine, Oschman stated, "All medicine is energy medicine" (2003, p. 14). Along these lines I would say that all psychotherapy is energy work. Body psychotherapy, in particular, reflects this. From foundations grounded in Reich's work with orgone energy (1942/1973, 1948/1973), to Lowen's Bioenergetics (1975) and Pierrakos' Core Energetics (1990), with others in between, the thread of human energy can be found woven into the fabric of body psychotherapy.

This paper introduces a model and key concepts from energy medicine that I believe may contribute to body psychotherapy and enhance the interface between the two. Since energy work in general tends to conjure up images of "healers" waving their hands over people's bodies, I want to mention that, as an energy medicine clinician with a background in somatics, I am primarily concerned with practical applications of energy medicine that empower clients through self-awareness, education and self-responsibility.

The Multidimensional Model

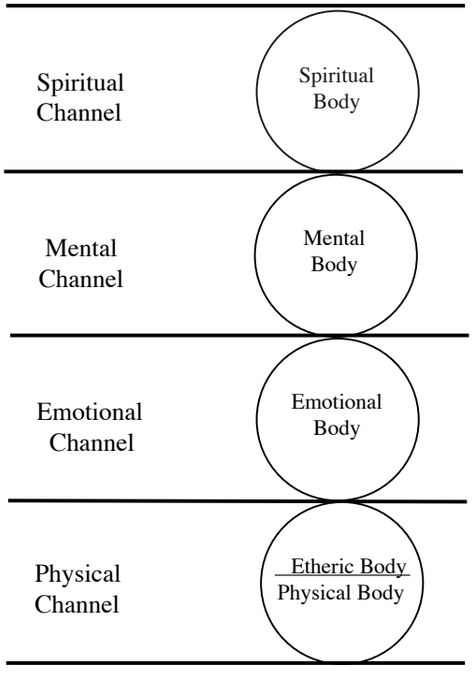
Energy-based models of human functioning that recognize various dimensions of reality have been around for thousands of years in Eastern philosophies. They hold that humans occupy multiple planes of existence simultaneously and that upon these planes are formed our vehicles of experience, our energy bodies (Bailey, 1922, 1951, 1953/1971; Jurriaanse, 1978/1985; Leadbeater, 1902/1969; Saraydarian, 1981; Yogananda, 1946/1998). According to these multidimensional models, energy is primary. Our thoughts, emotions and actions do not originate in the brain or elsewhere in our physicality; instead they originate at the level of energy and consciousness and play out through our physicality. Our energy bodies constitute the "equipment" through which we experience the various dimensions of reality, while consciousness is the mediator that holds the bodies and our experiences together.

This ageless understanding of the human energy constitution is gaining scientific legitimacy (Oschman, 2000, 2003; Rubik, 2002; Swanson, 2010; Tiller, 1997; Tiller, Dibble & Fandel, 2005; Tiller, 2007). Tiller's contributions in particular are significant because of his background in conventional science and due to the depth and breadth of his contributions to energy medicine. After 34 years in academia, he is professor emeritus at Stanford University and former chair of the materials science department. Tiller's stated mission is to build a reliable bridge that seamlessly joins conventional science with the various subtle domains of inner reality and the domain of spirit (Tiller, 2013). Through his approach, called *psychoenergetic science*, he has made significant strides in revealing how human consciousness interacts with physical reality.

Rich in heuristic value, Tiller's multidimensional model was used by Richard Gerber, M.D., in his seminal contribution, *Vibrational Medicine* (1988/1996; 2000). Meticulously researched and backed by the science of the day, the book essentially comprised the first energy medicine textbook of its kind. Charles Krebs, Ph.D., (1998) also used the model in his groundbreaking work on energy kinesiology, and I made use of the model in my recent book on energy health (Greene, 2009). When referring to the multidimensional model for the purposes of this paper I am drawing from the work of the aforementioned authors unless otherwise indicated.

Subtle Energy Bodies

According to the multidimensional model the human being consists of a spectrum of energy frequencies. Early depictions of the model describe seven dimensions, however, following Tiller's lead (Tiller, 1997), I condense these to four: the physical/etheric, emotional, mental, and spiritual. These four planes of existence comprise distinct yet overlapping frequency domains, or channels of experience, upon which the layers of our being—our four main energy bodies—are formed.



The four major channels of experience, also sometimes called the *planes of existence*, and the four main energy bodies that are formed upon those channels.

The energy bodies range from low to high frequency, with the physical/etheric body at the lower end of the continuum and the spiritual body at the higher end. Although such designations may seem hierarchical, these terms are merely used to describe positions, such as high C and low C on a musical scale. They are not meant as a valued hierarchy and do not indicate that higher is more valuable than lower. The gradations in between the physical/etheric and spiritual bodies consist of the emotional and mental bodies respectively. The emotional body is responsible for our emotions and feelings while the domain of the mental body is thought and cognition. The spiritual body, which is the highest or fastest frequency, allows us to have spiritual experiences. We humans occupy these multiple planes of existence simultaneously, making us wonderfully complex.

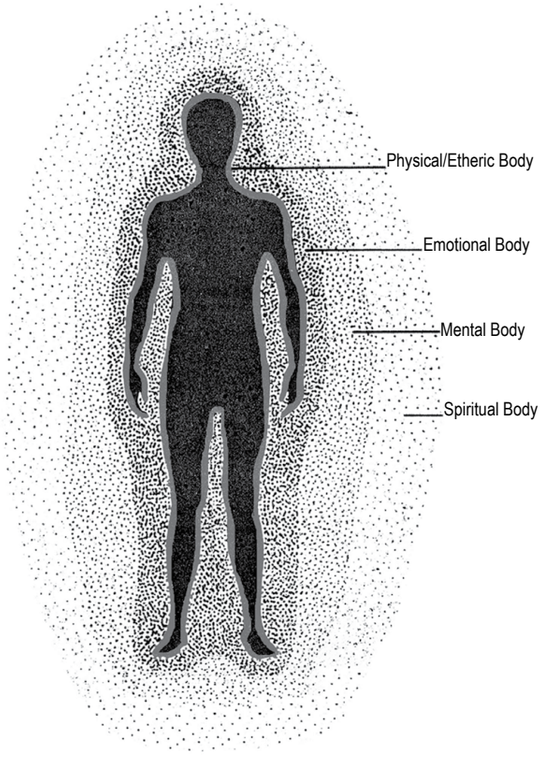
According to the model, our inner, subjective states determine our overall health and interactions; the outer physical body reflects our inner thoughts and emotions. When our multidimensional system is aligned and coherent we experience radiant health and are able to live our lives to the fullest. When any aspect of our system is out of balance, the entire system is affected, as is the quality of life in general.

The slowest or lowest frequency domain of the human energy constitution is the physical plane and we occupy this channel of experience by virtue of the fact that we have a physical body. Bones, organs, tissues, blood, glands, nervous system and brain, all fall within the purview of the physical body. But the physical body needs a power supply in order to function. It needs a life-force to animate it or else it is nothing but a corpse. In energy medicine this energy body is called by various names, i.e., the vital body, the biofield, the conjugate physical. For the purposes of this paper I use the term etheric body.

According to the model, the physical body and the etheric body are understood as inseparably woven together, as two sides of the same coin, when dealing with a living person. Thus, the physical/etheric is typically referred to as one body instead of two. Without the etheric body the physical body is a cadaver. The fact that Western medical science developed primarily through the study of cadavers helps explain how the etheric body got missed in conventional Western medicine (Greene, 2009).

The etheric body is the inner substantial form, the invisible scaffolding, upon which the physical body is built (Lansdowne, 1986; Leadbeater 1927/1997; Powell, 1925/1997; Tansely, 1972). It consists of a vitality-rich energy that goes by several names, *chi* in China, *ki* in Japan, *prana* in India, or *mana* in Hawaii (Greene, 2009; Rubik, 2002). The ancients knew this energy well and developed their practices accordingly. The martial arts from a variety of cultures are based on this energy, as are the healing systems of Traditional Chinese Medicine, acupuncture, Ayurveda, Tibetan medicine, and kahuna healing, to name a few.

The human energy constitution with four layers: the physical/etheric, emotional, mental, and universal bodies.



Homeodynamics

The multidimensional model recognizes the homeodynamic nature of human beings. This refers to our capacity to creatively respond to stressors by developing new progressive modes of functioning (Rubik, 2002). The concept of homeodynamics came out of contemporary sciences of complexity including open systems theory, self-organization, and chaos theory. Whereas homeostasis is based on classical physics and advocates a single or ultimate balance point, homeodynamics is based on modern biophysics and recognizes nonlinear dynamics of self-organization through strange attractors, nonlocality, and countless information flows (Rubik, 2002).

The term was coined by Yates (1994), a physiologist and biomedical engineer, and was first applied to energy medicine by Rubik (2002). In contrast to homeostasis, homeodynamics "emphasizes the ever-adjusting nature of the processes that maintain life functions. Once a new stressor is encountered, the organism never returns to its previous dynamic state, but establishes a new dynamic balance appropriate to this newly integrated experience" (p. 707). It appears humans are on an evolutionary path that includes the capacity to continuously recalibrate to higher levels of functioning. In homeodynamics, the organism integrates a massive number of information signals and life processes on multiple levels across various time scales to create dynamic stability.

The etheric body may act as a regulator of the important, complex functions involved in homeodynamics (Rubik, 2002). The etheric body is a foundational component of energy medicine that is gaining scientific legitimacy. As such, understanding this body from the perspective of energy medicine can broaden and deepen our understanding of energy dynamics in body psychotherapy.

The Etheric Body

The etheric body¬–and the physical/etheric plane that it occupies—are reminiscent of Reich's descriptions of the orgone and orgone energy. However, a complete science of energy anatomy is found in health systems from cultures that have devoted thousands of years to studying and working directly with these energies. It is beyond the scope of this paper to describe the etheric body in any detail. Suffice it to say that the discoveries of long ago, upon which entire successful medical systems were built, are being increasingly validated by Western scientific methods. Although medical professionals in the U.S. have been resistant to recognizing the etheric body, mainstream culture has embraced its ancient methods. We don't have to look far today to see the popularity of yoga, acupuncture, meditation, and the martial arts. Many of these practices emerged from cultures dedicated to complex and systematic study of the etheric body. When combining their contributions a comprehensive and detailed picture of human energy anatomy is formed.

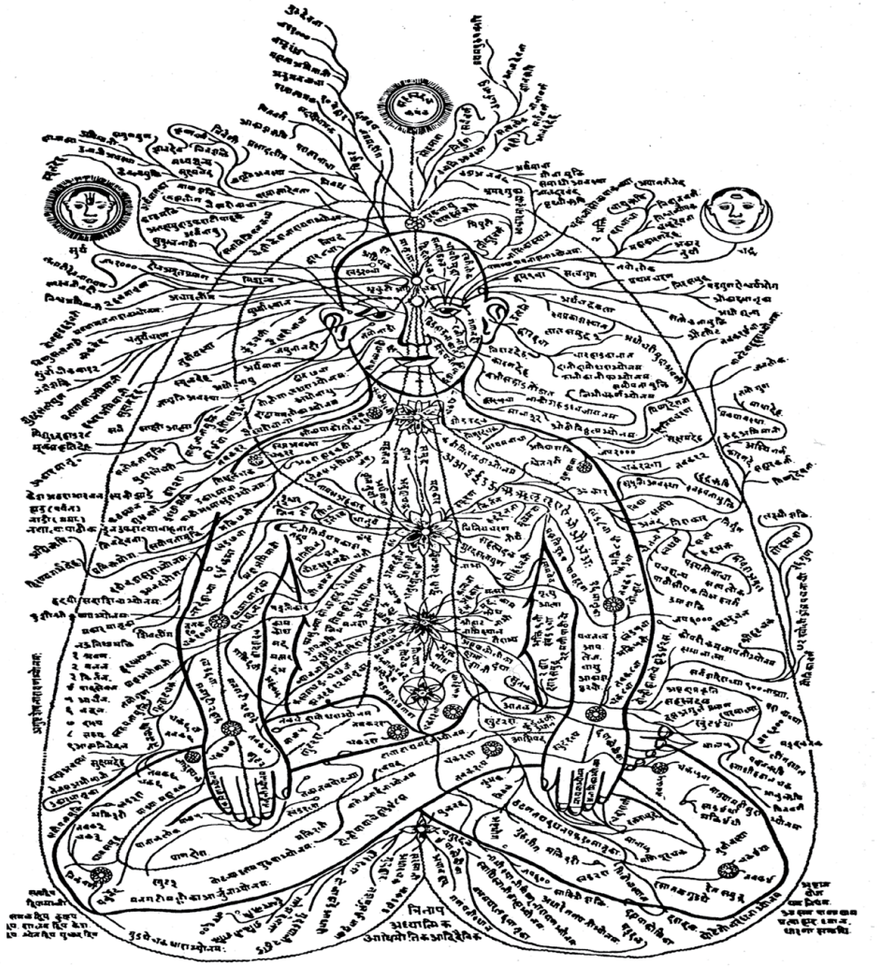


Chart depicting the human energy system circa 19th Century Tibet (attributed to the prophet Ratnasara).

Five principles that I believe have relevance to body psychotherapy govern the etheric body: the power supply, the interface effect, the replica effect, the blueprint effect, and the internal senses. Let's look at these one at a time.

The Power Supply

The etheric body is the power supply for the physical body (Lansdowne, 1986; Leadbeater, 1927/1997; Powell, 1925/1997). Without it, the physical body would be limp and lifeless. All movement is possible because of this energy body, a complex

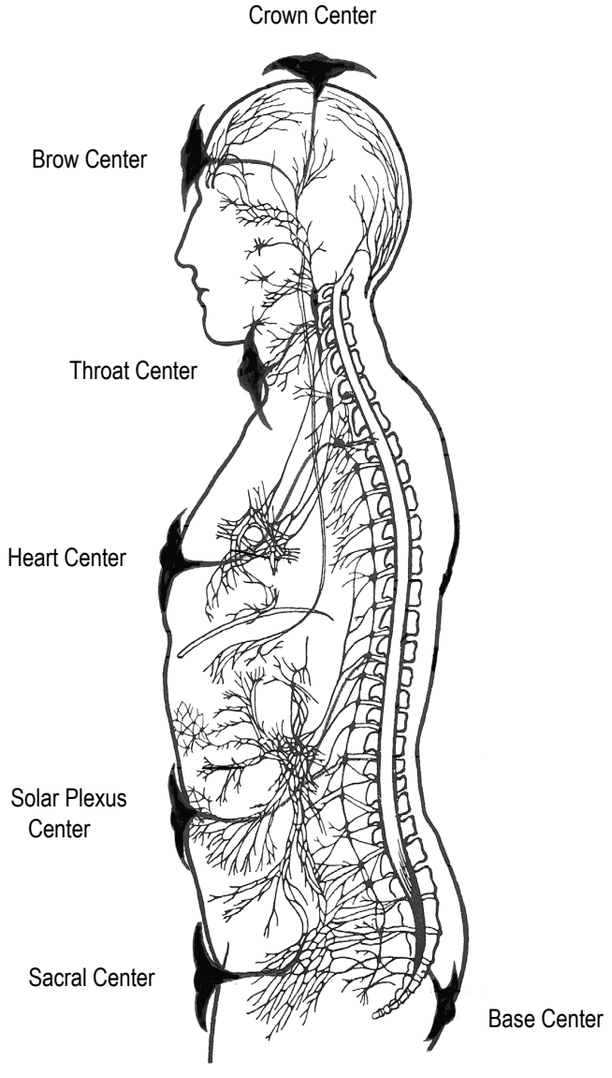
energy/information matrix that interpenetrates the physical body and extends several inches beyond it (Leadbeater, 1927/1997; Swanson, 2010). The etheric body consists of a vast energy distribution system that has three main components: chakras, meridians, and nadis (Gerber, 1988/1996, 2000).

The chakras are energy transformers that take ultra-high frequency energies and step them down into a more usable form (Gerber, 1998/1996, 2000; Lansdowne, 1986; Leadbeater, 1927/1997; Swanson. 2010; Tansley, 1972). *Chakra* is a Sanskrit word that means round or wheel. Those who are able to see these energies have described them as looking like spinning wheels or vortices that range in size from about two inches in diameter to several inches, depending on their stage of development (Leadbeater, 1927/1997; Swanson, 2010). It is likely the ancients had the capacity to see these wheel-like energy centers and named them accordingly.

There are seven major chakras (Lansdowne, 1986; Powell, 1925/1997; Swanson, 2010; Tansley, 1972). These align with the major nerve plexus of the physical body and have been scientifically verified with electrostatic measurements, sound frequencies, as well as electromyography (Gerber, 1988/1996; 2000; Hunt, 1995; Swanson, 2010; Tiller, 2007). The chakras, in turn, feed into energy/information channels, called *meridians*. There are 14 major meridians and several hundred minor meridians, depending on which healing system is used. Meridians have been validated by a number of scientific methods, including electromagnetic measurements, integrated polarization charge measurements, micro-photography, volt-ohm meters and magnetic resonance imaging (MRI) (Gerber, 1988/1996, 2000; Hunt, 1995; Swanson, 2010; Tiller, 2007). The meridians, in turn, send energy/information to the nadis, which act as tiny energy capillaries (Gerber, 1988/1996, 2000; Tansley, 1972).

Metaphorically speaking, the chakras are like power stations where high voltage energy is transduced and distributed through a divergence of power lines—the meridians and nadis. The etheric body interfaces with the physical body through the charka/meridian/nadi system, which corresponds to the physical nervous system (Gerber, 1988/1996; Lansdowne, 1986; Leadbeater, 1927/1997; Powell, 1925/1997; Tansley, 1972). "Anatomically, each major chakra is associated with a major nerve plexus and a major endocrine gland" (Gerber, 1988/1996, p.128). Ultimately, the stepped-down energy from the charkas is translated into hormonal, physiologic and cellular changes (Gerber, 1988/1996).

Chart depicitng the seven major chakras and the nerve plexus to which they correspond.



The Interface Effect

The chakras and meridians have been empirically linked to physical, emotional, and mental health (Eden, 1998; Gerber, 1988/1996, 2000; Krebs, 1998; Oschman, 2000). One explanation for this is the interface effect. It is believed that the etheric body acts as an interface between the physical body and the other energy bodies—emotional, mental, and spiritual (Gerber, 1988/1996; Lansdowne, 1986; Leadbeater, 1927/1997; Tansley, 1972). In the clothing world, an interface performs important functions. It is most commonly used in the collar of a men's dress shirt to make the collar stiff so it can stand up. The purpose of an interface is to reinforce or add substance to whatever it is sewn into. It is usually stitched onto the inside of an out-facing piece of fabric. When the garment is completed the interface is concealed between layers of fabric.

So it is with the etheric body. It reinforces the physical layer, adding form and substance to it. The etheric body is primarily "woven" onto the inside of the physical body (via the chakra/meridian/nadi system). As an interface, the etheric body reinforces the physical body, providing the energetic substance that holds the physical body together. Like a collar without an interface, if the physical body were without its etheric body "backing", it would be limp and inanimate, unable to stand up or move.

An interface goes between layers of fabric. Similarly, the etheric body "goes between" the physical and the three remaining energy bodies—the emotional, mental and spiritual--creating reciprocity among them. Any of the bodies can be accessed through the etheric body; the etheric body acts as a portal. This gateway works both ways as the higher frequency energies of the emotional, mental, and spiritual bodies heavily influence the etheric body, which, in turn, impacts the physical body (Gerber, 1988/1996, 2000; Lansdowne, 1986; Leadbeater, 1927/1997; Swanson, 2010; Tansley, 1972). In essence, the etheric body is the "go-between" allowing for two-way communication of energy/information among the bodies.

The interface effect is supported by research that demonstrates how individual cells register emotions even when the cells are removed from the body (Backster, 2002; Backster & White, 1985; O'Leary, 1989). In this procedure, a few loose cells are collected from a person by swabbing the inside of the mouth with a sterile swab, or by rinsing the mouth in a salt solution. Then the cells are hooked up to a voltmeter that measures and amplifies the weak electrical signal normally produced by the cells. The voltmeter is only a monitoring device; no current is passed through the cells.

Then the cell donor is taken away, usually far away. When the donor experiences a strong emotion (pleasurable or painful) the donated cells back in the lab respond by generating a spike in voltage (Backster, 2002; Backster & White 1985; O'Leary, 1989). This experiment has been shown to work with distances spanning from a few feet to thousands of miles. It has been repeated hundreds of times by various researchers using cells from a vast array of people (Swanson, 2010).

Again, conventional science has no explanation for this: why would physical cells far removed from the body register the real-time emotions of their previous host? The interface effect of the etheric body helps explain how cells can receive energy/information in the form of emotional stimuli from their previous host across distance and over time. Interestingly, the experiment also works effectively using cells from plants and animals (Backster, 1968, 1973, 2002; Tompkins, 1972; Vogel, 1976), verifying what the ancients have said for millennia: all living things have an etheric body.

The interface effect also helps explain why body psychotherapies are so effective on multiple levels simultaneously. In somatic modalities the physical/etheric body is the entry point into the therapeutic process. As such, the etheric body acts as a gateway allowing access to the other bodies (physical, emotional, mental, spiritual) in the process. The interface effect also explains why energy modalities that directly access the etheric body (such as acupuncture, homeopathy, Healing Touch, Emotional Freedom Technique, and Touch for Health, to name a few) help with physical ailments as well as emotional, psychological, and spiritual issues.

The Blueprint Effect

In addition to being an interface, the etheric body serves another important function—that of a blueprint (Gerber, 1988/1996, 2000; Lansdowne, 1986; Leadbeater 1927/1997; Powell, 1925/1997; Tansley, 1972). The conventional wisdom is that genes provide the blueprint for the physical body. However, groundbreaking research in molecular biology over the last couple of decades suggests otherwise. Although genes play a fundamental role in determining our physicality, the new field of epigenetics (*epigenetic* means above or beyond the gene) has revealed an influence beyond the physical level that determines whether or not a gene is activated (Church, 2007, Lipton, 2005).

According to epigenetics, our genes are more like building materials than blueprints. They are lined up, waiting to be given the order to be implemented. Metaphorically speaking, they are like the lumber, nails, sheetrock, and fixture choices that may or may not end up being included in the physical structure. Something outside of the gene can determine whether a particular gene becomes part of the building, or rebuilding, process. In these instances the command is not given at the physical level. It comes from the level of energy/information. Epigenetics reveals the mechanisms that influence gene activation can be nonphysical factors such as emotions, thoughts, perceptions, and states of consciousness (Church, 2007, Lipton, 2005). In light of the interface effect, this is the domain of the etheric body.

It appears that the true blueprint for the physical body is the etheric body. It may contain the energy/information instructions that determine what goes into the structure of the physical body. As well, it may be that all aspects of the physical body, including illness and disease, pre-exist in the etheric body (Gerber, 1988/1996, 2000; Lansdowne, 1986; Tansley, 1972). The blueprint effect of the etheric body helps explain why body psychotherapies are able to produce physical effects often without ever touching the physical body. It also helps explain why energy therapies are able to do the same.

The Replica Effect

The etheric body is sometimes referred to as the *etheric twin* or *double* in that the physical body is a replica—the etheric body is the "original" (Gerber, 1988/1996, 2000; Lansdowne, 1986; Powell, 1925/1997). The *replica effect* means that all glands, bones, muscles, organs and cells have etheric counterparts. In other words, our etheric bodies are comprised of a matrix of etheric tissues and etheric limbs. This helps explain two well-documented phenomena that conventional Western science has no viable explanation for: phantom pain and cellular memory.

About eighty percent of amputees report some kind of discomfort in their missing limbs--everything from pain and electrical shocks to itching and sensations of heat and cold. This phenomenon, documented in medical books since the 1700s, is referred to as *phantom pain*. To this day, modern medicine is hard-pressed to explain it. However, when the etheric body is taken into account, this mysterious phenomenon can be understood. In the instance of

amputation, even though a physical appendage had been removed, the etheric limb would still be intact and connected with the rest of the etheric body. If an amputee lost an arm the etheric arm would continue functioning and, as an energy/information matrix, it would carry on transmitting messages to the rest of the system.

The phenomenon of cellular memory, familiar to many body psychotherapists, is quite evident in instances when organ transplant recipients mysteriously take on the personality and behavior traits of their organ donors without ever having met them. In documented case studies, organ donor recipients have been shown to experience strange and sometimes drastic changes in personality (shifting from extroverted to introverted), or to take on the donor's qualities and habits (drinking, smoking, swearing, praying) and preferences (in terms of food, clothing, music, cars, and sexual behaviors) (Pearsall, 1999). They also experience memories and information from the donor's life that appear to have no other explanation except, perhaps, through recognition of the etheric body.

Probably the most profound example of cellular memory is a case documented by Paul Pearsall, Ph.D., in his book *The Heart's Code* (1999). An eight-year old girl received the heart of a ten-year old who had been murdered. The donor information was completely unknown to the girl or her family, yet soon after her transplant she began having disturbing nightmares about a man murdering a young girl. The dreams were so vivid and persistent that the mother finally brought the girl to a psychiatrist for help. The girl was able to describe the victim, the scene of the murder and the killer in such minute detail that the psychiatrist was compelled to contact the police. Using her descriptions alone they were able to locate and convict the killer. What she reported about the crime turned out to be accurate even though she had no prior knowledge of it.

Materialist science has no explanation for the phenomena of cellular memory. But when the etheric body and the replica effect are brought into the picture we can understand how this may work. Despite having been transplanted, the etheric heart of the victim would remain intact, woven into the physical heart, and would continue transmitting its messages to the transplant recipient. Indeed, the presence of the etheric body—with its invisible energy/information matrix—helps elegantly explain the phenomena of cellular memory which is routinely encountered and worked with in body psychotherapy.

The Internal Senses

A final principle that merits inclusion involves the internal senses. Just as we have external senses that orient us to the external world, we have internal senses that orient us to the internal, subjective world of subtle energies. The energy bodies, in general, and the etheric body, in particular, can be accessed and worked with through the internal senses. These include attention, self-sensing, self-talk, intention, visualization, and self-observation (Greene, 2009). The etheric body is highly responsive to input from the internal senses. As such, they are valuable inner resources that impact our health and wellbeing. Although the internal senses constitute familiar terrain for body psychotherapists, I will describe them briefly below within the context of energy therapies.

Attention

Attention is focused awareness. When we pay attention to something, we focus our external and internal senses on it. Attention is like a spotlight that illuminates and brings to life that which it is directed on. A well-known axiom in energy medicine is: *where attention goes energy flows*. Attention in and of itself has potency (Radin, 2002, 2002a; Radin & Nelson, 2003). What we focus our awareness on receives our energy/information and is changed at a fundamental level. Sometimes called *the observer effect*, the very act of observing something alters it in some way.

This surprising aspect of reality was first touched on by Nobel Prize-winning physicist Werner Heisenberg when he published the mathematics of the uncertainty principle around 1926 (Wheeler & Zurek, 1984). The notion was further supported by the Copenhagen interpretation in which an unobserved object is said to exist only as potential until an observer chooses what to observe (Heisenberg, 1979). This is one of the most commonly taught interpretations of quantum mechanics. It holds that the mere act of observation, of bringing awareness to something, inevitably changes it. Human attention (i.e., awareness) is a transformative energy tool that is foundational to energy therapies and body psychotherapies alike.

Self-Sensing

Self-sensing is the capacity to turn inward and focus attention on bodily experience. It is an inner-focused, subjective stance of experiencing from the "inside out". Self-sensing occurs by shifting attention away from an external focus and directing attention toward an internal focus, at times broadening that focus to include the entire body. Self-sensing allows for experiencing a vast array of internal functioning including bodily sensations, feelings, thoughts, intentions, insights, imaginings, and so forth. It is a mode of internal listening that puts us in touch with primary experience (Greene, 1995, 1997, 1997-98). Self-sensing is a channel of internal receptivity that opens us up to a variety of proprioceptive inputs.

Self-sensing can be focused on a selected organ or area of the body, or more expanded to sense how the body moves in general. It can also be used to sense pain or to apprehend more subtle internal cues (Hanna, 1988; Feldenkrais, 1990, 1997). Self-sensing is foundational to body psychotherapy. Bringing attention inside the body via self-sensing has proven therapeutic effects (Feldenkrais, 1990, 1997), as is evident in the consistent outcomes from a spectrum of somatic modalities and body psychotherapies. In energy medicine, self-sensing is used to experience subtle energy flows and to access and express the energy bodies.

Self-Talk

Self-talk constitutes the messages we tell ourselves about what we experience. None of us perceives sensory input in its pure form; it is always subject to personal interpretation. The meaning we give to what we perceive, how we view it, what we feel about it, the pictures we envision, the words and stories we tell ourselves constitute self-talk.

Some of us orient through an auditory channel and think in words. Some who are more visual conjure up clear, vivid mental images or movies. Others, more kinesthetic, will experience bodily sensations and feelings, a felt-sense about things (Dunn, Griggs, Gorman et al., 1995). Additional orientations include mathematical, spatial and musical. Ideally, we would want to employ as many channels as possible. Still, the three primary processes are visual, auditory and kinesthetic, with one of the three typically more predominant (Dunn, Griggs, Gorman, et al., 1995). Self-talk includes these modes of inner communication that form a perceptual layer over our "raw" experience.

Some researchers refer to self-talk as *explanatory style*, but most of us know it as the "tapes" playing inside our heads, the noisy mind, or the inner critic. In the paradigm of energy medicine, in which everything is energy, thoughts (Hawkins, 1995; Lipton, 2005; Sheldrake, 2003; Swanson, 2010), intentions, (Radin & Nelson, 2003), words (Emoto, 2004), and other aspects of consciousness are understood to impact physical matter (Swanson, 2010; Tiller, 1997, 2005,

2007). This is supported by research in neuroplasticity that shows that our mental experience actually changes the physical structure of our brains (Doige, 2007; Hansen & Mendius, 2009). In what has become the anthem of neuroplasticity: *neurons that fire together wire together*. By bringing awareness to and intervening at the level of self-talk--changing the pictures, sensations and words that constitute that inner channel of expression—the entire system can recalibrate to a higher homeodynamic frequency.

Intention

Intention is attention infused with will (another internal sense), in which we are not just focusing attention on someone or something; we willfully desire a particular outcome. A foundational axiom in energy medicine, *energy follows intent*, reflects the power assigned to human intent. Our energy bodies are extremely responsive to intent (Saraydarian, 1981) as research on the healing effects of prayer demonstrates (Braud, 2000; Dossey, 1993; Schlitz & Braud, 1997; Targ, 1997). Intent can be used to mobilize our own energies and to direct energies to any place at any time (McTaggart, 2007; Radin, 2006).

In Sao Paulo, Brazil, on June 3, 1998, three healers were directing healing intention to five volunteers who were over 6000 miles away in a research lab in Las Vegas, Nevada. The five volunteers were hooked up to various monitoring devices to measure their heart rates, blood volume, breathing, and skin activity. At the exact timed intervals that the healers were sending their healing intent, the volunteers' bodies were registering the effects as recorded by the monitoring devices (Radin, Machao & Zangari, 2000). During intervals when there was no intent, there were no effects--a clear demonstration of the precise power of intent.

Experiments such as this and hundreds of others confirm the effects of human intent on everything from fellow humans (Radin, Machado & Zangari, 2000), to animals, insects, plants, bacteria, DNA (Radin & Nelson, 2003), yeasts (Radin, Taft & Yount 2004), water (Radin, Hayssen, Emoto & Kizu, 2006), cancer cells (Radin, Stone & Levine, et al. 2008), computers (Nelson & Radin, 2001), electronic devices (Tiller, Dibble & Kohane, 1999; Tiller, Kohane & Dibble, 2000), and chocolate (!) (Radin, Hayssen & Walsh, 2007).

Visualization

As an internal sense, visualization refers to our capacity to form concepts in an intentional way. We all have this ability but some have developed it more than others. Unlike the name suggests, visualization is not limited to the visual realm. It includes other channels such as auditory and kinesthetic. Probably a better term would be *sensualization* (Greene, 2009). When I use the term *visualization* the other orientations are included as well, not just the visual.

Visualization, or guided imagery, is a potent tool for mobilizing energies and is used for this purpose in energy therapies. Like self-talk, visualization has profound effects on the structure of the brain and on our health (Doige, 2007; Hansen & Mendius, 2009). It is often used successfully by athletes to improve performance. In one simple study participants were divided into three groups. One group was asked to go to a nearby gym every day for 20 minutes and practice making basketball free throws. A second group was asked to stay home and simply visualize completing successful free throws for 20 minutes each day. The third group, the control group, did nothing. After a month there was only one percent difference in the achievement level of those who actually practiced free throws at the gym (24% improvement) versus those who stayed home and visualized (23% improvement). The control group showed no change (Martin, Moritz & Hall, 1999). This experiment and others like it have been repeated with consistent results.

Visualization is imagination coupled with intent. It is not daydreaming, brainstorming, or

stream-of-consciousness thinking, nor does it involve expanding the mind to see what floats in. Visualization is purposeful imagining, holding a specific focus through the power of concentration. The more focused the concentration, the stronger the results. This is why the vast majority of research conducted on intention is done using trained meditators, as meditators have developed the ability to hold a focus, which allows for more robust results.

Self-Observation

Self-observation refers to the ability to observe and become aware of what is going on inside of us. It includes access to the array of internal functioning mentioned above (thoughts, feelings, bodily sensations) and may sound similar to self-sensing. However, there is a fundamental difference. With self-sensing, we are experiencing the multitude, or specifically selected, internal functioning that we are focused on; we are actively engaged with the inner landscape. In contrast, with self-observation we are *observing* it in a more detached way. We are witnessing or watching what is going on inside, spectating, as it were, instead of actively participating (Greene, 2009).

Sometimes this practice is called *mindfulness* and it has documented therapeutic effects (Farb, Segal, Mayberg et al, 2007; Williams & Kabat-Zinn, 2011; Segal, Williams, & Teasdale, 2012). Self-observation is a foundational component of body-oriented psychotherapies. In energy medicine, self-observation is used to track subtle energies, to assess energy medicine interventions, and to achieve higher states of consciousness.

The internal senses of attention, self-sensing, self-talk, intention, visualization, and self-observation are means by which the energy bodies can be accessed and worked with. Presenting issues are understood as imbalances within and among the energy bodies. Although different labels may be used, many of the internal senses constitute familiar terrain for body psychotherapists. I have found that introducing them as *internal senses* to clients helps empower clients to realize these are not foreign or difficult skills they must struggle to attain. Instead, they are natural qualities that we intrinsically possess, similar to seeing, hearing, tasting, and so forth. Like our external senses, the internal senses can be refined and honed.

Top Down or Bottom Up?

The question then arises: would the multidimensional model be considered a top-down or bottom up approach? The answer is: it depends. The model is such that it recognizes multiple points of entry into the body-mind-spirit system. It is a holistic model in which the energy bodies are seen as distinct yet overlapping. In a bottom-up approach, we can enter the system through the physical/etheric body and gain access to all the other bodies. As I have suggested above, the multidimensional model and the interface effect of the etheric body offer an elegant description of how body psychotherapies work to effect change on all levels (physical/etheric. emotional, mental, and spiritual). In a top-down approach, we can enter the system through the spiritual body and effect change at that level which, in turn, would precipitate out to affect all the other bodies.

Using a framework other than top-down/bottom-up, one that is less hierarchical and more appropriate to energy work, we could think in terms of field effects or radiatory effects. For example, we can enter the system through the physical/etheric body and impact the emotional and mental bodies due to the close proximity of their frequency domains. Similarly, we can enter through the mental body and effect change in the emotional and spiritual bodies. These types of interventions, in turn, would radiate out to effect changes in the other bodies as well. In keeping with the principle of homeodynamics addressed above, the entire system would dynamically recalibrate to a higher level of functioning.

Inside-Out, and In Is Up

Ultimately, the multidimensional model is neither top-down nor bottom-up. It is nonhierarchical. More accurately, it is an *inside-out* approach. It privileges the inner world of subjective reality and first-person experience over objective reality and third-person experience. For this reason, it is also in alignment with body psychotherapy. Further, whether entering the system through the physical/etheric, emotional, mental or spiritual body, it recognizes the primacy of consciousness and its subset—personal awareness. It values self-observation and encourages our capacity to probe deeply into ourselves because "*in* is *up* dimensionally" (Comings, 2004). The deeper into our being we go, the higher up in frequency, allowing access to higher states of consciousness including, but not limited to, the spiritual body. As somaticist Thomas Hanna aptly put it: "God-consciousness has evolved to a par with self-consciousness" (1991, p. 47). These higher states of consciousness catalyze dynamic integration processes affecting each body on all levels as we continue on our evolutionary path.

If anything, we could say the multidimensional model is trans-directional, meaning, it transcends directionality. As such, it more accurately applies to what is now known about the true nature of human functioning. I believe the model is aligned with and contributes to the philosophy, theory and practice of body psychotherapies.

Conclusion

The multidimensional model of energy medicine and the etheric body, in particular, have relevance to somatic psychology in terms of explanatory value, clinical application, and pedagogy. The five principles of the etheric body—the power supply, the interface effect, the blueprint effect, the replica effect and the internal senses—contribute to our understanding of fundamental aspects of body psychotherapy practices. By taking a key model and concepts of energy medicine, and highlighting their relevance to body psychotherapy, I hope I have inspired an energetic bridge between the two and opened a dialog that is mutually beneficial.

BIOGRAPHY

Debra Greene, PhD, is an innovator in the field of energy medicine and mind-body integration. She has worked with thousands of clients and taught hundreds of workshops. Debra holds a Ph.D., from Ohio State University in communication and somatics. She is the creator of Inner Clarity (IC), an energy kinesiology modality, and Energy Mastery, a distance learning program; and author of the acclaimed book *Endless Energy: The Essential Guide to Energy Health.* She resides on Maui Island in Hawaii and offers phone/Skype video sessions worldwide.
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INTERNATIONAL BODY PSYCHOTHERAPY JOURNAL THE ART AND SCIENCE OF SOMATIC PRAXIS

Tandem Hypnotherapy[1]

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Abstract

Tandem hypnotherapy (THT) has recently been developed by the authors. It is a group hypnotherapeutic method for resolving psychic and psychosomatic pathology originating from pre/perinatal traumas. While multi-person touching happens, the patient and the co-therapist go into hypnosis together. Meanwhile, the therapist keeps a distance. A mutual attunement evolves during THT. By using THT the symptoms of pre/perinatal traumas can be replaced with an associative mode of prenatal experiencing which includes acceptance and love. The essence of THT is viewed as an integration of touch, trance, and transference. Three case vignettes are presented to illustrate how THT works.

Keywords: touch, trance, transference, mutual attunement

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By "tandem" we mean several things: 1. a multi-seated bicycle; 2. an acronym for **T**ouch of **A**ncient and **N**ew Generations with a **D**ialogue **E**xperiencing Oneness of **M**inds (**TANDEM**). Tandem hypnotherapy (THT) as a new form of group hypnotherapy—a method for resolving psychopathology of inter-generationally mediated pre- and perinatal traumas. It was developed by the authors a few years ago (Vas & Császár, 2011a). THT involves the participation of more than two persons: the client, the co-therapist and the hypnotherapist. During THT, there is a possibility for the co-therapist to go either into a superficial or a deeper trance together with the client in the tandem situation. The clients are usually in a deeper state of trance than the co-therapist. The aim of THT is to elicit a positive, corrective experience with the potential of resolving the client's trauma.

According to the number of participants, we can distinguish between two settings of THT. In case of a three-person setting the participants are the client, the co-therapist and the therapist. The co-therapist can be the client's natural mother, father or sibling, or may even be the patient's individual therapist (in which case the hypnosis is done by a supervisor hypnotherapist) or another professional person (a nurse, an occupational therapist, etc.). While the hypnotherapist keeps a distance from both the client and the co-therapist, the co-therapist makes body contact with the client, e.g. by touching his/her arm or having him/her sit on his/her lap. The professional co-therapist assumes a symbolic mother/father/sibling role (if the relative is not available or doesn't want to participate). The co-therapist can also assume the role of the patient's imagined twin brother or sister when twin-type THT is used. In the case involving a professional co-therapist, he/she may be of the same or the opposite sex as the patient. When a female or a male patient has suffered serious physical or sexual abuse as a child the framework of the therapy must be very carefully set because of ethical reasons. It should be arranged in a way that allows only the slightest amount of touch to be realized between the patient and the co-therapist of the opposite sex, i.e. touching of the hands. If we want to conduct the THT with a setting of more than three persons, there may be more than one client and co-therapist (Vas & Császár, 2011b).

The triad containing the patient, the therapist and the co-therapist forms a psychological healing team that functions cooperatively for the patient's benefit. The co-therapist's mediating role seems to be a significant component of THT because s/he supports and helps the patient cope with his/her trauma. As the therapist does not touch the patient, the co-therapist must then mediate the therapist's acceptance and love towards the patient. One may be reminded of the work of Michael Balint whose psychoanalytic technique was used to serve as a means of expressing primary love (Balint, 1965/2001).

Brief History of Touch in Psychotherapy

According to ethno-psychology, there are two types of therapies regarding spatial settings: first, proximate types which are characterized by physical closeness; and secondly, types of distal or distancing therapies characterized by spatial distance between the patient and therapist (Hermann, 1934/1984). While even ancient shamanistic practice involved physical closeness between members of a tribe (Krippner, 1993), proximate types of therapy have changed with the emergence of modern psychotherapy. There has been a historically reluctant attitude regarding touching that can be traced back to Mesmer—about whom the French Academy expressed an ethical judgment in a secret report regarding his magnetic cures—and Freud, who introduced the rule of abstinence. This attitude still applies to today's many practices and theories of psychotherapy. However, after Freud refused proximate hypnosis for the sake of distancing analysis, his follower, a Hungarian analyst Sándor Ferenczi (1933, 1988) applied the proximate method again and made the patient sit on his lap. Wilheim Reich's orgone therapy was based on bodily massage (Reich, 1976). Later, Frank Lake, Leonard Orr and Stanislav Grof practiced psychotherapies, dubbed "re-birthing therapies", to relive the birthing process (Grof, 2008). At present, several proximate types exist such as body psychotherapy, movement- and dance therapies, bio-energetic methods, haptonomy, etc (Meyer, 2010; Veldman, 1994; Young, 2007). Non-contact touch is also employed as an energy healing method in treating somatic illnesses (Krieger, 1975).

Distal therapies dominated the psychotherapeutic mindset throughout the whole 20th century regarding spatial setting, while proximity psychotherapies were relegated to the background. The situation with touch in regard to hypnotherapy seems to be the same. Touch is generally used as the hypnotherapist's ideomotor signaling technique to communicate with the patient's unconscious mind without words (Cheek, 1980, 1986, 1993). However, touch in tandem hypnotherapy has a different role. There have been several sessions throughout the history of hypnosis, which were called tandem hypnosis, when trance was employed with more than one persons, for instance with couples and family members, in order to reveal lost objects or vanished memories, or to improve

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relations among relatives (Kluft, 1987). However, touch and physical closeness never played an essential role in this type of tandem hypnosis. Recently, tandem hypnosis has successfully been used with identical female bulimic twins without touch (Túry, Wildmann & Szentes, 2011). Because of its emphasis on touch, THT is viewed as an original therapeutic approach both in the theoretical and the methodological senses, despite its similarities with the methods mentioned earlier as well as the following sources which serve as its theoretical and methodological roots: ancient shamanistic practice (Jilek, 1988), Jungian archetypal therapy (Jung, 1978), hypnotherapy (Bányai, 1998), psychodrama and hypnodrama (Moreno, 1987), contextual family therapy (Böszörményi-Nagy & Krasner, 1986), rebuilding therapy (Gass, 1997), evolutionary psychology (Cosmides, Tooby, 2001), ethno-psychology (Hermann, 1934/1984), developmental neuropsychology (Schore, 2003), prenatal and perinatal medicine & psychology (Janus, 1997), and transpersonal psychology (Wilber, 1986).

The authors suggest that the essence of THT is the integration of touch with trance and the multiple transferences that evolve among participants (which will later be described). This integration is viewed as a guiding principle along with the different approaches that are to be introduced in therapy.

Ethics of Touch in Psychotherapy

All psychotherapists know how careful they must be regarding touching their patients. In the 1980s, Patrick Casement's case drew attention to touch as a non-erotic challenge (Phelan, 2009). Touch is viewed as a normal act among people for expressing friendship, closeness and intimacy. However, the ethics of touch in therapy are essentially different and boundaries are found to be fundamental. Clinical studies of touch have come to the conclusion, regarding the conditions that patient's set for effective touch in therapy, that touch is therapeutically effective only if the patient wants to touch or wants to be touched; s/he gives permission to the therapist; s/he is able to say no; and s/he has an adequate diagnosis (no paranoid hostility, homophobia, or unbearable aggressive or sexual urges). The therapist's touch is effective in therapy if s/he possesses a strong foundation of knowledge and self-experience before using touch; is able to handle transference securely; has the opportunity for professional supervision; does not view therapy as a resource of his or her biological needs; and if s/he feels touching to be a natural thing (Bálint, 2005).

Zur and Nordmarken (2011) have recently compiled a list of clinical, ethical and legal considerations for touch within psychotherapy. They draw attention to the fact that Western cultures seem to exhibit an aversion to touch even in parents' attitude towards their children, which may easily explain why the relating rules of psychotherapy are so stringent. This is why the emphasis on touch in psychotherapy is for it not to be exciting, unpleasant, confining, aggressive, possessing or erotic. Before induction of THT, we always ask our patients to tell us how they feel about being touched by the co-therapist, and if desired, the necessary modification is done for the sake of the patient's comfort.

Pre/Perinatal Traumas and the Developmental Levels of Approach in Psychotherapy

Prenatal trauma occurs when an expectant mother and her fetus have distress in the form of either of the following: intrauterine infection (i.e. flu), intoxications like smoking, alcohol and drug addiction, the mother's severe somatic illness and/or surgical

intervention, starvation or physical exhaustion (Bergh, 2002), Blighted Twin Syndrome (Robertson, 2010), the mother's insufficient mourning of previous or current loss, the mother's negative emotional attitude toward or neglect of the baby, death or dire life situations of family members (Austermann & Austermann, 2008), attempted artificial abortion (Janus, 1997), or prenatal medical interventions like amniocentesis, etc. (Hugo, 2009). We can speak of perinatal trauma when some form of complicated delivery occurs such as a Caesarean section, intensive perinatal care, etc. (Emerson, 1996).

The patterns of coping with peri/prenatal traumas are built into the bio-psychological regulation of the developing personality, and when facing new stress situations, the coping strategies repeat the patterns of over- or down-regulation previously secured, having become incorporated into the personality as an implicit somatic memory (Turner & Turner-Groot, 1999; Verny, 1996). This implicit somatic memory will be repeated at the original sensorimotor level against new forms of stress, which can lead to somatic, psychosomatic and psychological dysregulation and in the worst cases, disorders.

How can this type of pathology caused by prenatal trauma be treated? According to developmental neuropsychology, touch appears to be the "mother" of perception and the first language of developing babies (Montagu, 1986). In the fetal period of life, touch is absolutely necessary to establish the frontiers of the body, and to evolve the boundaries of the ego and non-ego that is the basis for attachment and relationships. The experience of touch is processed in the right hemisphere, which represents relations and contexts (Siegel, 1999). Thus, touch is responsible for reliving spatial regression, which is an attunement with partners via mirror neurons (Bauer, 2010); in other words, touch is essential for experiencing protection, security, warmth and love. The neurochemistry of social support emphasizes the role of oxytocin excreted when people get close in order to touch one another. Touch is said to have stress-relieving, calming and love-inducing effects (Varga, 2009).

The earliest phase in the child's cognitive development was described by Piaget (1937/1954) as the sensorimotor period. We believe that the sensorimotor period of development starts as early as fetal life. We suggest that several psychic, psychosomatic and somatic disorders can originate from a deficit in the sensorimotor and visceral information processing at the prenatal period of life. This is why these disorders need to be treated by a therapeutic approach that functions on the same sensorimotor level on which the trauma occurred. This approach will be illustrated by the following cases.

Since the development of THT was based on inferences drawn from the authors' clinical experience, we describe first how the method works, and then the relevant theory for interpretation of its applications in clinical practice. The participants described below made reports based on their own experiences and gave their written consent for publication. The client names mentioned in this paper are fictional and non-identifiable.

Case Vignettes

Treating a Borderline Patient with THT (therapist: Dr. Vas, co-therapist: Dr. Császár)

The authors have been working with a broken family whose father, Sebastian, divorced his previous wife because of her massive alcoholism. They had three children, the youngest of whom, 17-year-old Esther, experienced fetal alcoholic brain damage and now struggles with the consequences: dyslexia, borderline personality disorder, attention deficit and lack of impulse control. Esther's mother started to drink alcohol regularly when she was pregnant with her.

In this THT session, Dr. Vas served as the hypnotherapist and Dr. Császár the co-therapist in a virtual mother-daughter context as Esther did not want to engage in tandem trance with her biological mother. As the co-therapist, Dr. Császár gave Esther a holding environment via touching and caressing. The therapist made Esther imagine a meadow and asked her to select a flower. She looked at a red tulip, which the therapist asked her to transform herself into. While being a tulip, she can feel well and experiences having a big bulb under the ground. The therapist tells her that the tulip is healthy probably because the bulb is strong and can separate nutriments from poisons in the ground so poisons would not be absorbed; poisons would be stored in the bulb instead of causing harm to the flower. In that moment, Esther burst into tears. When the therapist suggested that she would develop into a beautiful red tulip, she shed tears again. Upon returning to human form, she expressed that her chest had become lighter, free from a heavy burden.

It is important that the suggested metaphor be properly articulated. When asking Esther to imagine herself changing into a tulip with a big bulb under the ground which is able to separate poisons, the therapist took care to paint Esther's fetal alcohol poisoning in such a way that Esther's symptoms (dyslexia, attention deficit, lack of impulse control) were treated as a mechanism of bio-psychological selection of harmful stimuli that probably protected her life in the fetal period. Within the therapy, however, these symptoms are viewed as harmful and needing to be switched for more adaptive techniques.

This session can be viewed as a form of transference as well. Within the vocabulary of transference, we can interpret the therapist as representing a good father who wants to eliminate the harmful impacts Esther suffered as a fetus as a result of her mother's alcoholism. After hypnosis, the co-therapist stated that while she was in deep trance, she was not able to say a word. It may have happened because her counter-transference role was to hold Esther, her fetus, in therapy, as Mother Earth might hold her plants, namely a lovely red tulip.

After this type of THT was practiced three times, Esther became more relaxed than she was before. Since then her therapy has continued in an individual framework. Esther's therapy is not yet finished.

Treatment of Anorexia Nervosa With Mother-Daughter THT (therapist: Dr. Vas)

Angie, age 18, has a diagnosis of anorexia nervosa and weighs 33 kg at a height of 170 cm. As her mother had had an intrauterine infection during pregnancy, Angie was born prematurely. It is an interesting parallel that when therapy began, she was just about to graduate from high school, so she was in a premature state regarding both her emotions and her physical appearance. She has always suspected she had a twin-sibling who was lost prenatally. As a child, she was overweight and was bullied by her schoolmates. She started a drastic slimming diet a few years ago after breaking up with her boyfriend. Recently, her grandmother died and her parents' enterprise went bankrupt. The family atmosphere has been very tense. Angie felt that she had to starve to save money for the family. She became 33 kilograms and all she was able to do was lie in bed.

Angie and her mother—who was almost as thin as Angie—agreed to come to THT. Since Angie seemed to have ego weakness, Dr. Vas decided to initiate guided affective imagery with nature symbols of a meadow, a stream, a tree, and a flower. In tandem trance, her mother's role was to serve as a holding environment because Angie's security was fragile as a fetus from the intrauterine infection. Angie enjoys being in a meadow and watching a stream. Then, in tandem trance she is instructed to transform herself into the

stream. As a stream she feels she is moving, continually flowing, she can feel her energy ever-reviving because the spring water would always feed her. This can be regarded both as a symbolic message of purification from prenatal infection and of gaining ancestral power. At the sensorimotor and visceral level she is able to overwrite the traumatic prenatal experience of infection by experiencing herself as a fluid—a clear amniotic fluid, which exhibits features of self-purification and ever-reviving energy. The following thoughts are cited from her diary:

"During the previous imagination I had an incredible experience when I was transformed into a stream. This little stream was capable of purifying itself because it had immense strength. It is capable of coping with cliffs and other obstacles and it is capable of reaching its goal. It is beautiful when the sun shines on its surface; it looks like gold and silver. I consider this stream to be my ideal that I am going to reach my goals in every field".

In the next session Angie and her mother told us that after one year of lying in bed inactive Angie suddenly started to study so much every day that she slept only three hours a night. It seemed as if she had identified herself with a fast stream running down a valley. This hyperactivity and the previous period of inactivity raised the question whether she might have bipolar affective disorder. Dr. Vas then decided to change the course of the therapy and slow her down. Following the therapist's instructions, Angie and her mother imagine that as a stream, Angie reaches a little pool in which she is slowed and calmed down while deepening, in order to accumulate strength. As a consequence of this suggestion, her sleep gradually came to be a consistent six to eight hours a night. In a later session she imagined herself transforming into a tree with tropical flowers, which can be taken as a metaphor of her unsatisfied symbiotic fetal needs. She then started to exhibit feminine features in the eyes of others as well.

On a later occasion, they imagined Angie as a not-yet-born fetus. Angie says she feels joy being in the uterus and the therapist suggests that she sleep in the womb and have a dream in which she and her twin-sibling meet in the realm of unborn babies. She notices a nice girl, Wendy. Dr. Vas suggested that Wendy say that they love each other so much, she would like to be born at the same time, but that it is very hard to make it come true. Therefore Wendy emphasizes that one of them may fail to be born. If it had been the case, neither of them would feel sorrow or guilt because of the other having failed to be born. Instead one would have to keep in mind that either Wendy or Angie would love and guard the other twin during her life on earth. While this suggestion is given, Angie bursts into tears.

Later in real life, Angie performed excellently on her graduation exam. During the corresponding period of the therapy involving her mother in tandem, we were focusing on satisfying their symbiotic needs. In accordance with the fetal sensorimotor level of deficit, Angie had to symbolically assume the role of a fetus—this was her mother's unconscious symbiotic need. As a matter of fact, the mother's personality had gone through additional development as well via THT. Her main "transference" issue was to repeat her pregnancy with Angie in fantasy, to provide better mothering and expectancy (in a psychological sense) to her daughter and help develop her femininity. At the end of the four-month THT period Angie weighed forty-five kilograms and had no symptoms of bipolar affective disorder.

Angie's therapy is not yet finished as we plan to work on integrating feelings of separation into her personality in the framework of individual therapy.

Treatment of Trichotillomania with Mother-Daughter THT (therapist: Dr. Vas)

Regina, 38, had a miscarriage during her first pregnancy but later gave birth to three children. On the night preceding her miscarriage she had a dream in which a black-hooded horseman was chasing her. She was running to escape him but the horseman caught her, pulled a sack out of her body and threw it into the sky. Regina's grandmother on her mother's side was physically and mentally abused during World War II by soldiers of the occupying forces. Her mother grew up in an emotionally frozen climate and gave birth to Regina after a prolonged labor. Regina was born in the caul and she has lived within a "caul" of anxiety ever since her childhood. During the weeks preceding hypnosis, she had been experiencing recurring panic-like states though it was her daughter and not herself for whom she originally sought help.

Her daughter, Cynthia, age 14, has been plucking her eyebrows and eyelashes for around a year, communicating gender identity problems this way. She is the oldest child and is gifted, with ambitions of becoming a musician. She showed interest in hypnosis and was keen on joining her mother in trying it. During a joint interview, Regina revealed something Cynthia had not known previously: when expecting Cynthia, Regina was hospitalized for two weeks prior to Cynthia's due date, as the ultrasound examination indicated a small cranial size. The obstetrician therefore ordered that the nervous system be strengthened with medication. As Cynthia hadn't assumed the correct position in the womb before birth, a difficult birth was expected and a Caesarian section was applied. While listening to this story, Cynthia fiddled nervously on the sofa. As the therapist, Dr. Vas thinks that Regina and Cynthia could jointly re-experience pregnancy and birth and this time involve more successful coping with the situation.

The therapist's intuition suggests that Cynthia is ready to go ahead and experience THT for the first time in her life. Turned on her side, she is lying comfortably on the lap of her mother who is embracing her, and from that moment it seems most natural for her to go to the fetal age, the earliest phase of her life, step-by-step in her imagination. Dr. Vas could observe her intense experience. Answering his question of how she feels, she whispers, "It is wonderful here." Following Dr. Vas' suggestions regarding healthy growing and the assuming of contact with the mother and her impending birth, Dr. Vas tells them, "The obstetrician is going to say something which will shock you. Don't worry about it; it's not true; he is worrying without reason. Believe me, you will not have any trouble, you are a healthy, beautiful and clever baby. You will soon be born and then you will show yourself to your parents and others and everybody will see that you are a healthy, clever and sweet baby." Cynthia's face turns a bit worried, so Dr. Vas continues, "You will signal to your mother the onset of your birth; you possess the knowledge. You know how to move, how to pass through the birth canal." At this point, Regina joins Dr. Vas in saying, "Thank you Cynthia that you have chosen me to be your mother, and thank you for the wonderful nine months I've had of you growing in my womb." Cynthia starts crying and turns toward her mother who gives her a loving hug. Dr. Vas speaks again, repeating how Cynthia knows when to start moving in order to be born. Cynthia slowly starts to move by making two rounds and a half with her body while Regina takes a position lying on her back. Cynthia is lying on her stomach facing her mother and lifts her head, bowed until now. At this point, Dr. Vas says, "Your head has emerged into the sunlight; Cynthia, you have been born. You will be put on your mother's chest and you will look into each other's eyes, and you will know how much your mother loves you and that you love her, too." Again, Cynthia starts sobbing and they give each other a close

hug. Regina is crying, too. In Cynthia's crying, the therapist senses a release of traumatic feelings. They are both deeply moved.

When asked, Cynthia explains that during the de-hypnosis experience of her coming back from infancy to the present, she entered her classroom and punched the boy who harassed her at school at that time. Cynthia's crying gradually comes to an end. The following week, Regina reported that the eyelash-plucking became less frequent; now it occurred during times of stress only. Moreover, Cynthia began to look more confident. The hypnosis took place on a Saturday and the following Monday, Cynthia told her mother that when the boy started teasing her at school, she sent him packing to everyone's surprise. Symbolically it was the "aggressive" obstetrician whom she "sent packing" as it was his ominous prediction that, because of Regina's worries, undermined Cynthia's sense of physical integrity and thereby her self-concept. Moreover, two weeks later, Cynthia, who was the only girl in her class who had not yet "become a woman", had her first menstrual period. Two months later, she fell in mutual love with a boy even though she had always kept romantic relationships at a distance. Six months after hypnosis, Regina revealed to the therapist that when Cynthia was born by Caesarian section she herself was under a general anesthetic and after the birth the baby was put on the chest of the father first, who took his shirt off to allow a skin to skin contact. Thus, Cynthia had first looked into her father's eyes, which might give a plausible explanation for their almost imprinted relationship. Cynthia followed her father everywhere, always sat next to him, and so on. In the birthing experience of the THT session, it was Regina and Cynthia who looked into each other's eyes. Cynthia sobbed while hugging her mother and resolved the heavy feelings, and it is possible that it was in this part of the therapy that the early imprinting with the father became overwritten. Two years after that single THT session Cynthia switched secondary schools in order to reach her original goal of becoming a musician. She now feels well and reports no symptoms. THT has enhanced her sense of identity as a woman by resolving her self-depreciation caused by prenatal trauma. This case serves as an example of how intergenerational traumas can be treated with THT, as Cynthia's matrilineal line, including her grandmother and mother, suffered serious traumas that have been inherited by successive generations (Vas & Császár, 2011b).

The Theoretical integration of Touch, Trance and Transference

A cornerstone of our hypothesis is the wide experiential and meaning dimensions of touch. We suggest that merely imagining being intimately touched cannot be considered the same as being touched in actuality. Within the THT modality, touching is thought to function even before the central nervous system evolves in the embryo, which is the reason why representations of this touch cannot be made. The experience of imagining mother-fetus relationship in the context of individual psychotherapy can be considered a separate experience from THT. Participants in THT have regularly mentioned that in individual hypnotherapy they had never relived what they had experienced in a tandem situation, an experience that could hardly be expressed in words.

We propose that early nervous system functioning which is usually suppressed by ego processes to be preconscious or unconscious in the normal waking state can be relived via bodily contact in THT. The functioning of the fetal primordial nervous system may become conscious via the following: tactile and nociceptive information being processed through skin receptors; proprioceptive impulses being processed by receptors of skeletal

muscles; and emotional information being processed by the autonomous neural network of the heart and of other visceral organs (Chamberlain, 1993, pp. 9-31; Piontelli, 2010). It is likely that the embryonic nervous system works the same way as it works in adulthood.

It is proposed that the earliest sensorimotor level of functioning has an *associative mode of experiencing*. Every sensory moment is continuously associated with every other, and experiences and consciousness may be treated as one without any ego-reflection. As the central nervous system does not evolve before there is ego-consciousness, which is seen to be necessary for distinguishing and separating subject (inner reality) and object (outer reality), it is called "*primary oneness–experience*". After the central nervous system develops, ego-consciousness occurs, which is viewed as being able to differentiate experiences from consciousness to create separation between outer and inner reality (Oakley, 2008). In the course of the therapy conducted by guided affective imagery methods, the therapist can ask the patient to imagine a stream. The stream is seen to be suitable for a dissociative mode of experiencing because the patient doesn't see him/herself as identical with the stream. On the contrary, if the therapist asks the patient to imagine transforming into this stream, the patient then experiences at a bodily level how it feels to be this stream, which means being at an associative mode of experiencing, recalling implicit sensorimotor somatic and visceral memories from the earliest embryonic period of life. However, this type of experience can only be conscious by virtue of the patient's ego-functioning. That is the reason why it is called "*secondary oneness–experience*".

To be touched also seems to fall into the category of associative functioning in which all of sensorimotor and visceral experiences are collected. According to the bodymind theory (Pert & Marriott, 2007), all of our body cells, especially our skin receptors, preserve traumatic experiences that are processed at an associative level. So touch in THT can also influence those traumatic experiences preserved in skin receptors. The tandem-partner's touch that is felt by the patient during trance can be analogized with the caressing of the amniotic fluid that was once experienced. Thus THT can help patients relive on a sensorimotor level the positive experiences of once being in the womb prior to trauma. This positive sensorimotor associative experience can be regarded as replacing the prenatal or perinatal traumatic experience with a sense of acceptance, security and love.

While the client and the co-therapist are in physical contact touching each other, the therapist's next step is to create a trance state. During rapport, induction and trance, a mutual physiological, emotional and experiential attunement is established between the participants in tandem. The hypnotherapist prompts a specific division of attention, whereby the participants in trance, instead of focusing their attention on themselves, focus on the "meeting points" of their experiences. In this way, autonomous signals, involuntary behaviors, sometimes even the most minute of motions, mutually emphasize the development of a joint emotional and experiential focus, which can lead to a sensorimotor attunement between the tandem participants. The therapist builds upon the experiences that originated from joint bodily communication, creating calmness, warmth, and security. Moreover, a visceral level of attunement or a mother–infant kind of attachment may develop, which can regulate very early deficits of stress-coping functions.

Acceptance, security and love can be regarded as the essence of transference and counter-transference evolving among the participants in tandem and in therapeutic context, including the therapist. I, Dr. Vas, once asked Noémi Császár to go into trance as co-therapist with a relative of hers. Thus, she was the first person to ever gain self-

experience during THT. After the sessions, we discussed all the details in the frame of a collegial consultation. It is important to state that acceptance, security and spiritual or ontological love are viewed to be necessary conditions both between the therapist and the co-therapist, and in the context of the therapeutic dyad with the patient. As in family therapy, transference issues are to be handled with great tolerance, respect, and acceptance. To be practiced, this method requires highly qualified professionals who are capable of expressing their respect to all members involved in tandem hypnotherapy, as well as of maintaining psychological boundaries.

Indications and Contraindications

Natural mother–child THT is indicated in the case of a negative evaluation of one's own motherhood (e.g. "I am a bad mother"); physical/mental trauma which affected the mother during pregnancy or birthing of the child under consideration; or the child exhibiting behavior disorders such as a phobia or tic.

The joint trance of natural and/or virtual twins is indicated if aiming at the resolution of the ontological splitting involving the dilemma as to one's right to exist which might result in several types of pathologies, such as anxiety disorder, dissociative disorder, bipolar affective disorder, personality disorder, drug addiction or criminality. THT may also be capitalized on for its potential for gaining a sense of unity and thus incurring spiritual and psychological strength.

THT is contra–indicated by any psychological state which involves severe weakness of self-boundaries which thereby pose the risk of losing the sense of reality and an outbreak of psychosis; grave aversion to physical closeness and touching, for example myso- or homophobia; manifest paranoid anxieties; hostility; and uncontrollable aggressive or sexual urges.

Conclusion

From Freud's time on, there has been much debate about how catharsis works for healing (Gravitz & Gerton). We suggest that THT is a cathartic and catalytic method that aids patients who need to use their power to work through the intrapersonal and relational difficulties of their everyday life. For this reason, THT can be used when individual psychotherapy has come to an impasse because of pre/perinatal traumas and then the individual therapy can be continued after resolving them. The two case vignettes shown in the article are not closed, so the results we have are preliminary. To understand efficacy, more detailed research of THT is planned in the near future.

Finally, THT is a new method, which was developed by the authors, and belongs to transpersonal therapies. Instead of being symptom-oriented, it is characterized by a holistic, existential-ontological approach that focuses on the meaning of life and its marked events. The physical presence and mutual touches of those in the joint trance can facilitate the resolution of traumatic experiences from the past not only on an imaginary level but also in reality, with the possibility of eliminating entirely pathological consequences originating from relational traumas of the prenatal and perinatal periods. The aim of the method is to replace the repetition of traumatic experience with positive mutual attunement, which is called the "communication of ontological love".

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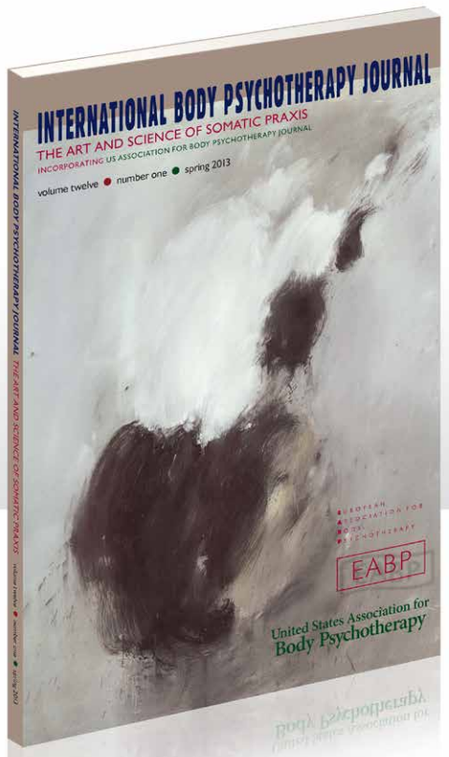

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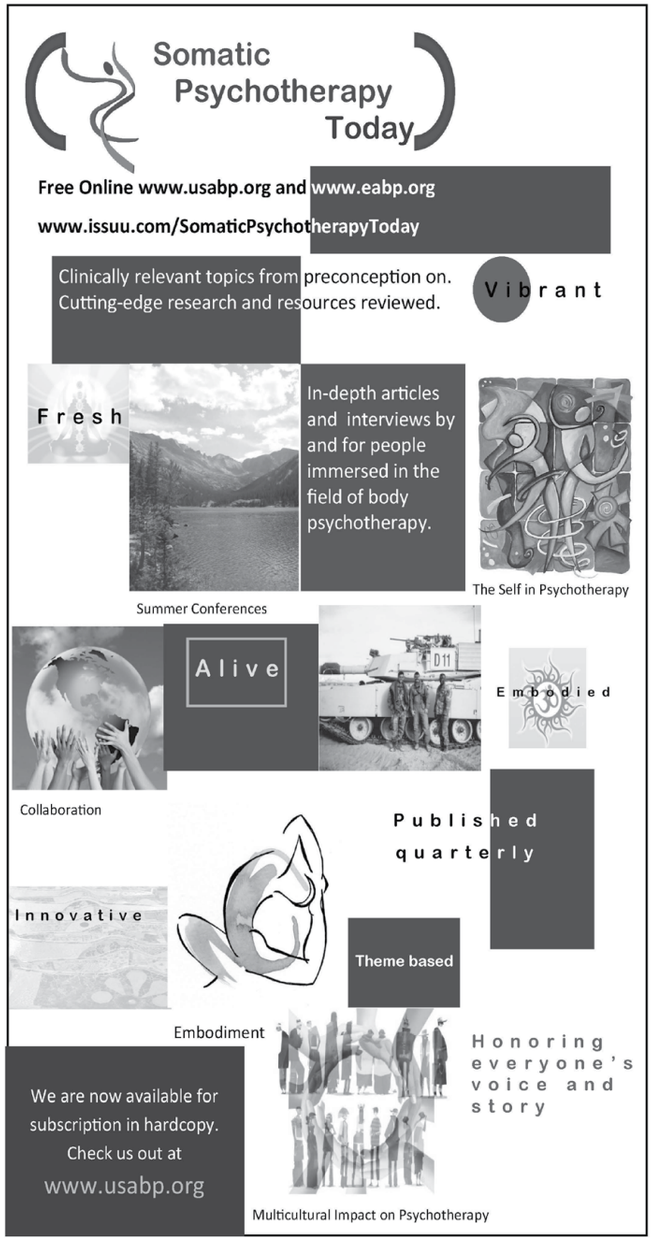

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