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Editor: [jacarletonphd@gmail.com](mailto:jacarletonphd@gmail.com)

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**Changes of address:** [secretariat@eabp.org](mailto:secretariat@eabp.org)

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volume twelve ● number two ● fall 2013

## TABLE OF CONTENTS

- 4 **Editorial**  
Jacqueline A. Carleton, PhD
- 7 **The Present as Morphogenesis**  
Stanley Keleman

## ARTICLES

- 9 **Idealism & The Goals of a Psychotherapeutic Process**  
Michael C. Heller, PhD
- 39 **Body Image Disorders**  
Bernhard Schlage, MA
- 50 **Military Culture and Body Psychotherapy: A Case Study**  
Diana Houghton Whiting, MA
- 63 **Filling the Holes-in-Roles of the Past With the Right People at the Right Time**  
*A way to open the door to happiness in the present*  
Albert Pessa

## BOOK REVIEW

- 88 **A Review of Barnaby B. Barratt's**  
*The Emergence of Somatic Psychology and Bodymind Therapy*  
Christina Bader-Johansson, MSC

### 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 • number 2 • fall 2013

Well, this is our second or twelfth year of publication, depending on whether or not you are counting the *US Association for Body Psychotherapy Journal's* ten years as a precursor of the *International Body Psychotherapy Journal: The Art and Science of Somatic Praxis*. In seeking to fulfill our mission to reflect, define and validate body psychotherapy in the global community, we are moving in ever-widening circles of connection and diversification. Since the transition two years ago, we have been committed to an open access, online publication with the alternative of print subscriptions for those who wish them. As I write this, our own website is in preparation and will be up in the next month or so. Its address will be [www.ibpj.org](http://www.ibpj.org). That means that the IBPJ will be accessible from three sources: the EABP website, the USABP website and its own website, in addition to being sent as an attachment to all members of both organizations.

As a part of our goal to disseminate the practice of body psychotherapy as widely as possible, we are committed to actively coordinating our other publications, events, and social media. We are planning to participate actively in the 2014 EABP Conference in Lisbon as well as the USABP Conference in 2015. Nancy Eichhorn, the editor of *Somatic Psychotherapy Today*, and I are in constant communication about the content and needs of both periodicals, and Nancy also serves on our editorial committee. The same is also true for Serge Prengel, who hosts an ongoing series of thought-provoking conversations with a broad range of practitioners and thinkers on *SomaticPerspectives.com*. Social media are also utilized, as by Serge whose Somatic Perspectives group on LinkedIn, with 2,500 members to date, is a place for stimulating discussions on such topics as Embodiment or The Role of Touch in Psychotherapy (see [linkedin.SomaticPerspectives.com](http://linkedin.SomaticPerspectives.com)).

In forthcoming issues, we will be presenting and encouraging dialogue among contributors in two related forms. Editorial committee member Asaf Rolef Ben Shahaar has invited Nick Totten to begin a series of dialogic articles on the concept of the self in body psychotherapy. Upon receipt of Nick's article, Asaf will invite comments from three colleagues, which will be published along with the original article and Nick's closing reply to them.

I have invited experienced clinicians to present case histories which will then be commented on by their colleagues. Colleagues will be asked to propose alternatives and then the original writer will write a rejoinder, which will include further information on the treatment presented along with comments on colleagues' suggestions and ideas. We would like to experiment with this form both within and between modalities. We hope such dialogues will become regular features of the *IBPJ*.

Honoring our subtitle, *The Art and Science of Somatic Praxis*, we begin this issue with a poem by Stanley Keleman. A pillar of body psychotherapy since the 1970's, he allows us to publish "The Present as Morphogenesis". Much of Stanley's work in other genres is initially birthed by him in poetic or sculptural form, so it pays to watch his subsequent work to see how it unfolds. At this point in time, he is just finishing a DVD of his seminal work, *Emotional Anatomy*. It is a semi-animated version of the text with added material about the exercise protocol and the dynamics of Formative Psychology.

Michael Heller actively participates in many of the above-mentioned venues of communication amongst body psychotherapists. Best known at the moment as the author of the *magnum opus*, *Body Psychotherapy: History, Concepts and Methods*, published by Norton in its English translation by Marcel Duclos in 2012, and reviewed in our last issue, Michael has also been a guest in the *SomaticPerspectives.com* series and has hosted a discussion of the goals of psychotherapy in the Linked In group. Inspired by that experience, he delves further into an aspect of the topic that particularly interests him in his article entitled, "Idealism & the Goals of a Psychotherapeutic Process". In this thoughtful essay, Michael explores several issues in the formulation of aims for psychotherapeutic treatments, especially for those including the body, clearly more interested in the questions and dilemmas than in any singular conclusions. He begins his discussion of this complex topic by pointing out that, "no one seems to know how to differentiate a mental illness from spontaneous manifestations of the imperfection of nature", citing the presently controversial treatment of ADD in children. He then moves on to the philosophical underpinnings of the discussion of aims of psychotherapy, contrasting the idealism of Plato with that of another Ionian philosopher, Heraclitus, in whose wake he places Spinoza, Darwin, and ultimately Wilhelm Reich. He poses the question whether psychotherapeutic treatment should take harmony and coherence as its goal, or whether it is better to aim instead for an enlarged capacity to manage conflictual forces both within and without of the organism. And, what of habitual responses of all kinds?

Can we embrace empirical idealism which assumes one form of adaptation is better than any other, or may we embrace the variety that otherwise ensues? Is our first concern building an intimate relationship with a new patient or alleviating symptoms? And, what about the ethical considerations around who, therapist or patient, decides on those goals either overtly or covertly? And, is there a main or initial cause of present symptoms that we should seek to uncover? Questions such as these engender illuminating but ever-inconclusive treatment. He concludes that while there may not be major differences between practical aims of a psychotherapy process, each practitioner/school rationalizes them quite uniquely. The editors along with Michael invite you to submit your own questions and thoughts thereon for publication in the next issue of the *IBPJ*.

A similarly speculative point of view is taken by Bernhard Schlage in "Body Image Disorders" as he attempts to open inquiry into the realm of what he calls the "second body". Taking a childhood experience of his own as a point of departure, he speculates on how this body might be linked to the physical body and the brain both in present and past cultures, some of which were more comfortable with body image variations than the culture from which he writes. He argues that body psychotherapy is in a unique position to work with both bodies and goes on to evaluate neuroscientific and neuroimmunological evidence for their usefulness in such treatment. In conclusion, he invites feedback from readers who share his interest in this burgeoning field of inquiry and treatment. We would add that this discussion has a sociocultural relevance as well as we watch the globalization of serious, often life-threatening body image disorders such as *anorexia nervosa* along with its more recent and equally serious companion, obesity.

In "Military Culture and Body Psychotherapy: A Case Study" Diana Houghton Whiting describes 10 weekly body psychotherapy sessions with a 65-year old male veteran of the Vietnam war who has been in a variety of treatments for PTSD over the last 15 years. Diana

was able in that brief time to help the client bring more awareness to his body, his emotions, and many habitual responses. She points out that attention to signals from the body is the exact obverse of military training to suppress bodily sensation in order to complete the assigned task. She briefly describes the process by which a civilian becomes a member of the military, “a well-oiled machine”, and how that can make re-entry for some quite difficult, especially for those who carry trauma. Although neuroscientific research has made some inroads, the American Veterans Administration only approves evidence-based therapy modalities for this enormous and underserved population. The need for research in the field of body psychotherapy is clearly urgent. This article fulfills a requirement for the Master’s degree at Naropa University in Boulder, Colorado. We applaud the practicality of the necessity for each student to undertake a project that results in a publishable article rather than a “thesis” of some sort that might just sit on a shelf somewhere gathering dust.

Albert Pesso, along with Diane Boyden, founded the Pesso-Boyden Psychomotor System more than 40 years ago. As I mentioned in the last issue, I was privileged to be a member of one of their very early groups at the Charles Street Meeting House in Boston. “Filling the Holes-in-roles of the Past with the Right People at the Right Time” outlines and simultaneously illustrates how initial questions about how some performers are able to do some moves that others cannot has become a very carefully worked-out and implemented modality of body psychotherapy. No stranger to their work, I found myself again and again confounded by the precision of the interventions described. What is particularly helpful are the minute dissections of each intervention with its theoretical and cultural bases explained. Questions seem to be a theme of this issue, and Al poses many: What can make the present feel that awful? Does it matter that interventions are in the here-and-now rather than the there-and-then when they were so urgently needed? What are the most basic drives/instincts in all living things? What three motivators propel most human behavior (one of them may surprise you) and what are two underlying, genetically available primordial energy systems needed to successfully maintain life? His answers to these questions provide the very specific bedrock of the work described. Concepts and principles continue to come up and be discussed in the course of a single “structure”. His moment-by-moment tracking of therapist, client and participating group members provides a window into a concise and detailed set of interventions that lead to a not unforeseen conclusion.

Finally, we have a review of Barnaby Barratt’s important new work, *The Emergence of Somatic Psychology and Bodymind Therapy*. It is described and analyzed by Christina Bader-Johansson.

I would like to take this opportunity to honor and thank our abstract translators: Albanian, Enver Cesko; French, Marcel DuClos; German, Elizabeth Marshall; Greek, Eleni Stavroulaki; Hebrew, Rachel Shalit; Italian, Fabio Carbonari; Russian, Evgeniya Soboleva; Serbian, Sasa Bogdanovic; Spanish, David Trotzig. The abstract of each article in the issue is translated into these languages and posted on the websites so that people for whom reading in English is a challenge can get an idea of whether they want to wade through a particular article. This is a very important service and other languages are welcome. Please volunteer!

Jacqueline A. Carleton, PhD  
New York City  
September, 2013

## The Present as Morphogenesis Stanley Keleman

June/2013, Berkeley Ca

The body the serpent of animation  
a ripening morphing from less to more,  
from a skin,  
into a cortex,  
the octopi of division and differentiation,  
that forms the pointillist  
living sky, a pointelle  
of throbbing delights,  
brightening the nights,  
ink,  
with its tongues  
desires,  
slithering from within  
by the body and brain  
the twins  
grow starlight’s,  
flowers, within,  
the cosmic armature  
in intimacy,  
of lying face to face,  
bending and blending  
pulsing together,  
in a gastrulating  
giving and receiving,  
appearing and disappearing

within the conceived world,  
 a hovering, wave,  
 waiting,  
 until death, to stay  
 in the deep silence  
 of dynamic intimacies  
 morphogenesis,  
 the molten, lava  
 that illumines,  
 the face,  
 and sends  
 echoes to the lips,  
 announcements,  
 there is time,  
 enough,  
 to be a presence  
 in the present  
 we make,  
 for our time,  
 which is the lived  
 embodied life we form.

## BIOGRAPHY

Stanley Keleman PhD is the director of the Center for Energetic Studies in Berkeley California, where he teaches the Formative Approach to human development. Awarded a PhD in Human Letters from Saybrook Graduate School in 2007, he is also the founder and developer of Formative Psychology, the director of research at the Center of Form and Development in Zurich, Switzerland, and a visiting lecturer at the Spectrum School of Humanistic Psychology in London, England. He has authored the pioneering books *Emotional Anatomy*, *Embodying Experience*, *Your Body Speaks its Mind*, *Insults to Form*, *Living Your Dying*, and *Myth and the Body*, in addition to numerous clinical books.

Email: [skeleman@aol.com](mailto:skeleman@aol.com) Website: [www.centerpress.com](http://www.centerpress.com)

## Idealism and The Goals of a Psychotherapeutic Process<sup>1</sup> Michael C. Heller, PhD

Submitted 19 March 2013; received in revised form 26 June 2013; accepted July 2013

### Abstract

This paper deals with the difficulty of proposing a short explicit list of the aims of a psychotherapeutic treatment that can be accepted by most psychotherapists. It presents a series of issues on the subject as a form of “mind sharpeners” for colleagues. In the first part I will show that a discussion on the aims of psychotherapy often raises implicit ideological issues such as those which are inspired by various sorts of philosophical idealism. I will then specify what we would need from scientific research to improve our understanding of the aims of psychotherapeutic processes. And finally I will discuss a few issues that haunt me when I practice psychotherapy.

*Keywords:* psychotherapeutic cure, aims of a treatment, body or somatic psychotherapy<sup>2</sup>, efficiency, implicit and explicit assumptions, idealism, coherence/incoherence of human nature.

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As man thrived in different regions of the globe, he increased in number, established himself in society with fellow creatures, and finally progressed and became civilized. His delights and his needs increased and became more and more diversified. He developed increasingly varied ways of relating to the society in which he lived, which, among other things, generated increasingly complex personal interests. His inclinations subdivided endlessly, and generated new needs that activated themselves beyond the scope of his awareness. These grew into a huge mass of connections that control, outside of his perception, nearly every part of him (Lamarck, 1815, *Natural History*, p. 278; translated by Michael C. Heller and Marcel Duclos).

### Introduction

Concerning Man (...). I desire to contemplate him from this point of view – this premise: that he was not made for any useful purpose, for the reason that he hasn't served any; that he was most likely not even made intentionally; and that his working himself up out of the oyster bed to his present position was probably a matter of surprise and regret to the Creator (Mark Twain, *Autobiography*, 2012, p. 165).

<sup>1</sup> I would like to thank Jacqueline A. Carleton, Diane Cai and Jill van der Aa, editor and associate editors of the International Body Psychotherapy Journal, for helping me with my English and editorial requirements.

<sup>2</sup> For the moment somatic and body psychotherapies designate the same schools. I therefore use them as synonyms, although I suspect that the difference of name covers differences that will be clarified in the future. Somatic psychotherapy is mostly used in North America, while body psychotherapy is mostly used in Europe.

A complete cure is the most obvious aim for all forms of therapies. However, available therapeutic techniques cannot cure all the illnesses that haunt patients. Therapists therefore need a hierarchy of aims. For example, one can cure a cold for a few months at the most. Or one can reduce the pain of migraines, but one cannot always eliminate them. Cancer and autoimmune diseases therapists can sometimes cure; often they can only propose a welcomed momentary remission. In other cases the most humane solution is sometimes to help a patient die as painlessly as possible.

This issue is germane to psychotherapy, but it also has an additional problem, in that no one seems to know how to differentiate a mental illness from spontaneous manifestations of the imperfection of nature. Recently the issue has been raised in the media, in discussions of the future Fifth Edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5)<sup>3</sup>. Newspaper articles and television programs predict that this manual includes in the list of psychiatric symptoms not only hallucinations, depression, and anxiety, but the need to make love several times a week, shyness and the incapacity to shut up. I have not yet read the manual, so I will not comment on it for the moment, but I know a bit more about recently created diagnostic designations such as attention deficit disorder (ADD) (Tuckman, 2009). Noting that some people have a more restricted working memory than others, and describing the impact of reduced short-term memory on a person's life, is a useful delineation that has helped millions of people. But if one accepts that all humans are different from each other, can we not expect an extreme variability of performance in all domains (intellectual, sexual, emotional, etc.)? For Darwin (1859, chapter V), variability is a crucial dimension of the creativity of biological evolution. If this variability is due to the spontaneous biological dynamics of chance and necessity, how can its manifestations be an illness (Heller, 2006)? Long before biologists created the theory of evolution, the notion of illnesses included painful discomforts caused by accidents (breaking one's leg, war wounds, infections, reactions to germs, etc.). Gradually medicine also included particularly dramatic manifestations of random biological creativity. This inclusion is becoming increasingly important. It would seem that nearly any chronic discomfort of the self or others could be treated as a medical symptom. Psychological difficulties are often mostly a disease if one refers to the original meaning of the term (a discomfort, a deep inconvenience). Human variety is being frontally attacked by powerful medical institutions. The push to classify all the individual particularities of a human being as symptoms is not a scientific endeavor when it is based on ideological ethical aims, such as various forms of eugenics.

Because attention deficit is classified as an illness, millions of children are forced to swallow an addictive drug called Ritalin. The observable fact that this treatment reduces the intensity of the deficit but does not cure it supports the hypothesis that attention is one of the characteristics that vary considerably within the human species. It is then for society to find ways of integrating the infinite variety that characterizes all the functions that animate human organisms. If the notion of attention deficit is robust, then the phenomenon has been widely spread for millions of years. It is highly probable that, in some societies at least, social pressure did not prevent people with weak attention from leading creative lives. I am astonished that recent studies which have allowed us to describe the variety of performances of working memory have not spent more time analyzing the specific creative gifts of people who suffer from attention deficit disorder; and the type of social regulation systems that can creatively integrate people with a weak working memory or even with chronic hyperactivity phases. One obvious explanation is that today fundamental research in psychology does not receive enough nonpartisan funding

with strict scientific ethical requirements, while research on attention deficit is easily funded by industries who thrive on Ritalin. My position is that it is only in particularly extreme cases that the notion of illness could be relevant for attention deficit issues. In all other cases the issue is mostly cultural and pedagogical.

The notion of therapy is medical in origin. The aims of treatment are initially based on a diagnosis (an illness), the tools one has to master this illness, and what prognosis the two preceding factors allow a practitioner to have. This movement has been animated by a profound ethical dedication to helping people in trouble and alleviating pain. Applying this frame to psychiatric illness is delicate because we do not have a really reliable diagnostic system or generally robust therapeutic tools, and we cannot be certain that what patients suffer from is illness. Psychotherapists attempt to reframe psychophysiological habitual procedures in such a way as to avoid strengthening spontaneous natural propensities and defense mechanisms such as destructive affects (e.g., anxiety, depression and stress), behaviors (uncontrollable violence and intrusiveness, difficulty defending oneself, unsatisfying sexuality, and socialization styles that incite rejection by others, etc.), and ways of thinking (e.g., paranoia, ungrounded phases of optimism or pessimism, etc.). These three factors, as well as others, often co-occur. Transforming a destructive set of procedures that structure a person's character is not exactly the same type of intervention as killing a germ that enters an otherwise healthy organism<sup>4</sup>. Nevertheless, even if these difficulties cannot always be addressed with current medical models, they badly need an appropriate form of support. Psychotherapy is a crucial therapeutic tool in such cases.

Psychotherapy was created by medical doctors (Freud, Jung, Reich, etc.) who at first adopted a medical way of thinking about mental health. They later realized that they should adapt the medical model to the requirements of the difficulties experienced by their patients. As an increasing number of psychologists joined the psychotherapeutic community, the models produced by psychotherapy schools often followed other tracks than those produced in medical facilities' models. It is possible that terms such as therapy, symptom, or illness, should be revised when applied to the field of psychotherapy. Some are afraid of going down this road, because they and their patients depend on healthcare institutions to fund the psychotherapeutic process (Kelley, 1992). Even if it does fit neatly into a classical medical frame, psychotherapy has proven to be a crucial form of intervention for many. As many psychological difficulties are caused by a blend of genetic factors and problematic behavior generated by social dynamics (abuse, trauma, harassment, war, etc.), one could imagine that such treatments could also be funded by a social insurance that attempts to repair the dangerous behaviors that are inevitable in a given cultural context, or maybe in our species. For example, a society may be held responsible for allowing pedophiles (e.g., parents and priests) to traumatize so many children.

I hope that I have said enough to show that deciding what the aims of the psychotherapy process are raises complex issues. As with most of my colleagues, these issues tend to remain in the back of my mind. However I was forced to consider this subject in more detail when Serge Prengel asked me to moderate a debate for *Somatic Perspectives on Psychotherapy* on LinkedIn. I chose a theme that played a central role in my book on body psychotherapy (Heller, 2012): *Harmony and/or friction? Which of the two is the most plausible aim for a psychotherapeutic cure?* I thought that this could be an interesting way of exploring the issues so often raised in discussions on the aims of therapy. Several colleagues in somatic psychotherapies participated in this conversation in January 2013. Their comments forced me to reconsider my simplified vision of the aims of psychotherapy. I will not attempt to summarize their points of view, because I am sure that the few sentences written by each of us on the subject was but the tip of

<sup>3</sup> <http://www.dsm5.org/Pages/Default.aspx>.

<sup>4</sup> Even physical illness can be multifactorial and difficult to assess.

the icebergs that roam in our minds. I thank them for their inspiring comments and proposals, and hope that our discussions have also been useful for them. I was also inspired by the many discussions that I had on the aims of psychotherapy with fellow members of the scientific and ethical committees of the European Association for Body Psychotherapy.

The field of psychotherapy is structured by a multitude of highly differentiated and competing training schools. It is for the moment impossible to synthesize the models they propose. The issues they raise are simultaneously metaphysical, spiritual, ethical, moral, ideological, scientific, clinical and technical. Apart from the obvious points mentioned in the first lines of this article, I have not found a set of common aims that are shared by all the schools I know. However, I hope I can provide a useful mind sharpener for practitioners who want to specify the goals that can be achieved when they propose a psychotherapeutic treatment. Although most of the following considerations involve issues that exist in the field of psychotherapy, I have focused on those that are particularly relevant to body or somatic psychotherapies.

In this article I would like to share my views on the aims of psychotherapy, based on more than 38 years of experience in that domain. My principle goal is to express my thoughts as clearly as possible, with the hope that they can be useful to some readers. I will therefore not even try to discuss at length the immense literature on the aims of psychotherapy, but will instead provide one or two examples of the sort of literature I refer to when I discuss themes that have been developed by colleagues. The focus of my argument is to transform often implicit assumptions and discussions into more explicit ones.

### Philosophical Bases of the Discussion

Discussions of the management of harmony and disharmony have a long history. For this article I will focus on some of the discussions that certain philosophers had on the subject during Greek antiquity, as they seem to have had a more or less direct but strong influence on some fairly widespread formulations proposed by body psychotherapists (Heller, 2012, chapter 3). In the realm of somatic psychotherapies one can distinguish approaches inspired by Plato's idealism that aim at rendering patients more coherently harmonious, and approaches inspired by Heraclites that find it more productive to help patients develop a pleasurable, creative, and grounded pleasure in conflict situations. The second solution is often referred to by somatic psychotherapists as developing the "warrior" in the patient (e.g., Heller, 2007; Audergeon, 2005; Brown, 2001). Most somatic psychotherapists seem to include both mindsets in their approach, but some do tend to focus on a search for harmony and coherence, while others focus more on forms of creativity associated with the grounded capacity to master friction. I also find it useful to oppose the perspectives inspired by Greek philosophers with another trend, which is prevalent in psychiatry, which I will momentarily call "scientific idealism". I know from my more philosophically minded friends and colleagues that these distinctions may be simplistic for philosophers, but I have found them useful in distinguishing therapeutic aims for practitioners who have not always read the philosophers. I will now summarize what these terms allow me to distinguish.

### Platonic Idealism and Body Psychotherapy

The soul when thinking appears to me to be just talking — asking questions of herself and answering them, affirming and denying. And when she has arrived at a decision, either gradually or by a sudden impulse, and has at last agreed, and does not doubt, this is called her opinion. I say, then, that to form an opinion is to speak, and opinion is a word spoken,

— I mean to oneself and in silence, not aloud or to another (Plato, 1937, *Theatetus*, 190, vol. II, p. 193).

### Does a Harmonious Constitution Breed Health?

Plato's main metaphor for idealism, which is inspired by the Ionian (ancient Turkey) philosopher and mathematician Pythagoras, is that when an organism dies the soul rises and visits a realm of perfect ideas. In this world the soul can taste a form of bliss that is the juice of absolute truth, beauty, harmony, coherence and justice. When the soul then enters a new organism, it still contains reminiscences of the absolute truth it has visited. Each time an inhabited organism dies, the soul will rise again to the realm of ideas. It will thus gradually acquire and integrate increasingly intense and refined tastes of these ideas.

The mind of the new organism is not aware that a soul is its neighbor. But, sometimes, a fleeting blissful perfume emanates from the soul, flows through a forest of conscious thoughts and enchants them. These delicious, enlightening vapors may be carried into our awareness by a dream, an intuition, or even at the most blissful moment of an orgasm. One can imagine that Reich experienced intense emanations coming from his soul during his orgasms, because he tried to convince the whole human species that only orgasms can free us from our chains and allow us to experience blissful enlightenment. Others may have become enthralled by similar experiences during meditation, breathing exercises, dance, trance or music. For Plato a philosopher is someone who increases the contact between what he is aware of (his conscious dynamics) and these absolute truths. This is why Plato's Socrates insists that one should learn to know oneself<sup>5</sup>. Knowing oneself is not the psychotherapist's urge to help people discover how their personal development structured what they have become; it is the philosopher's propensity to contact the deep truths that are tucked away somewhere in our organism. This aim is closer to those of meditation rather than to psychotherapy.

Platonic ideas are absolute truths. This implies that there is only one possible definition of what is beautiful, just, true, coherent, and so on. Nietzsche (Rey, 1973) defended a different position when he stressed that words are by nature polysemous, and that only tyranny could impose one meaning to such terms as "bad" and "good". There are of course several important traditional philosophical alternatives to Idealism, such as Epicureanism, the philosophical Empiricism of John Locke, George Berkeley, David Hume and Hermann von Helmholtz, or Edmund Husserl's phenomenology, but their impact on how the first body psychotherapists perceived the aims of psychotherapy seems superficial. Discussing these philosophical options is beyond the scope of this article.

I have the impression that a central implication of Plato's metaphor is that the mind and the soul form separate entities. Plato seems to distinguish a form of thinking that reacts to sensory data and attempts to organize it, a form of thinking that spontaneously emanates from the soul:

Thought is best when the mind is gathered into herself and none of these things trouble her — neither sounds nor sights nor pain nor pleasure, — when she takes leave of the body, and has as little as possible to do with it, when she has no bodily sense or desire, but is aspiring after true being (Plato, 1937, *Phaedo*, 65, vol. I, p. 448f).

Aristotle, who was one of Plato's pupils, did not preserve this separation. Henceforth it is only in spiritual movements that the separation between the emanations of the soul and current automatic and reasoned thinking continues to be an important point. Current philosophical

<sup>5</sup> Plato attributes this sentence to Socrates in six dialogues: Charmides, Protagoras, Phaedrus, Philebus, Laws and Alcibiades. See [http://en.wikipedia.org/wiki/Know\\_myself](http://en.wikipedia.org/wiki/Know_myself).

idealism assumed that the mind was part of the soul. This was for example the position proposed by Descartes in the 17th century. It is this unified vision of the soul and the mind that gradually became known as the psyche. The Greek word “psyche” designates the soul and the breath of life that animates an organism. It is this semantic root that is used for denominations such as psychiatry, psychology and psychotherapy. Somatic psychotherapists repeatedly stress that this linguistic root designates psychological procedures as cogwheels imbedded in organismic dynamics. Some use this argument to stress that the mind is a subsystem of the organism, and use formulations such as “embodied” or “organismic” psychological dynamics (Heller, 2012; Balcetiš and Cole, 2009; Marlock and Weiss, 2001); while others use this etymological history as a validation of the idea that the soul and its mind are a part of the dynamics of cosmic or vital energy (Lewin, in press; Pierrakos, 1990; Boadella 1987; Boyesen, 1970).

The idealist view has an important flaw: it has a hard time explaining how such a perfect universe could generate wars, torture, exploitation and illness (Ferry, 2012: 16f). The idealist's strongest argument is that evil is produced by a lack of contact with eternal truths, empathy, the soul, natural laws or cosmic energy. For the physician Eryximachus in Plato's Symposium, our organisms are structured by conflicting forces such as the elements contained in our bodies (water, fire, earth and air). He believes that illness is a form of chaos that enhances the conflict among these heterogeneous forces, while health emerges when these elements learn a form of synergic dialectical collaboration called love<sup>6</sup>. Plato situates himself in dialectical opposition with the views of another Ionian philosopher, Heraclitus, who assumed that knowing how to use the conflicting forces of an organism is what leads to health and creativity. According to Heraclitus, it is only once you have learned to master the frictions activated by heterogeneous forces that you can contact the underlying unity of the universe. His texts are lost, but we still have quotes that are used as aphorisms (Heraclitus, Fragments, 2001):

Harmony needs low and high, as progeny needs man and woman. (43)

From the strain of binding opposites comes harmony. (46)

The cosmos works by harmony of tensions, like the lyre and bow. (56)

From Hobbes and Hume onwards, certain British philosophers followed Heraclitus' point of view, but did not always assume that there existed an underlying coherence of the universe. Charles Darwin introduced a similar argument into the new science of biology. However, in present day Darwinism one can find both philosophical stances. For example the Nobel laureate François Jacob (2000) wrote beautiful pages on the underlying unity of a universe that generates an immense variety of heterogeneous phenomena. As all these points of view remain valid possibilities, psychotherapists tend to use whatever philosophical frame they can comfortably work with. Plato is probably the most influential philosopher who developed a vision in which the soul is distinct from the body:

The body introduces a turmoil and confusion and fear into the course of speculation, and hinders us from seeing the truth: and all experience shows that if we would have pure knowledge of anything we must be quit of the body (Plato, 1937, *Phaedo*, 66, vol. I, p. 450).

In the 17th century the Dutch philosopher Spinoza (1677) presented a form of pantheist idealism that assumed the universe is a creative, coherent and harmonious entity which

generates all of its components (galaxies, planets and organisms). In this atheist theory there is no God, as the universe created itself. If subsystems (a society, an organism, a cell, and so on) conform to the logic of nature they will remain healthy, but as soon as they deviate from these principles, disempowerment, illness and misery will emerge. Every part of the universe needs to follow these rules: the smaller phenomena (an atom) can only follow some of these rules, while the larger ones (a galaxy) contain a greater number of universal dimensions. In this vision the mind is also distinct from matter, but the vision is now more systemic. Affects as well as wisdom are not located in a dimension of the organism but in their coordination. The organism can manage a greater number of universal dynamics than the subsystems it contains and coordinates (Misrahi, 1992), such as just the mind or the body individually. This new approach to body-mind dynamics was initially proposed by Descartes at the end of his life. After years of envisaging the multiple and complex relations between mind and body in all sorts of ways, he concluded that the soul is probably “jointly” linked to all the parts of the body via the mechanisms that regulate “the assembling of organs” (Descartes, 1953, *Passions of the Soul*, I.30).

I situate Wilhelm Reich's Orgonomy in this movement (Boadella, 2004). During the 1940s, he claimed that we should all become aware of the logic of the cosmic energy that structures and animates the universe, which he called the orgone (Reich, 1951). He asserted that we need to be in contact with the dynamics of orgone if we want to become healthy responsible citizens capable of experiencing orgasmic love, fondness for other creatures, and respect for the nature we are a part of. For him, hating oneself is equivalent to hating nature. This has led many neo-Reichian somatic psychotherapists to believe that truth is in our body, and that listening to the pulsation that emerges from our organism will generate pleasure, health and wisdom. For idealist body-mind disciplines, health can only be attained if a person's mind learns to increase his awareness of the truths hidden in his body. What is idealized in such formulations is not that an increased interaction between body and mind often brings “greater inner richness” (Selver and Brooks, 1980, p. 117), but that there is more truth in the body than in the mind. When I trained in psychotherapy in the 1970s, most body psychotherapists were influenced by Wilhelm Reich. They learned that there exists a force that is of cosmic origin and that must be close to Plato's conception of love as one of its manifestations is orgasmic potency. Contacting this force activates a developmental process that harmonizes the great diversity of mechanisms contained in our organism, and allows us to experience the bliss of being a part of the universal dynamics from which we emerge in a coherent way. Chaotic forces engendered by current forms of social organization, on the other hand, generate conflict, hate, illness and sexual frustration. This mode of thinking led to a variety of body psychotherapeutic approaches that aim to help individuals become healthy, self-regulating, constructive and creative persons capable of orgasm with their sexual partners. Those of us who followed one of these post-Reichian approaches learned to express our negative and positive affects as fully as possible. Once the discharge had ended, we experienced incredibly powerful and deeply blissful moments of harmony, during which we had the impression of being a dynamic global coherent entity. It was evident from Reich onwards that these deep emotional states could only be experienced in a supportive cultural environment that was rarely available in the societies that existed in the 1970s. This view was in line with the humanistic ideology that became fashionable in the 1960s and 1970s, and the idea that certain rigid cultural norms on the management of emotional interactions could have facilitated the emergence of capitalism, slavery, racism, fascism and communism. It may be noticed that in this generation of body psychotherapists, colleagues did not necessarily believe that Reich's orgone was the best way of describing cosmic forces. They were aware that

<sup>6</sup> It may be relevant to remind the reader that a dialectical interaction is not the same thing as simple harmonious coherence. Coherence emerges from the dialectics that organize the heterogeneous elements of a system. During his psychoanalytic period, Reich maintained that the interaction between body and mind was dialectic. He was inspired by Hegelian and Marxist dialectical logic. It is only at the end of his life that he talked of a functional identity of the body and the mind.

Reich's formulations and techniques were only a rough initial sketch of what could become an incredibly powerful movement. Inspired by Jung, many preferred to refer to more refined formulations developed by spiritual movements for deepening their understanding of how nature animates us. Some began to use the term "soul" with its original meaning: that which shapes individual organisms (Boadella, 1987). These theories resonated with my youthful passion for Plato's *Dialogues*.

In the 1980s, my thinking departed from harmony and coherence as a main human (and therefore psychotherapeutic) goal, and I began to integrate the principles of Heraclitus, Darwin's original formulations, and the modular models of artificial intelligence<sup>7</sup>. They all stressed the impossibility of harmonizing water and fire. Even acupuncture supported this change of perspective. Hiroshi Nozaki, with whom I learned Japanese techniques derived from Chinese massage, taught us that metal is an element that can creatively regulate the conflictual forces activated by water and fire. Cooking and steam engines are well-known examples. Metal allows one to channel the antagonistic energies of water and fire without destroying the particular properties of each element. Paul Boyesen, Gerda Boyesen's son and colleague, reminded us that energy is often produced through friction, as when rubbing two flint stones against each other to light fires. A similar effect can be observed in electrical engineering: you need well-differentiated polarities (+ / -) to create and manage a strong difference of potential. An optimal differentiation is required to generate electricity without creating a short circuit that could damage an electrical installation.

Charles Darwin (1859, chapter V) was puzzled by the incredibly messy architecture of organisms who nevertheless find ways of surviving and reproducing. Learning to live within these disordered processes was for him the essence of biological evolution. Psychoanalysts like Melanie Klein posited that even infants are full of love and hate. The violent fights between brothers and sisters are a good example of a state of affairs that has been brilliantly caricatured in the 1993 second full-length film on the Addams Family: Barry Sonnenfeld's *Addams Family Values*. I do not think that nature necessarily functions in a coherent and harmonious way, but it is possible that some parts of the human mind need to expect predictability and coherence. This need appears to be particularly important for infants (Beebe, 2011). This is an example of a form of wishful thinking that seems to be imbedded in the human condition, and that can eventually be considered a symptom of psychopathology when it becomes extreme. These probably innate aims could be strong motivators to increase the quality of communication with others (Stern, 1985).

This is a summary of a long discussion on the aims proposed by psychotherapists to their patients developed and referenced in my book on body psychotherapy (Heller, 2012). Does the psychotherapist promise more harmony at the end of a successful treatment, or a greater capacity to manage the conflictual forces that structure his organism and his environment? These issues are open questions, because I do not think they can lead to a straight answer. Maybe both formulations can be blended as two complementary, albeit irreconcilable, aims. These choices are partially dependent on a psychotherapists' individual character and personal inclinations. Every therapist is more comfortable with certain types of interventions than with others. I have met brilliant and efficient psychotherapists who defend either of these options.

### Which parts of me know what?

Idealistic body psychotherapists tend to reject Descartes, because for them, he is an icon for those who believe that soul and body are unconnected distinct entities. In fact the closest classical theory that defends the options of idealistic somatic psychotherapies is Descartes' last theory, in which he wonders if the soul is not "jointly" linked to all the parts of the body via the mechanisms that regulate "the assembling of organs" (Descartes, 1953, *Passions of the Soul*, I.30). In these approaches everything happens as if becoming aware of bodily sensations is the same thing as becoming aware of the soul as defined by Descartes when he was 50 years old.

Another typical trait found among those who were influenced by Reich (e.g., Alexander Lowen and Fritz Perls) is the assumption that all forms of *habitual* organismic practices (e.g., thoughts, behaviors, gestures, emotional reactions and muscular tensions,) are necessarily destructive chronic defenses that should be removed. They have been introduced into the organism by destructive social rituals. To rediscover who one really is, one must therefore throw them away so that the organism can repair its spontaneous regulation systems. In most neo-Reichian therapies and training groups of the 1970s, every time you were sad and cried or angry and yelled, the therapist would congratulate you for being so authentic; while every time you did not cry or did not yell when you were sad or angry, you were asked why you blocked your emotions, and how you had lost your authenticity. This strategy was a quasi-Pavlovian way of imposing a so-called "humanistic" vision on patients. In my view humans are infinitely varied, have infinitely varied needs, modes of functioning and ways of expressing emotions. Most habitual schemas are skills we need to survive; others were useful once, but are no longer needed. They can be more or less useful, more or less creative. They can even be simultaneously destructive and creative. I therefore tend to call these behaviors "automatic regulators" or automatic ways of doing things. In some cases I may observe that a habitual behavior had been relevant, but does not fit with the present environment. For example sulking may have been useful with one's parents, but may be destructive in the family one has created for one's children. In other cases I may observe, for specific reasons, that some regulation procedures are used as a defense or may have a negative impact on other organismic regulation systems. But even when it is so, a schema may have several functions, in the way that a word may have several meanings. It is not because a skill is used as a defense against a treatment that it does not also have useful functions. In other words recalibrating automatic schemas is often a wiser therapeutic goal than removing them. A well-known example is the use of intelligence and intellectual integrity as a defense. In the 1920s, Jean Piaget became Sabina Spielrein's patient for a psychoanalytic process. After eight months she decided to interrupt the treatment, because — according to her — Piaget only used these sessions to express his critique of Freud's approach (Ciffali, 1986). In this situation Piaget's intellect seems to have managed to disempower his analyst, but that does not mean that the intelligence of one of the most important psychologists of the 20th century was only a defense system.

For today's psychologist, the useful part of these discussions of habitual behaviors is that they highlight how deeply imbedded in organismic dynamics such schemas can be. We know that some habitual professional postures can be destructive for spines, breathing patterns and veins (Heller, 2012, chapter 12). Their interaction with affective dynamics may also interfere with the fluidity of their regulation. It is impossible to know whether sitting uncomfortably is a sign of anxiety or a way of producing anxiety, but one can show that in many cases postural particularities and affects interact in a way that reduces the variability of certain moods. Even if one criticizes the way the psychoanalysts of the 1930s talked of defense mechanisms, one has to admit that their clinical intuitions highlighted the fact that a highly visible habitual behavior

<sup>7</sup> One of the authors who introduced modular models to European body psychotherapists was Francisco Varela (1979).

may be the tip of an iceberg, with a web of roots beneath, deeply imbedded in organismic and social procedures. It naturally follows that initiating an analysis of habitual behaviors, with the aim of discovering how they can be leveraged to influence deeper layers, is also a possible psychotherapeutic strategy (Heller, 2012, chapter 22; Downing, 1996; Downing, Bürgin, Reck, and Ziegenhain, 2008).

### Scientific Idealism

Do I contradict myself? Very well, then I contradict myself, I am large, I contain multitudes (Walt Whitman, *Song of Myself*, 1892<sup>8</sup>).

In the body psychotherapy training groups of the 1970s, we discovered inner worlds that no other known approach could introduce us to. However, many then continued their psychotherapeutic process using other techniques such as Gestalt therapy, psychodynamic approaches, Jungian analysis or Transactional Analysis to consciously integrate what they had discovered (Carleton, 2002). For example, at the end of our training with Gerda Boyesen in the 1970s, she advised us to accept that her work could cure certain aspects of our affective regulation, but not all. That is when I began to think that using methods based on harmony is akin to a harbor for sailors. It contains a moment during which we can rest and be thankful, which in turn allows us to become ready to climb once again onto our ships with renewed enthusiasm. However, it is not in such a harbor that we can develop the skills to face the ever-changing oceans. Being ready to climb onto a ship again is a worthwhile therapeutic aim in quite a lot of cases, even if it does not fit every need. This analysis led to a new vision which did not require that a psychotherapy method solve all the psychological problems of a patient. In the 1970s many psychotherapists chose a more modular approach, which assumed that each school had its domain of expertise, and that some people needed different forms of psychotherapy that focused on different aspects of their psychological dynamics. Approaches that claimed to encompass all the existing psychological dynamics were considered old-fashioned, utopic and/or omnipotent. This evolving context led to increasingly less ambitious and more specific aims of psychotherapy processes, which can change from one form of psychotherapy to another.

Gradually, an increasing number of psychotherapists accepted the idea that the efficiency of psychotherapy is real but limited. Some of them managed to finance empirical studies that could evaluate the relevance of specific modes of psychotherapeutic intervention for specific symptomatology, in the hope that psychotherapy would become more efficient (Röhrich, Papadopoulos, and Priebe, in press; Savarese, 2013; Segal, Williams, and Teasdale, 2002). For the moment the results provided by this trend of research are often helpful, but not really more efficient than the more classical forms of global-depth psychotherapy. However, their realms of efficiency seldom overlap. They are therefore complementary.

It is within these scientific and/or empirical discussions that one often observes what I call “empirical scientific idealism”, which appeared alongside the first researchers who explicitly presented themselves as scientists, such as Galileo and Newton. They believed that there is a single set of coherent laws that govern every phenomenon of the universe, and must respect non-contradictory laws. The causal laws that animate the universe are so coherent that they can be expressed with logical, geometric and mathematical formulas. These scientists believed that one day we could mathematically describe everything that happens, even psychological dynamics. It is in this context that Spinoza, in his *Ethics* (1677), attempted to describe how humans function with a logical model.

In medicine this form of empirical idealism expresses itself in a spectacular way with anatomy books. These manuals assume that all spines should have a certain shape, all muscles a

given tonus, and so on. The argument that defends this assumption is based on mechanics and thermodynamics. It supports, for example, the requirement that a correct movement is the one that makes a minimal demand on muscular tone while remaining in harmony with its purpose<sup>9</sup>. Any deviation from this reference model is considered pathological. The same type of reasoning is applied to psychiatric classifications developed from the 1990s onwards. The present trend is to consider psychopathological any form of psychological or behavioral discomfort as soon as it is durably embedded in the dynamics of an organism. It is this ideology that is often highlighted by the media when criticizing the DSM-5. I have the impression that this trend is another form of idealism, because it leaves no room for considerations that assume the human condition is not necessarily comfortable, or for Darwin's thoughts on the spontaneous messiness of biological evolution and of the organisms that emerge from it. Empirical idealism assumes that there is one form of adaptation that is better than all other forms of adaptation. For instance the companies that produce genetically modified organisms tend to look for an ideal apple that can survive in all contexts and facilitate industrial agriculture, while nature tends to produce a wide variety of apples that fit particular ecological niches and have distinct properties. Personally, I prefer a world in which apples can offer a wide variety of tastes and textures, even if they seem to be less “perfect” for the eye.

### Research and Clinical Experience

#### Combining Scientific, Empirical and Clinical Observations

One point that is well known, but nevertheless has a strong impact on the difficulty of providing clear principles that define the aims of psychotherapy treatment, is that the scientific study of human psychological dynamics is a relatively young discipline. Clinical psychology and psychiatry have not yet been able to provide robust models that can be used by most practitioners in a reliable way. We do not have a well-established map of the dynamics that are activated during psychotherapy sessions. It is therefore difficult to propose a robust, reliable and explicit set of goals for a psychotherapeutic intervention after a few diagnostic interviews. That is why some talk of the art and science of psychotherapy<sup>10</sup>.

Even if we assume that we do not yet have an adequate theory to understand what psychotherapists do, we have enough experience to know that certain forms of intervention can be useful for a wide range of cases. This is an important aspect of our expertise. Many of us have observed that paying attention to the specifics of experiences associated with bodily sensations, as well as emotions, often may foster a constructive process, and that this type of process can require different pedagogical procedures for each person. Even if we do not know exactly what a client needs or what his goals are, we know how to pay attention and help him sharpen his awareness of how he functions in his<sup>11</sup> cultural environment. For François Lewin (in press) a psychotherapist can use his clinical knowledge a bit like a fisherman who, sensing the currents of a river, often has a good idea of where to throw his bait. His experience allows him to know where, most likely, he can find fish. Nevertheless he knows that his intuition is not always right. He then uses optional strategies that often work.

<sup>9</sup> Some of my Chinese tai chi teachers also used this formulation.

<sup>10</sup> For example the International Body Psychotherapy Journal has the following subtitle: The Art and Science of Somatic Praxis. See also Schore, 2012.

<sup>11</sup> Patients and psychotherapists are either male or female. I can only regret that there exists no term to explicitly render homage to both sexes. I will use the traditional masculine form when the sex is unspecified for these terms, as an ethically fair vocabulary would make the text more difficult to read.

Empirical researchers are gathering data that indicate the procedures used by psychotherapists based on clinical know-how are often reliably efficient (Despland, Zimmermann, & de Roten, 2010). This experience is calibrated by nonconscious procedures and a few explicit guidelines (Snyder, A.; Bossomaier, T., and Mitchell, D. J., 2004). A psychotherapist will tend to use what I call “placebo theories” (psychodynamic, Gestalt, Reichian, cognitive, behaviorist, and so on) that he appreciates because they were fashionable in his training environments, and/or because he was attracted by them, and/or because they support and channel his intuitions and spontaneous creativity in a relatively efficient way. The fact that a psychotherapeutic theory may be recognized by many but never by all respected psychotherapists is a part of the ethnographic context of psychotherapy schools. However the crux of the matter is that none of these theories actually allows one to describe more than a few of the phenomena that are at work during a psychotherapy process. For example psychoanalytic theories provide rationalizations for why psychodynamic psychotherapy works at least some of the time, but I do not think that these rationalizations can be used as reliable explanations (Stern, 1995).

In my scientific studies of nonverbal interactions between psychotherapists and suicidal patients (Heller et al., 2001), I discovered that most of the interactive patterns our team observed were not predicted by known psychotherapeutic theories, and that none of the phenomena we analyzed could be easily integrated by a recognized form of psychotherapeutic intervention. For example we observed that patients who made another suicide attempt after we had filmed them were often more expressive than those that did not make another suicide attempt. This was counter-intuitive for nearly all of my colleagues, as they assumed that the more expressive patients were necessarily healthier. This may often be the case, but here we saw cases that clearly limited the scope of that generalization. It would seem that a truly scientific exploration of the phenomena that are activated during psychotherapy could lead us towards unexpected findings that will require new formulations. This will inevitably lead to new modes of intervention and a new way of understanding what psychotherapists already do. These results may also help clinicians to revisit old strategies (Kramer, de Roten, Perry, and Despland, in press) and find new ways of explaining why they are efficient. This impression is shared by several psychoanalysts who are also involved in research (Roussillon, 2011; Beebe and Lachmann, 2002; Bucci, 1997; Stern, 1995; Haynal, 1993). One of the difficulties is that the first psychoanalysts used their conscious potential to describe phenomena that regulate the individual conscious, unconscious (in Freud’s sense) and nonconscious<sup>12</sup>. They did their best, but given the means that were at their disposal, they could only describe how they explained for themselves what they were aware of, and then teach the theoretical models they could imagine.

What we do not have enough of is *fundamental research* on the mechanisms that structure psychotherapeutic interactions (for example, Donnellan, Hill, and Leary, 2010; Archinard, Haynal-Reymond, and Heller, 2000; Frey, Jorns, and Daw, 1980), that will allow us to create a scientific understanding of how psychological dynamics can be calibrated by interpersonal procedures. Current empirical research does not satisfy this need, as it focuses on ends rather than on an understanding of the *procedures* (physiological and psychological) that are activated by psychotherapy. What we need to analyze are the nonconscious procedures that structure a process, and that are structured by it. Such a research project requires a large community of researchers that will study the phenomena with a wide variety of methods and theoretical constructions. It is this adventure that is slowly putting itself together. It requires a combination of data on introspection, physiological phenomena, nonverbal interaction between patients

and therapists, sentiments, impressions, thoughts, and an understanding of the cultural system that structures the field of psychotherapy. This research requires developmental data, as we need to know what happens to a patient and a therapist after a treatment<sup>13</sup>. If such a scientific exploration can gather momentum, it will not only give us much more information than standard empirical strategies that are used for evidenced-based treatments, but it may also help therapists to understand what is really happening during their treatments. Such research would allow us to combine hard data with subjective data in a unique way.

Scientific research will inevitably challenge classical psychotherapeutic assumptions. For example Ralph J. Savarese (2013) reviews studies which claim that empathy is not a coherent entity, but rather three partially dissociable systems: sentiments, cognition, and expression. They then show that autistic children are capable of experiencing affective empathy, but not the other two forms. They suffer from an “alteration of motor performance” that has a negative impact on their cognitive performance. The motor disturbance influences their capacity to express themselves (verbally and bodily), and inhibits current feedback systems between sentiments and expression, or between thinking and doing. Once this has been shown, researchers recommend “addressing motor development in early intervention treatments” with autistic children. This is a concrete example of research setting a specific aim for psychotherapeutic treatments by demonstrating the therapeutic salience of a specific issue. These observations can suggest specific options, but not concrete practical procedures. It is for people such as somatic psychotherapists, body-mind therapists and psycho-motor therapists to find ways of exploiting these results. This type of research confirms the need to intervene on a variety of organismic regulation systems (e.g., the motor system) to re-educate psychological dynamics (e.g., the intellectual capacity of certain autistic children), but it does not validate a specific form of sensorimotor intervention (Donnellan, Hill, and Leary, 2013). However, now that we know that there exists a correlation between specific motor deficits and IQ testing, we can test which forms of clinical treatment positively influence this correlation for autistic children. This will then allow us to combine information gathered by research in experimental psychology, evidence-based strategies, and the know-how developed for depth therapy to increase our understanding of autistic children and the support they need. Such studies show how experimental research can illuminate points which were previously considered secondary by clinicians but are in fact central.

### Contacting the Dynamics of Intimacy in and/or Focusing on Alleviating Symptoms

Classical psychotherapy required that a therapist help a patient understand himself in such an explicit way that he could then help the therapist to understand him. The therapeutic goal of this strategy is to explore how a person coordinates his inner dynamics with that of others, as this is often a difficulty of the client. The therapist may then fit shared meanings into models while empathically digesting through his own affects the general tone of the patient’s nonverbal behavior.

In somatic psychotherapies the patient is encouraged to express his experience through gestures and sounds that are explicit enough to be grasped by his therapist. They can then try to forge together an explicit web of meanings that can be associated with the patient’s behavior and impressions. Today this trend still exists as a way to resonate with patients (Kignel, 2010), understand them, and produce more refined models of how humans respond to internal and external events. Today the awareness of the psychotherapist is also supported by a steadily increasing body of evidenced-based research on the efficiency of the strategies used by

<sup>12</sup> My (Heller, 2012) understanding of nonconscious dynamics is that they cannot become conscious. One reason is that they manage more data and more complexity than an individual consciousness can apprehend.

<sup>13</sup> One often forgets that psychotherapy may also influence the way a psychotherapist regulates.

psychotherapists to tackle specific psychological, affective and behavioral procedures.

The initial aim of psychotherapists was one of understanding a shared intimacy. They noticed that offering a frame in which such a dialogue could be established could help people who were locked in their internal dilemmas. It is this basic initial aim, probably unheard of in the history of human therapeutic skills, which justified the fame of the first psychotherapies in all cultures, from Europe to Asia and the Americas. Even the refined body-mind approaches developed in the Far East, like meditation, have not produced such a clinical knowledge of a citizen's current intimate dynamics. Although meditation is an incredibly powerful way of exploring mental impressions, it was often associated with spiritual beliefs that sought to transform existing human dynamics according to spiritual requirements developed independently of the needs of specific individuals. Janet and Freud (Brown et al., 1996) wanted to understand frustration, pains and affects as they exist in everyday life. Their therapeutic aim was to find ways of improving the social support system (e.g., psychotherapy is a social support system) so that current chaotic affective dynamics could develop in less painful ways. It is this achievement that has changed the relations between social procedures and individual needs in most cultures of the planet. Knowing each other as we are is thus a basic directive for early psychotherapeutic movements. As psychotherapy is only 120 years old, most psychotherapists are still strongly influenced by this trend.

One of the difficulties that the new trend of empirically based eclectic approaches needs to resolve is that each classical approach is a more or less coherent package of techniques, methods, theory, ethics and philosophical intentionality. All these elements support each other. For the moment, taking a technique out of its context may be perilous, as the limits of a specific type of intervention may not be sufficiently compensated by the other techniques used in an eclectic context. For example some body techniques used by a somatic psychotherapy school may become harmful if the therapist has not received the necessary training to evaluate the implications of using these techniques. These methods require a certain form of awareness, respect and insight that psychotherapists trained in other modalities may not necessarily have acquired. This was for example the case of Wilhelm Reich, who had been trained in psychoanalysis but not in the use of body techniques. He was surrounded by experts in body-mind approaches, but did not use their knowledge to become familiar with his own sensorimotor dynamics. Since Reich's initial proposal in the 1930s, most neo-Reichian schools have proposed a more professional approach to body-mind connections.

### **Combining Ethical and Clinical Points of View to Define the Aims of Psychotherapy**

#### **Ethical Considerations Related to an Individual's Social Support Systems That Have an Impact on the Aims of Psychotherapy**

I assume that I am not the only psychotherapist who often navigates between the traditional and the new strategies developed by psychotherapists. Somatic psychotherapy is well placed in this discussion, as its theoretical stance allows psychotherapists to combine exploration of one's deepest sentiments with educational and medicated forms of intervention. For example the efficiency of psychiatric drugs demonstrates the need to approach affective dynamics from a somatic perspective. Body psychotherapy is the tool that allows patients to constructively integrate somatic activations and impressions induced by exercises, medication and dreams.

The psychoanalytic model assumed that sexual malfunction activates strong psychological discomfort, and that most of these sexual perturbations are manifestly generated by social

dynamics such as beliefs that go against inescapable instinctual needs (e.g., religions that make one feel guilty about experiencing sexual pleasure or having one's own sexual style, poor working conditions that generate stress, and so on). This epidemiological approach to neurosis was at first developed by Freud and the youth movements at the beginning of the 20th century (Geuter, Heller, & Weaver, 2010). It was then developed in a more systematic way while Reich was still a psychoanalyst. He created structured political movements to demand that sexual needs be supported by social institutions. This led to the creation of powerful institutions that support family planning.

In the present economic and political context, people are often used and abused by their professional environment until they have a burnout, become depressed, or commit suicide. They are then taken over by medical care and social support systems, while employers feel free to use the same strategy with new employees who are — for the moment — still in a healthy condition. Psychotherapists can coach patients out of their present crises and help them learn how to defend their interests more efficiently in the future, but they cannot modify the social dynamics that destroy individuals. However, they can inform the authorities and the media that this vicious circle is spreading as rapidly as the warming of the Earth. For me, this is not only an ideological issue, but a central ethical and therapeutic concern for all therapists. Reich would warn his patients that they cannot be completely cured in the present social context, and that one of the aims of a psychotherapy treatment is to discover why it is important that patients become active militants that demand a better world for their children than the one they were born into. This multi-generational strategy has already proven its usefulness in domains such as the rights of women, defense of children against abuse, and AIDS. Psychotherapists cannot cure patients who have suffered from abuse, but they can try to alleviate their symptoms and then support political campaigns that will fight for more constructive social environments and preventive measures. Thus, publications, public presentations and helping patients to hope and fight for a better future are also a set of crucial aims of a psychotherapy treatment.

#### **Therapeutic Ethical Considerations That Have an Impact on the Aims of Psychotherapy**

Alleviation rather than cure is a justified aim for many adults who need psychotherapeutic support, if one assumes that it is difficult to completely disentangle a set of destructive modes of functioning from organismic regulation systems that have calibrated themselves through decades of functioning in a given habitus or way of living<sup>14</sup>. Psychotherapists once had the ambition of definitively curing someone from difficulties such as anxiety or depression. In some cases this does happen, but today psychotherapists know that it is more realistic to aim at helping patients to live with recurring cycles of depression or anxiety (Segal, Williams, and Teasdale, 2002). They therefore seek to help the patient a) survive the present crisis, and b) improve his way of dealing with the cyclical aspect of the syndrome.

Ethical considerations recommend that therapists avoid using simplistic empirical research or ideological considerations. For example, colleagues manifestly influenced by Reich's proposals explicitly included in their goals that their treatment should help their patients to find a greater inner harmony and coherence, using tools such as the dissolution of body armor, developing orgasmic potency, the spontaneous capacity for self-regulation and self-respect, and the ability to energetically pulsate (expand and contract) with ease and power (Lewin, in press; Brown, 2001; Heller, 1993; Rosenberg, Rand, and Asay, 1985; Lowen, 1975). Most of these goals are respectable, but some are more ideological than therapeutic. They can never be the only aims of

<sup>14</sup> This term is used in this way by sociologists like Pierre Bourdieu (1979), who studied how an organism is shaped by the social rituals that a person has practiced (sports, furniture, eating habits, profession, etc.).

psychotherapy. Even for Reich, developing one's creative professional potential was as important as orgasmic potency. A patient's belief system may be quite different from those defended by his psychotherapist. Both may be equally respectable. Sometimes a patient may have more refined aims than his therapist. I have had patients I admire. They came to see me because they suffered, not to exchange intellectual ideas with me. The ethics of psychotherapy require that a psychotherapist should try, as much as possible, to explicitly discuss with a patient how they may combine what a therapist can do well with what the patient needs to integrate. When such an explicit co-construction is avoided, the patient may need to develop defense systems that allow him to survive in such a psychotherapeutic context. He may for example appreciate the anti-anxiety procedures taught by the therapist but dislike the therapist's constant need to impose his worldview (*weltanschauung*). In such cases the therapeutic procedures may become counter-productive, as the psychotherapist may not realize that his ethics create the defenses against the treatment.

### Who Decides What the Aims of Treatment Are?

Patients that enter psychotherapy seldom know what they really need (Reich, 1949; Fenichel, 1935). They just want less pain and guidance around future choices. Most of them do not think of harmony or the integration of conflicts unless they already appreciate theories that use these notions. It is also possible that the use of such terms is a simplistic polarization of a wide range of issues that can help therapists to navigate and contain the process that the client takes to get to where he wants to be.

Other body psychotherapists use a language that is clearly not Reichian. They prefer to use recent criteria such as the reduction of symptoms (PTSD, anxiety, depression, etc.) and strategies that teach required skills, improve affect regulation, resilience, and so on. These approaches can also use a combination of body and mental techniques. They are manifestly inspired by recent trends such as cognitive and behavior therapy and/or neuroscience. These approaches tend to abandon the need to focus on specific psychological requirements, and seem to put psychological, affective, behavioral and somatic dynamics in a mixer, to observe what emerges.

Balancing the variables that will determine the aims of psychotherapy also raises ethical issues about the authority of a specialist vs. the empowerment of patients. Psychoanalysts attribute unconscious issues the patient does not perceive (e.g., an abusive use of notions such as the Oedipus complex or castration), Reichians analyze the body structure of a patient and deliver a diagnostic (e.g., Lowen, 1975), and clinical psychologists use tests that may be presented as a scientific way of determining what the patient needs. Abuse of power by psychiatric institutions and psychotherapists has a long history. Except in particularly dramatic cases that are supervised by the judicial system, the recommended position is that patient and therapist need to discover together, through a mutual co-construction, what the patient's underlying dynamics and needs really are. I sometimes have the impression that when they have a deep crisis, patients are not competent judges of their needs; but most of the time they are highly competent evaluators of themselves, even if they suffer from current psychopathological ailments.

Current psychiatric testing techniques developed by clinical psychologists are also useful, but their value is based on statistical notions that do not always provide a reliable evaluation of a particular person. For example I have used the same tests (e.g., the Beck Depression Inventory (BDI) and the Hamilton Psychiatric Rating Scale for Depression (HRSD)) to evaluate the anxiety of suicidal psychiatric patients and those who come to see me in my private practice. I noticed that a psychiatric patient who is used to extremely strong anxiety attacks may refer to his present state as being of a medium intensity, while a patient who is only used to lower

intensities may consider an equivalent intensity as extremely high. This is a current problem with psychiatric tests. Nevertheless testing techniques have become increasingly refined. When patients who come to see me already have a psychological evaluation based on tests, I have always found them useful and instructive, even if I mostly use deep psychotherapy procedures.

To deal with these issues I like to use the metaphor of layers or strata, as often used by Freud and Reich (Reich, 1940, p. 90; Breuer, & Freud 1895, p. 206ff), to analyze a psychotherapeutic interpersonal dynamic. The issues I have just mentioned can be situated in different strata of a person. A patient arrives at therapy with a conscious goal (e.g., my wife wants me to see a psychotherapist because I have increasingly violent fits of anger), unconscious goals (e.g., I need to find a father who can help me to manage my fear of mothers) and nonconscious goals (e.g., since my difficult birth anxiety tightens my breathing and this generates even more anxiety). In the same way, the therapist may want to use standard procedures for anxiety, have unconscious reactions to men who fear mothers, and feel a knot in his stomach every time this patient enters the room. It is only gradually that the implications of this dialogue of patterns will become increasingly clear, and that we can create a more explicit common representation of the issue that brought the patient to psychotherapy. Often (but of course not always) the "official" symptoms of a patient (e.g., panic and low self-esteem) depart in a few months, but then it will require another year or two to clarify the issues that really motivated the patient to come. Sometimes it is the opposite.

### In All Cases Psychotherapy Combines Multiple Goals

It is also useful to distinguish aims that concern the body, affects, lifestyle, and cognition of the patient, as well as problems that others may have with him. These factors can be more or less tightly related. Assuming that all the events occurring in an organism are necessarily closely related<sup>15</sup> is a belief that is not confirmed by my clinical observations. Dimensions of the organism (Heller & Westland, 2011) often — but not always — interact with each other. The modalities of these mutual impacts can be highly variable, and are often asymmetric. For example, muscular tensions influence moods in one way, and moods influence muscular tensions in another way. In some cases the chronic muscular tensions of a person relax when he is less anxious, but relaxing his muscles with massage or relaxation when he is anxious may increase the level of anxiety. The interfaces among all these dimensions can be highly varied. They vary from one individual to another, or even from one moment to another. Deciding that a psychologically tense person needs relaxation is often a valid aim, but not always. The same has been observed with anxiolytic drugs.

Back pain may be due to biomechanical forces caused by the chair used by the patient in his office, they may be a way of controlling anger, and/or a back pain may activate endorphins that ease anxieties caused by a separate set of issues. Two symptoms may have independent causes, but can associate later for a variety of reasons. Thus an association between a back pain and anxiety may be strong today, but have had a different past history.

There may also be a gap between the ambitions of a therapist and those of a patient. Some patients come for a specific psychological pain, and want to stop therapy as soon as this pain has disappeared. Many psychotherapists find that this is a pity, because they were beginning to understand the deeper inner conflicts of the patient. The psychotherapist's passionate interest in the deeper structures of the mind is an important motivator, but learning to remain close to the patient's limitations and needs is even more important. This interest can also be put in the basket of implicit goals that animate many psychotherapists. Most people cannot afford to

<sup>15</sup> As when Alexander Lowen (1975) talks of functional identity between body and mind.

spend hours understanding their deeper selves. My way of dealing with this is to encourage the shortest psychotherapy possible; but at the end of a treatment I help the patient to understand what we have accomplished, and then mention other “chapters” that may require another set of psychotherapy sessions in a few years. I have had patients come to see me several times throughout their lives, or who later consulted with other colleagues to deal with the next chapters I outlined for them. I was amazed to notice that those patients who came to see me again often began with issues they had raised in the last sessions of the previous set of sessions. For example a patient mostly worked on her father during a first set of sessions, but mentioned a few difficulties with her mother. Five years later she came to work with these issues which had recently become increasingly intense. Separating a process into different “chapters” has several advantages:

1. A patient must digest the often complex matters that structure his life. Integrating what we discovered during a set of sessions may take years. A patient does not always need to see a therapist while this recalibration process materializes into a new way of dealing with self and others. In some cases continuing the psychotherapy may even prevent this much needed recalibration in real life.
2. Psychotherapy, in my experience, is particularly efficient when the sessions focus on themes that are manifestly problematic in the present situation of the patient. One patient came to see me a first time because she could not have sexual relations, for mechanical sexological reasons. I mostly used deep vegetotherapy, which involved the exploration of movement, muscular tensions, breathing patterns, emotional expression and the orgasmic reflex as defined by Reich. Because of the dreams that appeared, we mostly worked on how she perceived her father. Ten years later she came to see me because she became depressed once all her children were at school. In the meantime she had married, experienced sexual pleasure and become a good enough mother and wife. We then worked on issues linked to her mother’s intrusive behavior. Ten years later a new depression emerged when her grownup children left home. She was looking for a job, but did not have enough confidence to make relevant choices for her new career. This time she needed to work on her problematic relationship with a sister. Since then I have only seen her for three sessions, during which she needed to discuss a difficulty that arose with the institution in which she was working.

This case, as well as several others, raises the issue of whether one should try to solve all the problems of a person in one therapy, or if psychotherapists should only aim for what the client can integrate at that given moment.

### **Finding One’s Way in the Vicissitudes That Connect an Individual Psyche to Other Dimensions of Interacting Organisms**

It is one of the mysteries of our nature that a man, all unprepared, can receive a thunder-stroke like that and live. There is but one reasonable explanation of it. The intellect is stunned by the shock and but gropingly gathers the meaning of the words. The power to realize their full import is mercifully wanting. The mind has a dumb sense of loss – that is all. It will take mind and memory months, and possibly years, to gather together the details and thus learn and know the whole extent of the loss (Mark Twain, *Autobiography*, 1896-2012, p. 165).

### **Many Roads Lead to Rome, but Some Are More Convenient Sometimes**

As already mentioned, Wilhelm Reich’s idealism, as well as the belief that we have a soul, supports the impression that a part of us can truly know. If it does not know the whole truth, it is at least closer to the truth than the other parts. Among somatic psychotherapists there is often the belief that the body knows more than the mind (well-discussed in Hull, 1997; see also Warnecke, 2011). If we consider that the mind is only a part of the organism, one can assume that the organism manages more information than its parts. However the mind is like an Internet connection. It can contact forms of knowledge that are not contained in the individual organism (Rochat, in press), as in learning breathing techniques, rituals that protect one’s health, scientific knowledge, and so on.

When I want to understand where a patient needs to go, I listen to what he has to say, observe how his body moves, the texture of his skin, his gaze, breathing movements, postural dynamics, nonverbal communication, and attempt to reconstruct in myself what it must be to experience what my patient communicates about himself. This implies becoming aware of the impact my interaction with the patient has on all the dimensions of my own organism. I cannot follow all these dimensions at once, but during a year of sessions I have usually visited some of them several times. All these factors structure the general atmosphere in the room. An atmosphere for me is the brief summary of what is happening that is created by my nonconscious procedures for my conscious thoughts. This impression is structured by most of the events that have an impact on a psychotherapeutic dyad or group. Its sources are not exhaustive and it is not a neutral summary, as it includes how I insert myself into the present situation<sup>16</sup>. However it is a rich source of information for someone who wants to explore how our intimacies interact. As I always work in the same room, I can become highly sensitive to small variations in the atmosphere. It is this constant dialogue between my complexity and that of a patient that allows me to discover what dimensions and techniques could help a given patient at a given moment. Clinical knowledge and experience are also an important calibrator of the way I understand what an atmosphere conveys.

When it seems relevant, I may discuss with the patients the limits of my knowledge and may sometimes refer him to a colleague, or ask him to join a group in another approach while he continues his psychotherapy with me. Today, most patients refuse to do more than one session a week, even if they would need to see me more frequently and can easily afford it<sup>17</sup>. However, if I ask them to join a yoga group to learn how to work with certain connections between mind and body we do not have the time to explore, they may follow my advice. I can then focus on those aspects of their process for which my expertise is particularly relevant. I may also recommend certain psychiatric drugs<sup>18</sup>, and then explore with the patient the impact of that drug on his habitual ways of experiencing himself and others.

### **How Much Understanding is Required?**

Another issue in the aims of psychotherapy is to evaluate how much understanding can be dealt with in a specific psychotherapeutic process. Psychoanalysts require insight (Ahumada, 2011) and “making the unconscious conscious” (Fenichel, 1953b, p. 185), Gestalt therapists aim for an increase of awareness (Perls, Hefferline, and Goodman, 1951), cognitive and behavior therapists mostly look for awareness and the internalization (or learning) of relevant exercises and models (Reinecke & Ehrenreich, 2005).

<sup>16</sup> Nice examples can be found in Prengel & Somerstein (eds), 2013.

<sup>17</sup> Several hours a week was standard until the 1980s.

<sup>18</sup> In Switzerland medication can only be prescribed by a medical doctor.

The iconic expression “making the unconscious conscious” is often attributed to Freud, without any referencing, as if the main aim of a psychoanalytical cure could be summarized by such a simplistic iconic sentence. Freud only used this formula at the end of his life, in his 1933 *New Introductory Lectures on Psycho-Analysis*, in chapter 31<sup>19</sup>: “The whole theory of psychoanalysis is, as you know, in fact built up on the perception of the resistance offered to us by the patient when we attempt to make his unconscious conscious to him.” Freud is actually writing about a psychoanalyst who helps a patient to become aware of specific unconscious material which “has a strong upwards drive” (1933, p. 75) to become conscious, maintained out of consciousness by a resistance that is active in a particular transference context. He is not saying that at the end of a psychoanalytic therapy, information flows on a highway that can bring all that is in the unconscious into conscious dynamics. Yet this formula was nearly immediately used to convey that last meaning by the young psychoanalytic trainees of the time — including Fenichel (1940, p. 185) and Reich (1949, p.11), as if constructing such a highway is not only possible, but one of the main aims of psychoanalysis. Freud did not think that consciousness has the capacity to perceive and integrate all the information that circulates in the unconscious and the preconscious (Freud 1938, p. 30f)<sup>20</sup>. Making the unconscious conscious was for him an impossibility if one has a correct understanding of his psychological system. Transforming unconscious content into conscious thought requires “an expenditure of effort” (Freud, 1933, p. 76) that is enormous, for both therapist and patient. This enormous “expenditure of effort” is familiar to all schoolteachers. Even when a teacher tries to transfer a small and simple part of his explicit conscious knowledge to schoolchildren, the expenditure of effort is enormous. Furthermore each system has different aims, tasks and functions: “Everything conscious was subject to a process of wearing-away, while what was unconscious was relatively unchangeable” (Freud, 1923, p. 176). Consciousness adapts to what is happening in the here and now, while the unconscious is more like a library for past experiences. Nor did Freud want defense mechanisms to disappear. He wanted them to lose their rigidity: they should have enough tone to protect the consciousness from being intruded upon, but they should also have a flexibility that can channel a fluid circulation of information. This more complex formulation is, in many ways, closer to what is discussed in non-psychodynamic models such as Gestalt therapy (Perls, Hefferline, & Goodman, 1951)<sup>21</sup>. Even Fenichel finally agreed that the famous formula was not a realistic aim for psychoanalysis: “Conscious phenomena are not simply stronger than unconscious ones; nor is it true that everything unconscious is the ‘real motor’ of the mind, and everything conscious merely a relatively unimportant side issue” (1945, p.15).

I have detailed this debate to highlight the idea that psychotherapy does not require of its patients that they become illuminated beings (Freud 1933, p. 86). The self-understanding a patient can acquire during a psychotherapy is often enlightening and empowering, but of course limited. Even scientists cannot understand how humans function (Stoljar, 2005). Even I cannot fully understand my patients and how my interventions work. The crux of the matter is that individual consciousness can only manage a limited amount of truth and information. That is why science can only progress as a community that gradually integrates the sometimes explosive truths some of its members may bring forth. That is another reason why I prefer psychotherapeutic processes that advance by chapters explored at different moments in one’s

life. There always comes a moment when the minds of patients and therapists are saturated by the amount of data they manage. Letting this “blooming confusion” (James, 1890, p. 462) rest for a while is often useful. Once it has been digested and integrated by nonconscious procedures and has generated new skills, a person may be ready for a next meal, if he still needs it.

This does not prevent me from trusting the know-how that the community of psychotherapists has created in the past 130 years. Psychotherapists have noticed that their work somehow activates a general reshuffling in the nonconscious dynamics of a patient’s organism that often allows him to develop in a more constructive way for himself and his environment. When a patient takes an anti-depressant, it often helps him to think more clearly, and to react less impulsively and destructively to what happens around him. A similar effect can also be activated by meditation. We do not really know how psychiatric drugs alleviate depressive symptoms, and we cannot always predict which drug will have a particular effect on a particular person (Krishnan, and Nestler, 2008). I have observed that often a constructive reshuffling of nonconscious procedures can emerge months after a patient has stopped psychotherapy and/or taking anti-depressants and/or going to a meditation group.

In some cases a few simple explanations or actions can trigger such a nonconscious realignment. For example touching an arm or speaking of a dream may activate in the patient’s organism a set of independent heterogeneous local procedures (or modules) that are not coordinated. In other cases these modules may have an impact on more general procedures, such as breathing, metabolic activity, moods and cognitive procedures. In other words simple and clear interventions may have complex implications that a psychotherapist can learn to detect and follow. If these adjustments only slightly increase a patient’s capacity to self-adapt to what happens in his environment, the therapist knows that for the moment he is going in a constructive direction.

### Is There a Main Cause?

It is not the isolated experiences that produce neurosis, however. It is the accumulation, the load of one bad experience after another that does it (Janov, 1913, *The Feeling Child*, p. 13).

At its beginning, the aims of psychotherapy were of two types:

- I) Freud suggested that neurosis was caused by a single traumatic event. He thought that once a patient became explicitly aware of these causes the neurosis would just disappear.
- II) For Pierre Janet, on the other hand, “physical and mental action range from the most primitive, reflexive, and elementary to the complex and sophisticated actions that require a large degree of integrative capacity” (Ogden & Minton, 2001, p. 131ff). These organismic mental levels function relatively independently from each other, and follow different sets of procedures and goals. Traumatized persons tend to rely on lower level responses, even when they could have used more complex ones. Learning to find ways of integrating such heterogeneous internal modalities is, for Janet, one of the goals of psychotherapy (Janet, 1890, part I, chapter III).

I still have patients who come to me thinking that they will be cured as soon as they recover the memory of an event repressed in their unconscious. Some even believe that this repressed memory is necessarily that of a sexual abuse that occurred in their childhood. Such a view was indeed presented by Freud in three articles published in 1896. He speaks of the first thirteen cases of hysteria that would have been healed after being able to recover the memory of “a precocious experience of sexual relations with actual excitement of the genitals, resulting from

<sup>19</sup> I thank André Haynal for his help in finding this quote. It is rarely referenced.

<sup>20</sup> For a recent study on the limits of conscious explicit attention see Gallivan, J. P., Chapman, C. S., Wood, D. K., Milne, J. L., Ansari, D., Culham, J. C., and Goodale, M. A., 2011.

<sup>21</sup> Laura and Fritz Perls undertook psychoanalytical training in the 1930s in Berlin, where they studied with Fenichel and Reich.

sexual abuse committed by another person; and the period of life in which this fatal event takes place is the earliest years — the years up to eight or ten, before the child has reached sexual maturity” (Freud, 1896, p. 152). Somehow social myths are stuck on what Freud wrote in these articles.

I have met well-trained psychotherapists who came to see me in the hope that body psychotherapy would help them find the ultimate cause of their anxieties, which they had hitherto not been able to find during their psychoanalytical processes. I have been able to help some of them, who are now less anxious than when they came to see me, but we did not always find a core cause of their anxieties. We often arrived at a system of highly varied events which we tried to untangle together. Their anxiety was caused by a Gordian knot that was much too complex to be apprehended by conscious procedures. In most cases we managed to untangle important sets of marking events, but in the end we did not feel that we had found a basic cause. As the recurrent anxiety crises that brought them to my practice had become rarer and less intense, we nevertheless had the impression that our meetings had been useful.

When Reich (1940, V.1; 1949, I.I–III) began his character analytic work at the end of the 1920s, he was trying to solve the following preoccupation raised by Freud and Ferenczi<sup>22</sup>: some patients became conscious of an initial traumatic situation, but that did not help them. These psychoanalysts assumed that this was due to the fact that the patient had retrieved cognitive information from their memory, but that the emotional dimension remained in the unconscious. In other words, the defense system had managed to split the cognitive content from the emotional experience. This raised a new “technical” issue: how to ensure that the unconscious repressed memories would only reach consciousness when the cognitive and emotional dimensions of a traumatizing situation could both become a part of the emerging conscious memory. After spending several years trying to solve this problem, Reich (1949, I.II, p. 11) came to the conclusion that psychoanalytical theory cannot explain this problem, and that its approach cannot solve it. He realized the real problem is that remembering a traumatic event is not enough to repair the damage created by it in an organism. Managing to experience events emotionally as well as cognitively was a step in the right direction, but not the end of a psychotherapeutic process.

While, in the 1940s, some of Freud’s pupils and trainers were still struggling with the hope that making the unconscious conscious could cure all, Freud could claim that he had clearly explained why he abandoned this goal forty years before (Freud, 1895). He, for example, had noticed that patients who suffered from what he called anxiety neuroses blended (as does hysteria) physical symptoms (excessive cardiac palpitations, respiratory and digestive problems, bodily shaking and trembling, cravings, vertigo, etc.) and mental symptoms (fear and anxiety). This type of neurosis could also have a sexual origin, but they were caused by repetitive frustrations rather than by a single event. For instance, as there was no reliable form of contraception at the time, a husband would withdraw before ejaculating when he made love to avoid having a child. It is that repeated frustration that, according to Freud, caused anxiety neuroses. For these cases Freud proposed a model that was closer to Janet’s, in which automatic instinctual behaviors were regularly inhibited by socially constructed habits.

Among professional psychoanalysts the hope of finding the initial cause of a neurosis became less central but never disappeared. With vegetotherapy, Reich innovated: he defined

his treatment as a systematic loosening of psycho-vegetative defense systems. This type of character analysis is relatively independent from content. The therapist simply loosens the defense mechanisms and observes what emerges. Reich himself was too much of a classical psychoanalyst to perceive that his method could be used in this less biased way. He still hoped that once he had loosened all the muscular armor he would discover the initial cause of a neurosis. Still a Freudian at heart, he assumed that the pelvis should be dealt with at the end of the process, and that he would inevitably end up discovering that the origin of a neurosis was an infantile sexual trauma (Reich, 1940). However, what his clinical cases show is that largely the loosening of the armor activated a wide variety of repressed emotions and memories that were often equally dramatic<sup>23</sup>. Only a theoretical bias could attribute what emerged when the vegetotherapist worked on the pelvis to a deeper —or more fundamental — nature than what had been previously worked on. Near the end of his life he went beyond therapeutic aims when he claimed that only an unarmored person could contact his inner orgone pulsation and be cured (Reich, 1951). What is proposed here is a search for perfect human beings of the same type as the search for illumination proposed by the meditation processes of yoga and Buddhism.

At the end of his life Reich despaired that his therapy could transmit the qualities that, according to him, he had probably acquired by developing qualities he had had since birth: orgasmic potency, no armor and a deep sensual contact with orgone energy. A striking example of Reich’s idealism is revealed to us in a moving recording that he left for posterity on April 3, 1952, after a serious accident caused by his experiments on orgone and nuclear energy<sup>24</sup>. Clearly depressed, Reich (1952a) gives witness that he is the only one to have grasped the actual situation and to have been able to propose adequate solutions. He is desolate to be surrounded by incompetent persons (too neurotic) to understand, as he did, what was at stake. He is obviously the one through whom cosmic truth can express itself and incarnate itself in this world (Reich, 1953). This implies that even his patients could not achieve the goals he had set for vegetotherapy and organomic psychiatry.

If we leave Reich’s idealist ideology aside, we can observe what emerges when one tries to understand and modify body-mind structures, and then decide what a patient needs to integrate to finish a creative chapter of his personal development. This stance was developed by neo-Reichian therapists in the 1970s (Boadella, 1987; Lowen, 1975; Boyesen, 1970). I remember that during my training with Gerda Boyesen, she would tell us that she had once completely eliminated the armor of a patient. He became psychotic and was sent to the psychiatric hospital where he was supported with a different type of treatment. Gerda Boyesen was also influenced by Fenichel’s critique (1935) of Reich’s vegetotherapy, in which he defended the utility of defense systems and the idea that armor was more complex than the rigid segmentation Reich had imagined. In an interview in 1952, Reich even became openly pessimistic that psychotherapy could modify deep human structures (Reich, 1952b). Gerda Boyesen was not the only neo-Reichian who destroyed patients using such a drastic aim<sup>25</sup>. I have friends who also ended up in the Geneva psychiatric hospital because of primal scream treatment (Janov, 1973). These “accidents” were not frequent, but they occurred often enough. Eliminating the armor of a person is an aim that is rarely defended today in the field of body psychotherapy.

<sup>22</sup> A more psychoanalytical discussion of this theme can be found in various parts of Haynal (1987). It would seem that Freud, Ferenczi and Balint included in the discussion of the psychoanalyst’s difficulties in combining the cognitive and emotional dimensions of a transference dynamic.

<sup>23</sup> I have for example observed that working on the rigidity of eye movements could activate extreme affective discharges (Heller, 1983).

<sup>24</sup> I discovered this tape in Bjorn Blumenthal’s library (Oslo).

<sup>25</sup> It is to be noted that disastrous effects of psychotherapies have been observed in all psychotherapeutic schools. For example I have friends who have suffered from their psychoanalytic treatment.

Before the Second World War psychotherapists mostly saw neurotic patients. Other character structures were rarer in a private practice. However, hysteria and other forms of neurosis are now less frequently seen—perhaps because psychotherapy can be effective. In the field of body psychotherapy, it is traditionally assumed that neurotic patients are over-armored. Loosening their armor can therefore be a useful aim (Heller 2012, p. 507f). However, by 1949, Reich (1949, chapter XV) had already noticed that schizophrenic patients do not have enough armor. He then renounced formulations that implied that no armor is the road to health. In the 1970's an increasing number of patients with insufficiently strong defense systems were seen in private practice. This required new ways of practicing psychotherapy, which generated a new vocabulary (narcissistic and borderline personalities, trauma, PTSD, etc.), and new authors (Warneke, 2011; Marlock & Weiss, 2001; van der Kolk, McFarlane, & Weisaeth, 1996; Kernberg, 1975; Kohut, 1971). This change in clientele led body psychotherapists to develop less intrusive body psychotherapy methods (Heller, 2012; MacNaughton, 2004; Levine 1997) and to revisit Janet's aims (e.g. Ogden and Minton, 2001 2001; Downing, 1996). Although most of these authors have been trained in neo-Reichian schools, they now include in their synthesis of body psychotherapy cognitive and behavior therapy methods and refined body techniques. Like Janet they tend to focus on specific sensorimotor patterns which are activated by procedures that complex conscious schemas cannot apprehend in a direct way. They are also close to Freud's aim of fluidifying the connections between the procedures of the organism, rather than believing that they should all function in a coherent way. Respecting the different requirements of each organismic procedure is for me the same thing as respecting individual particularities. As soon as automatic sensorimotor reactions are differentiated from more complex cognitive procedures, working on how explicit conscious procedures integrate actions they cannot understand becomes a key feature of psychotherapy. This implies working on the coordinations that emerge when a new repertoire of schemas modifies the old repertoire<sup>26</sup>.

This more recent formulation, inspired by Janet, was proposed by psychotherapists working with patients who well remember their initial trauma. This is often the case when the trauma(s) occurred after the first years of life. In these cases dealing with the power of memories becomes a central issue. Traumatic memories tend to pop up at different moments, with full-blown affective charge, or to associate themselves with trivial events in ways that put the person in crisis.

### Conclusion

In this article I have mostly shown why we should be careful when we use implicit idealistic principles in our discourse. However one also needs to understand why idealism has been so effective. My sense is that the idealism of Plato describes the impression we need to have to think efficiently. When I speak with someone of green grass, my consciousness assumes that those I speak with have the same definition of what is green. Without this assumption communication would soon become impossible. Because this impression is a requirement of explicit conscious procedures, we are often seduced by theories that associate this impression with deep, spiritual and/or cosmic forces. Furthermore, scientific idealism has shown that its assumptions can create approaches that describe and manage the universe with spectacular efficiency. It is only with the appearance of psychology and the social sciences that we can seriously begin to doubt that idealistic presuppositions really describe reality as it is<sup>27</sup>. This explains why idealism is still so popular.

<sup>26</sup> Once again meditation techniques are also helpful to refine the interaction between our awareness and inner phenomena we cannot apprehend.

<sup>27</sup> I am aware I am taking a shortcut here, but a longer more subtle paragraph would arrive at the same conclusion.

After having taken long detours, I nevertheless arrive at a conclusion that has been at the back of my mind for decades, which is that a basic aim of psychotherapy is to complete a person's education by helping his strategies to become more varied and flexible. The first step is to check what skills are available. Some required skills may be absent, poorly trained or developed in a counterproductive way. One then needs to analyze the coordination systems of skills that emerged. This is the part of psychotherapy that is not just a recalibration of the repertoire of skills, but psychotherapy in the proper sense of the term. Psychotherapy should be an experience during which one has felt protected and peaceful, and in which one has been able to experience one's capacity to address conflicting aims. The key for me is to become able to appreciate transitions that in turn allow one to appreciate variety as being a part of the creativity of life, rather than as a heap of chaotic contradictions. The patients that find transitions difficult are often those that suffer the most.

Psychotherapy also has a necessary explorative dimension, first of all, because it is an essential research tool, and secondly because some patients may find it useful to learn to continue this exploration after their psychotherapy. Exploring oneself through psychotherapy is a way of strengthening one's capacity to integrate an increasing number of "truths" about the self and others, a concept close to what psychoanalysts call insight. The focus of a self-exploration inspired by psychotherapy is to understand one's drives and the way we integrate them when we interact with others. In some schools, the explorative process is clearly differentiated from pedagogical aims. For example, psychoanalysis is an explorative process, while psychodynamic therapies are more pedagogical. Some colleagues even told me that psychoanalysis is always interesting, but not always a constructive psychotherapeutic process.

I am aware that I have covered only a small portion of the issues concerning the aims of a psychotherapeutic process. For example it is obvious that caring for what a patient needs is the first ethical aim of psychotherapy. On the other hand, supervision of psychotherapists who work with perverted patients also shows that a psychotherapeutic treatment only functions in the long-term if it induces a constructive process for the therapist. The patient is there to learn how to induce constructive relational dynamics with others. If it is not the case, the therapist has the ethical duty to discontinue work with this patient long before he is polluted by burnout, and transfer the patient to a colleague who may know better how to deal with such a person. This is an example of a long discussion that would need another article to be developed. I have also left out discussions on psychotherapeutic interventions that try to keep a person in a stable state (for example with persons who suffer from manic depression and certain forms of schizophrenia), because the psychotherapist's main aim is then often close to coaching. This type of intervention is often crucial for patients who do not want to spend their life in and out of psychiatric services heavily medicated.

After 40 years of discussions with colleagues, I do not think that there exist major differences between psychotherapists when we discuss the practical aims of a particular psychotherapy process; but as soon as we try to rationalize these aims, the differences in perspectives that structure our field become salient.

### BIOGRAPHY

Michael C. Heller is a US and Swiss citizen, born in Paris (France). He is a psychologist who has studied, as a researcher and a clinician, the relation between mind and body. As a researcher, he has primarily studied the influence of status on postural dynamics in the Geneva Psychology Faculty (FAPSE) and the nonverbal behavior of suicidal and depressive patients in the Geneva University Psychiatric Institutions. As a clinician, he

trained in body psychotherapy in Gerda Boyesen's school, and has participated in the development of body psychotherapy with his colleagues of the European Association of Body Psychotherapy (EABP). He has participated in the creation and development of several journals in the field of body psychotherapy, and has occupied key posts in the EABP (Vice-president, chair of the Ethics Committee and Scientific Committee). He publishes and teaches regularly on clinical and research issues related to the body and mind. His most recent book, published by W.W. Norton, is entitled *Body Psychotherapy: History, Concepts and Methods*. He is now a psychotherapist and supervisor in Lausanne, Switzerland, while continuing to teach and publish at an international level. Email: [mmaupash@aqualide.com](mailto:mmaupash@aqualide.com) Website: [www.aqualide.com/](http://www.aqualide.com/)

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<sup>28</sup> I have not found an English translation of that book. If you cannot read French you can read: The Mental Janet, P. (1893), State of Hystericals: A Study of Mental Stigmata and Mental Accidents, translated by Caroline Rollin Corsin. Bristol: Thoemmes, 1998.

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## Body Image Disorders Bernhard Schlage, MA

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### Abstract

Coming out of a childhood experience of an 'expanded body image', this paper postulates the existence of a so-called 'second body', a body different from but linked to the physical body and how this body relates to parts of the brain. Drawing on historical and cross-cultural research, the author shows how this 'second body' can help us toward a better understanding and therapy of various body image disorders and phenomena, such as anorexia/bulimia, neuropathies, dream states, body dissociations, and body neglect phenomena. This article seeks to avoid descriptions of phenomena in practice, and instead focuses on different definitions and models of understanding in the hope of coming to new modes of working with these phenomena.

*Keywords:* body image disorders, neuroplasticity, peripersonal space

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### Body Image Disorders: A Unique Field of Body Psychotherapy

*There is but one temple in the universe  
and this is the body of man.  
Nothing is holier than this high form.  
- Novalis*

As a point of departure for the ideas in this article, I would like to relay an experience from my childhood.

I was not yet five years old when I was lying alone in my bed one night and started experiencing strange and new body sensations. My inner images of loneliness and emptiness evolved into scenarios increasingly out of my control. I was walking along a path, the contours of which were increasingly dissolving, eventually consisting of nothing but flowing colours. My growing fear made the scene play faster, which increased my fear all the more, thus further increasing the tempo of the experience. There was also a feeling of space, which became wider and larger. Somehow in its limitlessness it was also soothing. Almost by accident I noticed my hands, which seemed huge, and streaming sensations flickered through my body. There was so much tranquility in this relaxed expansion. It was still accompanied by the fear that I might in some way lose control and so I did not dare confide these unusual sensations to anybody else at the time.

I would have forgotten about all of it if I had not accidentally read Michael Ende's book *Momo* (1973) more than ten years later. There is a "street" in this story where the same sensations appear as in my childhood dreams: the more restless the spirit moves in this street,

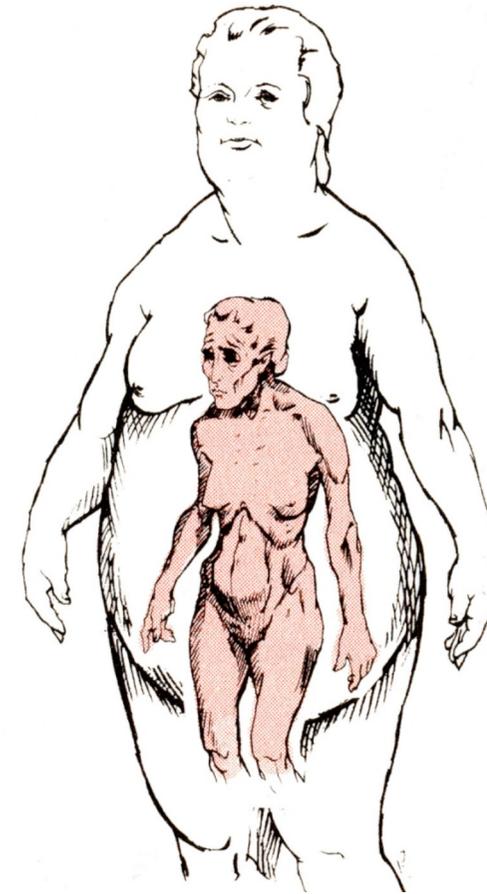
the faster Momo is carried by the turtle and as soon as there is a calming down in Momo the street seems to emerge out of time, so to speak .

I later found the experience of the augmented hands referenced by Wilhelm Reich as an expression of early sexual sensations (Reich, 1987; Reich, 1942). Coming from a home with a mentally ill mother, I had the tendency to see unusual physical sensations as something that might be pathological and hence went to great lengths not to let anything like that show. Although understandable in my family context, this habit of hiding prevented me from getting any clarifying feedback from anyone for years and thus also the understanding that these sensations were considered normal in society. Both aforementioned texts made it obvious to me that these sensations are rather common in the human context of experience and so I was able to deal with them in a more conscious way.

I would first like to stay with these rather diffuse terms and write about the importance of these phenomena for body psychotherapeutic practice, so as to give an introduction to the wide range of items that will be touched upon while looking at this theme. Terms such as body image, body schema, subtle body, astral body, dream body, and much else will be used in the discourse. Our clients, too, use these terms to describe their experience — intuitively in the beginning — before approaching a more detailed understanding of their experiences.

**I will begin with short descriptions of phenomena pertinent to the practice of body psychotherapists which probably involve body image disorders:**

- First of all there are of course disorders involving body image and eating — namely, cases of anorexia and bulimia in which clients typically perceive themselves to be extremely fat (Keleman, 1992), as well as some adipose patients (overweight) who reversely perceive their body as thin and petite (Küpper, Müller & Unland, 2002).
- Secondly, there are all those disorders of the body image that result from a nervous system disorder: for instance sensorimotor neuropathy or diseases of the myelinated layer of the nerves, in which a failure of traditional physiotherapeutic treatment is common because the nerve connections with the client's consciousness are damaged (Schlage, 2007).
- I am reminded of those clients who usually describe their body as standing in front of them or hovering above them while being asked about their physical state or during body exercises. This means that they are not able to perceive their body within the confines of their own skin.
- In trauma therapy, there is a series of diagnostic references related to 'dissociation' from one's own body image. The people concerned find themselves, due to stress, feeling out of their body, either standing next to their body or behind it. Similarly, people suffering from schizophrenic psychoses may also report dissociative symptoms (coanesthesia or delusional modifications of their organ experience).
- We will then have to name the so-called 'neglect' disorders apparent in stroke cases in which cognisance of one side of the body is missing (as if that part of the body did not exist) (Sacks, 1984/Sacks, 1993). In extreme cases people behave as if these body parts do not even belong to their bodies anymore (Sacks, 1985/Sacks, 1990).
- In some of our clients we may find evidence of a fragmented body image. We used to call these disorders 'schizoid character types' (Lowen, 1982). They are now classified as those clients with early developmental disorders, who might also be traumatised, in whom ego development was impaired at an early age and so too the concept of a complete body image.



Keleman, S. (1992). *Verkörperte Gefühle*, p. 173.  
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- People with near-death experiences also fall into this category, such as Peter Nádas who wrote a diary about his last year of life and the changes that happened to his body image (Nádas, 2002).
- In his book, *Quantenmensch* (1996), Michael Murphy documented examples of extraordinary modifications to the body images of competitive athletes (whereby the outer appearance of the physical form was changed, among other things) by visualization exercises or the martial arts, where the perception of one's own body in space was extended into cosmic dimensions, similar to what I have experienced during fever dreams and described at the beginning of this article.
- We know from shamanic dream work that there are people who experience their own body in dreams, and thus have physical experiences that do not seem possible in reality as it is generally understood: flying or being eaten by wild animals without dying (examples in: Garfield, 1974/Garfield, 1983, p. 166; Castaneda, 2001, p. 35 and p. 150).
- When standing at the helm on my first sailing trip, I experienced once more the effectiveness of "modifications" to body image: Just as car drivers learn to get a "feeling" for the outer limits/movements of their cars, skippers learn how to develop

a sense for the movements of the hull so that the helm can be handled more easily. Thus, they do not have to use a compass to balance each course deviation when they cross the crest of a wave, although they still notice the basic deviations. This means that they must expand their sense of the outline of the body downwards until it is the size of the ship's hull.

- Facilitators of cranio-sacral movement therapy achieve better treatment success when they can imagine the connections of the cranial bones in a more detailed way. This takes place in areas of the treatment where the motility of the bones is below one millimeter!
- As to the plasticity of our sense body image, I will report Vilaynur Ramachandran's 'Pinocchio's nose' experiment:

Your own body is a phantom which your brain has construed temporarily simply for practical reasons. I know this sounds unbelievable, hence I will prove to you how malleable your body image is and in what a short time you are able to significantly change it. You need two helpers for the first illusion.

I will call them Julia and Mina. Sit in a chair, let your eyes be blindfolded and ask Julia to turn towards you and to sit down in the chair in front of you. Ask Mina to stand at your right side and give her the following instruction: "Take my right hand and bring my index finger to Julia's nose. Move my hand rhythmically back and forth, so that my index finger repeatedly touches her nose in random intervals, just like a Morse code. Touch my nose with your left hand in the same rhythm and at the same time intervals. You have to touch my nose and Julia's in complete synchronicity. With a little luck, you will have the eerie illusion after thirty or forty seconds that you are touching your nose somewhere outside of your body and that your nose has transformed and is now half a meter long. The more random and unpredictable the sequence of touches, the more astounding the illusion. (Ramachandran, 1998/Ramachandran, 2002)

The above examples indicate that alongside the physical body, which we realize by observing it in a mirror or by the touch of other people, we possess a second "inner" body, so to speak, which is only available to our own perception.

Since Hippocrates' ancient case descriptions (Lebensordnung, 1993), there are indicators that the first expressions of illness or convalescence may coincide with a change to body image. I have the impression that in contemporary literature the Swiss physicist and Jungian training analyst, Arnold Mindell, follows this question most clearly, for example in his book, *Working with the Dream Body* (1985) or more recently in, *The Quantum Mind and Healing* (2004). We shall note later in this article Frank Röhrich's definitions, which were developed in the nineties at the Dresden Body Image Workshops (2009).

In other cultures, too, there are indications of the existence of body image variations: Tibetan Qi Gong, for example, speaks about the development of a 'rainbow body', which is said to be able to vitalize the physical body. There are also stories, which may seem strange to Westerners, about a person who has experienced the rainbow body and, after his death, leaves no other remnants of the physical body except some hair and fingernails (Geshe Tenpa Choephel, 2007).

In *Anthroposophy*, Rudolf Steiner lists practices for experiencing the astral body. This means that a person who in a dream is outside of the physical body and can perceive it from the outside, may still be able to describe it and even move it: "...that the 'I' that is out of the physical body appropriates images of life in the dream which it usually appropriates in the outer reality via the physical body" (Steiner, p. 116-123).

### **Have we always possessed this 'second body' (Monroe, 1985/Monroe, 2000) or do we have to understand it as an anthropologically new evolutionary acquisition?**

The observation of the philosopher Jean Gebser (2007) is remarkable to me in this context, namely that the representation of the physical body stayed quite two-dimensional until the 15th century (i.e. in the church's iconography, in the art of weaving carpets and in paintings). Thereafter, there were several scientific discoveries that fundamentally changed the perception of the human body: Kepler's discovery of the planets' movements founded the transition of the geocentric to the heliocentric worldview. Galileo Galilei clarified that the celestial bodies, as well as the Earth, are not discs but balls. He thus created the preconditions for a change in the perception of space. The important anatomist Vesalius eventually broke the church's taboo of opening the human body. Through his anatomical studies, people in the West were, for the first time, able to learn about the interior of their bodies (Gebser, 2007). In his important work about body image in ancient Egypt, Hans Georg Brecklinghaus (2002) writes, that, although the artistic representation of humans took place in the form of reliefs at the time, there was already a three-dimensional self- and body perception, although he does not discuss it any further. Schipperges (2001) quotes Albertus Magnus from the 12th century: "*As an animal perfectissimum man is a model for that cosmos that is planned in a transparent way from above, from below it is formed in layers, seen from the inside it is so transparent that it has all its creatures participate in being to various degrees.*" It is questionable if the perspective of medieval scholars of the universe also corresponded to the experiential reality of people in those days.

At the turn of the 20th century, we eventually find the first texts with detailed descriptions of body image. Bonnier (1905) assumes that there is possibly a place for it in the central nervous system. He thinks that body image is part of our phylogenetic heritage and that it is, as such, the foundation of essential functions concerning our attitude and behaviour. He also writes that, "*we do not register many functions in their normal state but only when there is a dysfunction.*" It is my hypothesis that with the discoveries of the 15th century, not only did perspective in painting come into existence, but also a new perception of the human body. Gebser (1970), for instance, talks of the change from the theocentric to the anthropocentric world image. The physical perception of the inner space has to be seen as a rather new human ability. In the process of becoming human beings, we each must learn it individually in the pre- and perinatal phases. From attachment research (Stern, 1985/Stern, 2007), we are able to understand today how vulnerable we are when we establish it and how significantly it can negatively affect our lives when this process is disturbed. I assume that there is a neurologically fixed part of that body image in us, one that has been passed on phylogenetically, and another part that gets established in our early relationships. We become conscious of its existence only when there are dysfunctions, injuries and accidents to our body image. We also have to expand our body image when we have to master special challenges in the fields of arts or sports.

### **In summary, the existence of body image enables us to perform the following everyday activities:**

- Noticing how our body and its individual parts are organized, how far it is extended and if there are any deviations from common physical experiences without having to check them visually. Thus, we are able to estimate the power, extension and speed of our movements and their relation to certain objects: we touch a glass of wine in a different way than we handle a rugby ball without having to think about it.
- Orienting appropriately in time and space: To know up from down, right from left. Because we are able to sense ourselves now, we are also able to determine the past and the

future. With the help of our body image, we are thus able to find out in front of a mirror which physical representation of our bodies we are occupying due to practical reasons.

- Perceiving our physical needs in a differentiated way and gauging their fulfillment through our actions or contact with other humans, animals, flowers, stones. The perception of contact allows us to feel our longing for touch from another human being, the longing to touch an animal or to feel the surface of a diamond.
- Intensifying experiences by increasing association with the body while experiencing pleasure, or weakening experience by increasing dissociation while dealing with pain.
- Having our bodies assume certain conscious or unconscious positions, or learning new positions that will later become part of our automatic repertoire of behaviors (for example, how we get up, how we sit, how we ride a bike and how we walk). On the one hand this gives us the freedom to occupy our mind with other things while acting (i.e. where do I want to go to, etc.). On the other hand it narrows our behavior when we have forgotten how to change a compromising automated behavior. (Once we have a certain automated head position when we are reading, we will then have a hard time figuring out how we can read without tension.)
- Reviewing/expanding our skills in situations that are merely imagined (creative imagination) or anticipating an action in our mind so often that we eventually dare to act on it; for example, a skipper or driver expands the physical sensation of the body to encompass the whole vehicle while using it at the same time; an athlete anticipates achievements in sports on a visual level. Compellingly, there are examples of these visualizations having a tangible influence on our physical appearance, the so-called phenotype. (Zane, 2008; Murphy, 1992/Murphy, 1996)
- Adapting our behavior to various realities: letting our body fly in a dream, for example; being eaten by beings from our dreams and still knowing where we are; having conversations with plants in our imagination and learning how to understand our sense of hearing in an inner dialogue.
- Perceiving perturbations in mental states and adapting behaviour appropriately before the physical body falls sick, or — when we are already sick — acting in a way that has a regulating/balancing effect on our physical body. (When we sense what would be healthy we can behave in a suitable way.)

In summary, it can be said that there is a well-established assumption of the existence of something that feels like our body, but is not the same thing that we sense in the surrounding of our skin; while Blakeslee & Blakeslee call it 'peripersonal space' (2007), in this article this will be called 'second body' in our tangible reality. This is revealed to people in various life situations, and it has been given different names throughout history. The original matrix of the 'body image' perhaps naturally involves a certain plasticity, so that it develops dynamically by training and changes in consciousness into fields that can seem mystical.

The central thesis of this article is that only body psychotherapeutic techniques are able to change 'body image disorders' while giving our clients the psychomotor-feedback the brain needs to change the 'second body', the 'peripersonal space' or however you would name it.

We are now going to have a look at different theses, to explain these phenomena.

#### How can we theoretically explain 'body image'?

One of the phenomena described could be explained by changes in nervous conduction

or by changes of the representation in the so-called 'somatosensory homunculus' (Schlage, 2008).

The illustration shows the different representation of body parts in the motor-cortex: you may see that hands and tongue are represented as much bigger, because of their functions in movement, eating or speaking (Ludwig). Another aspect can easily be explained through diseases that impair the afferent neurological pathways or of their respective representations in the cortex, as is found, for example, within the neglect syndrome. (See the example in the previous section).

Ramachandran's experiment, 'Pinocchio's nose', clarifies that our brain organizes realities according to probabilities (i.e. according to habits, even if the result of a given representation might seem rather bizarre). This leads us to those aspects of the body image experience that have to do with perceptual psychology. How detailed, how deeply and how consistently we experience our body is directly connected to what we experience on a physical level and what we have experienced in our life. Pinocchio's dissociation or a trauma patient's stress-related dissociations could provide researchers with indications as to which brain area is the origin of body image disorders.

Singer (2004) explains neurobiological connections, which let us recognize how the brain deals with itself and how "meta representations of one's own states" (p. 235) can come to existence "by iteration of cognitive operations and reflexive applications on oneself" (p. 255). He not only explores the human body image, but also searches for an explanation for the existence of self-awareness. Furthermore, we know from infant research which kinds of sensory and movement experiences are needed to develop a complete body image and by which interventions this experience can be neurologically enhanced at an early age. Taking into account the research that has been done by Blakeslee & Blakeslee, we can assume that the neurological resource of body image disorders is located in the parietal part of the brain.

#### But how can we understand the 'out-of-body' aspects of body image?

In the framework of this article, we first have to free ourselves from the imprecision of an esoteric view of these experiences. Hence, we postulate that all experiences in this regard necessarily rest on the changes of the incoming sensual stimuli. Hans-Peter Dürr describes in his book, *Traumzeit*, (1984) how such phenomena are made possible by substances that have a sedating effect on the skin receptors. We also know that sensorimotor and kinesthetic perception is decreased in patients with dissociation (Anzieu, 1991).

Does this mean that if somebody has out-of-body experiences (consciously induced or due to illness) we have to assume a dysfunction of the sensorimotor feedback of the skin stimuli or of the sense of gravity in a person's vestibular system? One option would be a study on potential body image disorders with astronauts who were in a state of weightlessness for a longer period of time and who suffer from exactly the same lack of sensorimotor feedback, which is what we assume to be the basis of out-of-body experiences.

Another place to turn to for possible answers is the well-documented neuro-immunological effects of visualization exercises in oncological treatment and allergy research. Can we infer from our consciousness's capacity for cell change that it is possible to separate proprioceptive



Ludwig, Petra. www.Buecher4um.de, Open Resource

and kinesthetic sensual experiences from their sensory input, so to speak, to then transfer them to another (i. e. imagined or dreamt) reality and thus achieve a particular perception of body image akin to the sensation of flying? Dysfunctions of the body image would then only be creative imaginings of our mind. Would it then also be possible to explain the rainbow body phenomena of the Tibetans with the help of recent space-time-models such as Stephen Hawking's 'wormhole theory' (1988, p. 200) or Brian Green's model 'teleportations' (2004)?

If we follow these speculative assumptions, we can understand why people with a so-called 'body integrity identity disorder (BIID) syndrome' sometimes feel that one of their extremities, experienced as strange and lifeless, might have come from a "former life". On the practitioner side of things, it is amazing to behold the strange research that concludes that people can not only have a normal life after successful amputation, but indeed that sufferers of BIID would strongly wish to be amputated in the first place (Bayne & Levy, 2005).

If we now want to describe the variety of body psychotherapeutic approaches when dealing with body image disorders, we need to differentiate various notions. For that, I mainly follow the basic differentiations developed by Frank Röhrich and the *Dresdner Werkstatt Körperbild* (Dresden Body Image Workshop, 2009).

Röhrich, Joraschky, and Loew's (2009) assumptions about the gamut of body image disorders have served as the basis for the development of different therapeutic treatments, and are as follows. Body image disorder treatments:

- aim at the establishment of a 'body schema' (approaches of perceptual psychology)
- aim at body knowledge and the fantasy about the body, making the 'body-self' tangible as connected with, or differentiated from, outer relationships and which allow for differentiation between the outer and inner perception
- are on the topic of our emotions when we deal with our body or our satisfaction or dissatisfaction with its existence — the so-called body-cathexis
- deal with 'physical expression' (facial expression, gestures, posture and movement patterns).

Thus the approaches inherent in the psychology of perception are considered basic for the therapy of body hallucinations which accompany a psychosis. Approaches referring to the 'body-self' are of paramount priority in the treatment of a trauma and the so-called functional disorders. Some authors (Röhrich, Joraschky & Loew, 2009) also report test procedures concerning the diagnosis of an existing disorder and its dynamic therapeutic process.

If we take a look at the range of body psychotherapeutic approaches as presented in the current standard work regarding the variety of methods (Weiss & Marlock, 2006), we discover another field of applications based upon the influence of 'body image' in its various presentations. Among them we find neo-Reichian therapies, such as orgone medicine or vegetotherapy, dance therapy, catathymic image perception, structural therapy methods (such as rolfing and postural integration) and psychosomatic therapy. We also find work with body image disorders in clients suffering from eating disorders as well as schizophrenia, analytical methods which work with the "embodiment of the unconscious", pre- and perinatal psychology and the neurological promotion of development. Additionally, sensorimotor processing of post-traumatic disorders, breathing therapies, movement education and the application of neurophysiological findings in the educational field of learning, the use of imaginative approaches in (competitive) sports up to the methods of transpersonal psychology such as Felicitas Goodman's trance techniques are also relevant.

Even though the above is not a complete enumeration of all the procedures that could be mentioned in this context, it still clarifies in just how many professional fields specific

body-image techniques find their implicit or even explicit application. It also suggests how meaningful a comprehensive development of specific therapeutic tools may contribute to a greater efficiency of the approaches.

### Conclusion

The Fall of Man has taken place. We have eaten from the Tree of Knowledge. Ken Wilber (2001) would probably write that we have left the self that merely conforms with regulations and roles, and that now we strive to recognize a uniqueness that conforms with our individual consciences. In doing so, we have left the basic unity of body mind and soul. We are alienated. The body no longer is the "basis of our perception" (2003) and does not serve anymore as a "sensitive instrument of our knowledge" as it was postulated by the sensualists of the 17th century (Baumgarten, 1983) and as Goethe appreciated it.

The body has long become an object of our volition: it is subject to ideas of beauty, as is the case in the new excessive body cults around bodybuilding, tattooing or piercing (Hauner & Reichart, 2004) and it has to be altered according to our personal ideal image of it. It is deprived of ageing naturally and is subjected to all kinds of anti-ageing concepts. Embryos are bred using in vitro fertilization methods and they are examined for genetic diseases before they are born. The search for the ideal, allergy-free, attractive, designed embryo clone without any cancer genes is already a reality in our society. The last remaining or developing defects may eventually be cured by invisible neuro-implants.

Body psychotherapeutic approaches with their possibilities of working toward the restoration of coherent experiences in an individual, and in their varied forms of expression, will play an important role in this culture in the future. The treatment of dysfunctions of the 'second body' is of practical importance as a corrective at this level of experience. This seems to precede all other aspects of our phenotype, i.e. our physical appearance in a reality of consensus. New and further research in this still-young field of scientific and practical findings can certainly be regarded as a central endeavour to the professional relevance of body psychotherapy in the realm of psychotherapeutic approaches in the health system.

A fast and result-oriented collaboration of all parties involved is of great importance for the well-being of psychosocial development. The author invites varied and creative feedback to this article!

### BIOGRAPHY

Bernhard Schlage has given workshops in most European countries and has been teaching since 1980. He has run a private body psychotherapy practice since 1984 and has given lectures at international congresses in San Francisco, Paris and Sydney. Bernhard Schlage is author of more than 100 articles about body image and has written four books. He co-founded an adult education center for health care in northern Germany in 1986 and later was in charge of a mental health center until 2008. He has been a trainer for Postural Integration since 1999 and an ECP-holder since 2001. Specialised in treating psychosomatic disorders, he is now focusing his work on training the next generation of healthcare practitioners and body psychotherapists. Email: post@bernhardschlage.de Website: www.bernhardschlage.de

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## Military Culture and Body Psychotherapy: A Case Study

### Diana Houghton Whiting, MA

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#### Abstract

The military has its own culture and teaches it to all recruits as soon as they step onto their first training site. The norm within military culture is to suppress signals from the body in order to complete the task at hand. Therefore body psychotherapy (BP) is helpful for uncovering what the body holds to help facilitate healing in those that have experienced trauma. This case study explores the intersection of military culture, how veterans hold trauma, and how body psychotherapy can be used in the context of this culture to help the population heal from trauma.

*Keywords:* military culture, body psychotherapy, evidence-based practices

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#### Introduction

Military personnel come from diverse backgrounds and are brought together under a single culture with its own language and ethics. A cultural norm of “ignore the body to complete the mission” is ingrained in the veterans. Body psychotherapy (BP) facilitates healing by utilizing both mind and body to explore what memories the client holds. This case study examines the intersection of military culture and body psychotherapy, and how veterans can use BP to heal from trauma given their enculturation within the military.

The United States military culture is taught to all personnel the minute they step onto their first training site. For the enlisted ranks this happens in basic or boot camp, and for potential officers in military academy, the reserve officer training corps, and/or officer candidate school. Military values and ethics, bearing, customs and courtesies, as well as history of their branch of service, are all taught alongside control of emotions, mind, body, and discipline of the recruits’ actions and words (Halvorson, 2010). The military culture depicted in the pages below is a broad description of the principles and values taught to all personnel. There are differences in the culture for those who serve in the enlisted ranks versus officer ranks as well as differences in each branch, but this is a portrayal of the commonalities.

The mission during training is to transform the recruit from a civilian to a service member. The trainers break down the individual and then build him/her up in the image of their branch of service. The expectation is that all personnel will think and act similarly to everyone else (Volkin, 2007). The intent is to prepare these new service members by increasing physical and mental toughness and removing ego and pride so that they will follow given orders. Recruits are no longer individuals, but members of a well-oiled machine. This is ingrained in recruits and becomes part of who they are; when they leave the military to reenter civilian life, they tend to use this same mindset in their interactions in life, at work and at home.

Veterans are a diverse population, presenting different socio-economic statuses, races, ethnicities, genders, ages, sexual orientations, educations, and abilities. Many volunteered for the military and some were drafted into the armed forces. The common thread is service to their country and the culture of the military, which becomes the core of their mind, body, and spirit. Part of the training and expectations of the military person is that they will silence the body if it is fatigued or in pain, so that the job can be done and the objective achieved. How does this training and cultural expectation affect the body of a veteran? Is body psychotherapy a viable modality of treatment for trauma and posttraumatic stress disorder (PTSD) for this population?

#### Body Psychotherapy with Service Members

Body psychotherapy operates under the theory that there is a functional, nonhierarchical unity that exists between the mind and the body. “There is no living human without mind — no soma without psyche” (Totton, 2003, p.24). It is from this perspective that body psychotherapy uses the explicit memories (those held in the mind that can be examined and discussed) and the implicit memories (those stored in the body that are communicated through movement) in the healing process. When the therapist approaches the human body, he/she also approaches the human mind (Totton, 2003).

The military views the body of an individual as a tool, like a weapon or a vehicle. It is to be kept in good physical condition, making it as effective as possible. Unlike a vehicle or weapon, the soldier has a mind/body that remembers what has been endured. Body psychotherapy tries to uncover the messages transmitted by the body, helping the person integrate troubling or traumatic experiences and recover mind, body, and spirit.

According to the National Institute of Mental Health, trauma can be categorized in two types: physical and mental. “Physical trauma includes the body’s response to serious injury and threat. Mental trauma includes frightening thoughts and painful feelings” (National Institute of Mental Health [NIMH], n.d.). The criterion for a diagnosis of PTSD is that the person was exposed to a traumatic event which involved actual or perceived threatened death or injury, or threat to the physical integrity of self or others, and which can involve combat, natural disaster, or assault (Friedman, 2007). During the event, the individual experienced intense fear, helplessness, and/or horror. Later, he/she may experience intrusive thoughts, nightmares, and flashbacks that evoke emotional and psychological reactions perhaps months and/or years after the event. Many with PTSD may experience hypervigilance and hyperarousal during certain situations, which can cause them to take actions to create safety for themselves. Finally, the DSM IV states that the person must have experienced these symptoms for longer than a month, and may be dealing with social and/or occupational distress (American Psychiatric Association, 2000).

As a counselor at the Veterans Health Administration (VA), I heard many examples of these symptoms from clients, both in individual and group session settings. The majority of veterans report being uncomfortable with crowds and staying out of congested places such as stores or sporting events, and many have flashbacks and intrusive memories that can be triggered by a sight, smell, or sound. Most have had extensive training on weapons such as handguns and rifles, and they rely on this training to feel safe such as keeping a loaded weapon behind each door of their house. They can also feel the need to check the perimeter of their home multiple times a night to ensure the doors are locked and that no one is on their property. This can become a nightly routine with the perimeter extending further and further afield depending on their experience.

“We know that trauma has profound effects on the body and nervous system and that many symptoms of traumatized individuals are somatically driven” (Ogden, Minton, and Pain, 2000, p. xxviii). Many trauma survivors report coping with disregulated body experiences, and dealing with strong emotional and physical responses to situations or interpersonal contact. Many of these reactions cause distress to the trauma survivor, and their friends and family members. The veterans that I worked with discussed questioning their sanity, and feeling guilty about reactions to partners and children. A fair number reported multiple divorces, loss of long-term friendships, strained or nonexistent relationships with their children, and estrangement from parents and other family members. Trauma on its own can shift the individual’s perspective and make interactions between self and world more difficult, but military culture may also place its own communication barrier between the soldier and civilian society. The soldier learns a new way of speaking and reacting in the military, basically a language apart from civilians. Add trauma and the language shifts even more. Those that knew the person prior to his/her military service have no context for the person that the soldier has become.

### Psychology Modalities and Trauma

There is a large body of literature that discusses military veterans, the stress of combat and potential for developing posttraumatic stress disorder (Dye & Roth, 1991; Gates et al., 2012; Marshall & Dobson, 1995; Ready et al., 2012; Sautter, Armelie, Glynn, and Weit, 2011; Sherman, Zanotti, and Jones, 2005). Studies vary on the statistics of how many combat veterans will develop PTSD, ranging from 12-24% (Gates et al., 2012; Ready et al., 2012), with 40% of them suffering chronic PTSD symptoms ten plus years after onset (Sharpless & Barber, 2011). The overarching themes of the research are how the Veterans Health Administration (VA) serves military veterans, what types of therapies are offered, and recommendations about different therapies (Gates et al., 2012; Hunt & Rosenheck, 2011). There seem to be many articles on exposure therapies, specifically Prolonged Exposure (PE) and Cognitive Processing Therapy (CPT), which are named most often (Karlin et al., 2010; Ready et al., 2012; Sharpless & Barber, 2011). The majority of the research also acknowledges the comorbidity of depression and anxiety with PTSD.

In addition to the evidence-based practices (EBP) that the VA offers to clients, there have been investigations of mindfulness practice, relaxation, and meditation (Perlman et al., 2010). One article discusses hope as a change mechanism, noting that veterans who report that hope has increased over the course of treatment for their depression and PTSD show a reduction in symptoms (Gilman, Schumm, & Chard, 2012). This research is correlated with the evidence-based practices of CPT and cognitive behavior therapy (CBT).

The evidence-based practices that the Veterans Health Administration has to offer can be categorized under the Western medical model of treatment. Body psychotherapy has not really been explored by the government and tends to be considered more unconventional. BP practitioners have had to provide their own research to prove the effectiveness of their therapies. The majority of body psychotherapy literature brings neuroscience into the discussion. This information seems to be missing from the articles written about trauma and the veteran population in the system of the Western medical model. Neuroscience is used to provide evidence that the body can be a repository of memories, holding trauma just like the mind does. These articles investigate the idea of a “bottom-up” approach to therapy, working with the body as a vehicle for healing, and comparing this to the “top-down” approaches that VA offers, which work with the mind and tend to ignore the body (Lopez, 2011; Madert, 2007; Ogden, 2003; Samardzic, 2012).

Many of the articles written about body psychotherapy (BP) and trauma are studies attempting to show the efficacy of different types of BP. These authors focus on specific courses of treatment such as Sensorimotor Psychotherapy (SP) (Langmuir et al., 2012; Ogden, 2003; Ogden & Kekuni, 2000), Bioenergetics (Helfaer, 2010), Spontaneous Healing Intrasystemic Process (SHIP) (Steenkamp et al., 2012), and Observed and Experiential Integration (OEI) (Bradshaw et al., 2011). These treatments discuss trauma at length and theorize about how trauma develops and how to treat it.

There is a small and growing body of work that talks about BP and veterans coming from U.S. government sanctioned studies. As is the trend with BP and trauma there are studies that discuss very specific types of treatments that fall under the BP umbrella. These studies look at healing touch, massage, craniosacral therapy, and biofeedback as vehicles for healing (Jain et al., 2012; Peniston, 1986; Price et al., 2007; Upledger et al., 2000). The majority of this literature also uses diagnostic instruments such as the Beck Depression Inventory (BDI-2), Beck Anxiety Inventory (BAI), and other PTSD measures to track the client’s progress or lack of progress toward relieving symptoms of PTSD.

Eye movement desensitization and reprocessing (EMDR) is a therapy that some consider to fall under the BP umbrella, and that the VA has embraced as evidence-based therapy. There have been multiple studies conducted that prove its efficacy in reducing symptoms of PTSD as well as depression, anxiety, anger, physical pain, and other somatic presentations (Rogers et al., 1999; Russell et al., 2007; Sharpless & Barber, 2011; Silver et al., 1995; Silver et al., 2008).

Along with the journal articles described above, BP with veterans is being explored in magazine articles, specifically *Somatic Psychotherapy Today: The USABP Magazine*. While not a peer-reviewed journal, it is a newly established magazine that produced an entire issue concentrating on how different aspects of BP could serve returning military veterans. The topics ranged from the role of early childhood trauma in combat psychology, to somatic experiencing and military mental health, to recognizing body sensations while treating combat veterans (Eichhorn, 2011; Hurley, 2011; Monell, 2011). These articles seemed to be the most current and all-purpose information about body psychotherapy’s usefulness with military veterans.

The VA has a culture of using therapies that have been studied and tested thoroughly, revisiting the evidence, and retesting the approach to verify its efficacy. Body psychotherapy has its own research/evidence-based review for its efficacy with trauma in general, but appears to be missing this sort of repetition. Just look at the meticulous framework the VA has set up for EBP. There is evidence that BP interventions can meet a trauma survivor’s presenting issues better than more traditional cognitive therapies (Eckberg, 2000; Ogden, 2003; Ogden et al., 2000; Totton, 2003). Is this as true with the veteran population as it is with civilian populations?

This has left me with many questions in regard to BP, U.S. veteran population and U.S. military culture, and EBPs provided by the VA. What would evidence-based body psychotherapy look like? How would it be structured, what are best practices related to using BP as a treatment modality at the VA? The VA tends to produce manuals and instructions on what is the best way to proceed with therapies offered to the veterans. How would BP navigate this communication trend that the VA has adopted? How can body psychotherapy use its own culture and work with the military culture present in the VA?

### Case Study

The setting for this case study was the Veteran Administration Medical Center (VAMC) in Cheyenne, Wyoming which is part of the Veteran Health Administration (VA) system and is a government-run agency, employing many military veterans. Military culture is strongly woven into the policies, procedures, and approaches to healing those they serve. The veterans are

categorized as patients, utilizing a clinical Western medical model approach to this population.

In the military, expectations are outlined explicitly. If certain tasks are completed then promotions and commendations will follow. This formulaic approach is seen at the VA as well. If a certain therapeutic approach is used the expectation is that a certain result will happen. If one of the prescribed therapies is not successful then the provider goes back to the menu of approved approaches and tries another one from the list. These EBP options tend to include timetables for success, in the hope that the VA can motivate the providers to get clients in and out as quickly as possible.

The culture of the VA prefers therapies with a strong set of evidence to back up their effectiveness. In presenting this case study the hope is that a conversation will be started about evidence-based body psychotherapy as it relates to trauma in military veterans.

### Client History

This case study covers ten weekly sessions. The client, Mr. J, is a 65-year-old, Caucasian male. He first served in the Army in the enlisted ranks, then became an officer a few years later. He is a Vietnam-era soldier, meaning that he served during the Vietnam conflict but did not serve overseas in a combat zone. He received his basic training in the late 1960's and served until 1978 when he requested and received a transfer to the inactive reserve with the rank of Captain.

Mr. J describes his upbringing as emotionally abusive and his parents as having had rigid expectations of him and his siblings. The family cultural norm was to rely on cognitive responses to situations and to suppress emotional expression. Intellect was valued highly in his family, and it was important to Mr. J that he be perceived as smart, hardworking, and extremely capable. The training he received in the military reinforced these same standards that were set for him in his family of origin. Additionally Mr. J has two college degrees, one in psychology and the other in electrical engineering. The one that he utilized most was the engineering degree which required a cognitive approach to most problems. This is how he tends to deal with issues to this day.

Mr. J has been in one form of therapy or another for fifteen years. He started with the VA system in the early 2000's and his therapists have utilized CBT, ACT, EMDR, meditation training, hypnosis, and 'body emotion desensitization' to help him resolve presenting issues. In addition to the emotionally abusive childhood with alcoholic parents, Mr. J was first responder to an accident that left his brother dead after being shot in the head. He was also a first responder during basic training when a mess hall exploded and he had to help render aid to wounded soldiers. When he was an officer, he once woke up in his bunk with a knife to his throat, and was able to talk the soldier down and get the knife away safely. On another occasion, he was held at gunpoint by a soldier who was on guard duty. The soldier was high on LSD and Mr. J talked his way out of that situation as well.

At the beginning of my internship at the Cheyenne VA I witnessed sessions facilitated by my supervisor before I starting facilitating my own. I watched my supervisor facilitate an EMDR session with Mr. J during the summer of 2012. As my supervisor and I debriefed the session later, we talked about a feeling in the room that we described as being cut off from our bodies. Mr. J has strong cognitive tendencies and can tend to ignore his body and physical responses. My supervisor agreed to let me work with Mr. J for a number of sessions using body psychotherapy interventions. The intent of these sessions was to see if BP could be used to help the client bring awareness to his body states and notice if there were sensations associated with the emotions he was working through.

Given the cognitive orientation at the VA, there was very little movement involved and my supervisor was the only person I had witnessed who tried to bring any body sensations or awareness to a session. I was curious to see what would happen with Mr. J if he got up and moved, redirecting his perspective away from cognitions and toward the body. My original intent was to do this for a few sessions and then have him sit with my supervisor for another EMDR session and see if anything shifted and if it did, what changed for him.

As we started to build a rapport and work together I saw an opportunity to have a more concentrated look at our sessions, document them, and turn them into a case study, having not seen individual case studies in the literature about veterans and body psychotherapy. I scheduled a meeting with Mr. J and my supervisor to discuss the possibility and we all agreed it would be interesting to see what the outcome might be. It was in the fall of 2012 that Mr. J and I started working with the understanding that the work was now for a case study. In reading about the military and talking with different veterans I had developed a better understanding of military culture and the military mindset. I was now curious to see if BP was a viable form of therapy for those who rely heavily on their cognitions and habitually suppress the messages their bodies try to send to them.

The setting for my sessions with Mr. J shifted over the course of the study. Each week we ended up in a different room or office around the mental health department. Sometimes it was a room where groups met and at other times we were in offices ranging in size from uncomfortably small to roomy. With each room came different furniture arrangements so that sitting and standing, video camera placement, and space to move differed from session to session. Our norm before the case study started was to sit facing each other and talk. I was titrating the idea of body states and sensations. I would notice hand gestures and other small body movements and I would also ask if he would describe sensations he noticed in his chest, back, and neck as he was talking about his different dilemmas and issues. My intent was to get him used to the idea of feeling into his body before we started any movements.

Mr. J tends to be hypervigilant, does not like surprises, and does not trust easily. It was important that I was explicit with everything that I was attempting and why I was suggesting different movements. Part of being open was giving the client copies of articles and papers I was reading relating to him and the case study. I believe that this helped to put him at ease as we started to go deeper into our work.

### The Sessions

Our first session started in the same manner as our previous sessions, seated facing each other discussing what was present for him. Halfway through this session we stood up and started moving. The movements were small and I was very directive about what he should do. I asked him to hold his hands out in front of him, meeting my hands and pushing into me. We alternated from him pushing me away to me meeting his push with my own pressure. Mr. J reported that he felt a lessening of tension in his chest when he pushed me away and he had a fear response with tension and anxiety growing when I met his push.

Mr. J has stated in the past that it was dangerous for him to have emotional contact with his parents and that at an early age he learned to quickly hide his internal experiences. I was curious if these emotions were related to his tendency to feel safer by himself and the discomfort that came when I remained in contact with him. From what he reported, he had ample reminders that people are unsafe and that in some ways he is safer by himself. However, he also talked about being lonely and wanting companionship. He has had this struggle for many years; it is

very tender for him, and was brought up in multiple subsequent sessions.

The next three sessions worked with Mr. J's back and the *Five Fundamental Actions*. This movement sequence was created by Susan Aposhyan (2004) and has five different motions: yield, push, reach, grasp, and pull. Each of these motions has a corresponding meaning associated with it. The yield can be related to becoming grounded and connecting one's feet to the earth. In the push, a person is creating boundaries, learning to say "no". With the reach, there is exploration and desire, a curiosity to see what is out there. When grasping we think of making connections with new objects, people, and concepts. Finally, the pull is bringing new things into the person's life.

From what I have seen in the past, Mr. J likes to do things correctly, as quickly as possible. In working with his mistrust of most people and situations, I surmised that it would be better to demonstrate the actions first before walking him through the exercise. I did this with my hands, arms and upper body. I chose this expression of the *five fundamental actions* because it was easy to do standing or sitting and was the least dangerous way of moving for my client. There was a teacher/student feel to this but I felt it was important to help Mr. J settle into the exercise and work our way toward not having tutorials in future sessions.

As he was going through the sequence by himself I noticed that the reach was almost non-existent. After three times through the actions we talked about it and I found a prop for him to reach toward. He was able to find reach but when we talked about it again, he skipped over discussing it and talked about grasp and the meaning of it. I had to bring it up again for him to talk about it, but even then it was quick and he was off again on another topic.

When things were bothering the client his neck, shoulders, and back tensed pretty visibly. He described it and I have observed it as an involuntary response. He did this, and then noticed it had happened. As I was asking what it would be like if I were to walk around him and go to his back, he jumped back away from me about six inches, and said that he did not like the idea at all. At this point I felt that I did not want to cause him more distress and asked him if he wanted to go forward with the experiment or if he would rather we just talk about what it would be like. He said he wanted to go through the actual motions. I walked around his back, telling him what I was doing the entire time I was walking.

The exercise was repeated a few times during the session and he told me it got easier to withstand with each rotation. Toward the end I was not talking as much and just moved around him. As a final experiment I stood with my back to his and we talked a little in that position. With each suggested movement on my part, walking around to his back or standing behind him, he reported a shiver that went down his spine and stayed there for the entire time that I was behind him. It would linger there for a while even when I had moved to face him again.

He related the two attacks he had managed to endure successfully to his sensitivity to having his back exposed to others. Mr. J's hypervigilance tends to manifest with him keeping his back to a wall in public. He stations himself in the corner of a restaurant or other venues, keeps an eye on the exits, and can see all of the action going on in the space. Having anyone at his back causes a fair amount of tension and his physical response is to try to get his back covered as quickly as possible.

The fourth session put the *five fundamental actions* together with his back. I asked Mr. J to go through the actions with his back this time instead of his hands and arms. I also told him that I would not show him what to do and he was going to have to figure out how to accomplish the task given to him. He was hesitant at first and had to practice the motions with his hands as in the previous sessions. He wanted to remember them before he tried the new way of doing the actions, which he did with his back and shoulders. He noticed the muscles in his chest had loosened and that he was clasping his hands together when he was going through the

grasping motion. He reported a tension in his back as he was grasping and his stomach muscles tightening when he went to pull.

The fifth session was more verbal than the previous meetings. It was almost like Mr. J was self-regulating his experience to bring it to a more cognitive level. I felt that he was titrating the last few sessions and preparing for the next set of sessions and where we would go from there. There was a lot of verbal interaction and bringing it back to body sensation. He was able to name some body states, and he seemed to be more in tune with what was going on and was noticing things that he had not noticed in the past. He started naming his own movements and becoming curious about them as he did them.

The next set of sessions hit a couple of tender themes for the client. Mr. J's tendency was to change subjects quickly when he started feeling emotional about a topic. He was discussing his desire for a partner, someone to confide in and be a part of his life. As he was describing his past marriage and another relationship that was unsatisfying, he changed topics. This happened multiple times in session. I let him go with it for a while and then asked if he noticed what was going on. We went palm to palm again and I asked him to push on my hands any time he felt the urge to change the subject. This helped keep him on topic and we were able to work with the subject for longer periods of time. At the beginning of the exercise my arms were straight but by the end of our discussion my arms were completely bent. I wanted to stay in contact with Mr. J and not get pushed away so I stood my ground and let my arms fold more and more as he talked. I felt the client's tension between wanting to change the subject and his need to talk about his feelings. He was able to use me to motor through the topic and stay with the discomfort and vulnerability he was experiencing.

During this series of case study sessions we touched upon two of the traumas that happened to him in the military. These were when he woke up to a knife at his throat and when he had an M-16 pointed at his chest by a soldier on guard duty. He tells the story of each of these events and reports a choking feeling in his throat while he talks about what had happened. He tries to make light of the situation and tells them in a "funny" manner. I maintain two ways of thinking about these events: At first I thought he was choking down anger at himself and self-judgment about the situations. He was able to talk his way out of both situations and walk away unhurt — but I wonder if there was something else he wished he would have done that he did not do.

In the last two sessions we hit upon both of these events again. He mentioned the choking feeling in his throat and as we went further into the topic he mentioned there was another event he has never told anyone about. He said a lot of times he used the knife and gun events to talk about this other incident. I am curious if the choking sensation is about what he does not say, not allowing himself to tell anyone about what happened during this other trauma.

### Evaluation of the Sessions

At the end of our first session he had noted that he liked standing and since then we started every session standing so it became rare for us to sit at all during any of our time together. Although neither of us made it an explicit rule, at the beginning of each session he would take up a standing position in the room as we started our work. Starting in this position seemed to help Mr. J notice his body more, and he is quicker now to notice his sensations and motions. As our sessions progressed over time, he would start to notice what his body was doing before I could ask or get curious about his posture or gestures that were manifesting at that moment.

One of the biggest themes that came up implicitly and explicitly was trust. Could he trust me, our work together, and how I might act and interact with him, as we deepened our therapeutic

relationship? It was a slow process with as much transparency as I could provide, to earn his trust. I also noticed that the more I disclosed about myself and my process, the stronger our rapport was. For him to trust we had to build a strong relationship of give and take. Bringing body movement into a session was a slow and careful process. First, we had to work with sensation and description before movement. There was still some shyness about movement: it was easier for him to ask for and receive a prescribed movement than to execute a spontaneous movement.

Family of origin coupled with military culture taught Mr. J that the safest place to be in his body is in his brain. Intelligence, logic, and persuasion were tools that he had used with great success for decades. He dealt with alcohol dependency in the past and I believe it was a tool to help him suppress his mind and body when his old coping strategies were not working well anymore. In seeking help for his dependency he started therapy and has been working with therapists ever since.

There were times during the my work with him that I would assign homework to Mr. J. When we were working with his back and the shiver response I asked if he could go with someone he trusted to a restaurant and sit with his back to the crowd. He chose his son, a martial arts black belt, to watch his back as he completed this assignment. He reported that he was able to do it and notice the shiver in his back and the impulse to grow eyes in the back of his head.

I also asked him to sign up for a tai chi class (a slow meditative physical exercise designed for balance and health) to see what it was like to move in front of others. Mr. J is close with his elder son, the martial artist, and admires his practice, the forms that they do and how his son talks about the benefits of this practice. When we talked about it, he was uncertain if he wanted to try it. He talked about a senior's golf class that he had signed up for and gone to previously. He noticed that a lot of the participants knew each other and he did not, so he chose not to go back.

In the tasks Mr. J undertakes he likes to be seen as minimally competent and prefers to be good at things. The tai chi class was something that he had never done before. Not only would he be moving in front of others, he was not trained or practiced in the activity before stepping into the class. He attended multiple classes and brought the movements into the sessions with me. He also became aware of body sensations while practicing these forms, describing different feelings with his in breath and out breath and how they corresponded to the different movements.

Throughout our time together I watched Mr. J get close to a tender emotion and then use his body to quiet his emotions and move into cognition. Now there is awareness around this tendency and he can name it after it happens. He is conscious of tension in his body, and how he holds it in his back, shoulders, and neck. He has also developed ways to relax and release this tension after he realizes it is there. There is still a tendency to change the subject when he is feeling emotional and this is something that can be brought up again in therapy and worked with.

The BP interventions that were brought into therapy have seemed to help the client bring awareness to his body, his emotions, and many of the different habits he has acquired over the years to quiet the feelings and sensations that he did not want to, or could not deal with. Mr. J can fall into depression and self-isolate as a way to cope with his lowered physical and emotional states. He reported that he felt his depression come back to a certain extent in the last month of our work. He had tried to wean himself off of antidepressants at the beginning of the study and was feeling the effects of this.

His doctor prescribed another anti-depressant. Mr. J has reported that even though he felt the urge to self-isolate again, he was going out and attending his classes, finding time to play golf, and picked up playing basketball again. He stated that he felt better after doing these activities and this helped him to stay active. He also traveled back to his hometown, a place he had avoided for many years. Mr. J then took time to travel around parts of the country to test out a desire to get out more.

## Conclusion

Military culture and training can stay with a person even after leaving the service and can be brought into his/her civilian life. It can lead to problems down the road when the individual is confused by the messages the body is giving. Why is there pain in this part of the body? Why does my heart go a million miles an hour when I interact with other people? Why am I angry after I talk with most people? Why can they set me off with a look?

In our sessions together Mr. J made connections and found new information in the movements that he was working with. It became a tool to express a need while still discussing an emotional topic, and he was eventually able to talk about what was distressing him without changing the topic. It was tough for him to say the topic was tender and it was easier to show it by pushing into me and monitoring the need to express it.

The challenges in our sessions together were that both the client and I tend to be cognitive people and it was easy for me to let the session become about the talking. I had to be mindful about bringing in body psychotherapy interventions and utilizing them at the appropriate time while not becoming overbearing with them. Mr. J needs to trust those he works with and this trust comes slowly and is easily lost. Movement and sensation needed to be titrated slowly over time so that he did not feel like I was bulldozing over him in the sessions.

There was some countertransference that I was aware of as we worked together. Again, being a cognitive person myself I found it easy and understandable when he was telling a story. There are traits that he carries that remind me of my father and my husband (both engineers). There were times when I would feel like I totally understood where he was coming from or would get annoyed with him because he would remind me of them. I would have to check these and make sure the next question came from a place of curiosity instead of interpretation. I would go back to description when I had these feelings and go with what was in the room.

I believe that he was trying to be the "good" client on many occasions. There were times when I was curious whether he did what I asked because he was being the good client and I was in a position of authority or if it was where we needed to go. I checked this out with him and he suggested that both were probably true.

The study that I undertook was with one individual who had already had many years of therapy. He had come to me with some awareness of his body sensations, where he held his stress, and how his body held tension. He had been dealing with depression off and on for years, and it waxed and waned in our time together. Before we started Mr. J stated that his tendency was to self-isolate during down times and though he was still working with the symptoms, he reported that he has not given in to the urge to hide in his house like in the past. Overall he stated that he feels better and is pleased with the trajectory of our sessions together. I have seen a person who had previously been unaware of certain movement tags and habits name the motions as he did them. These brought him information and he was able to realize and name emotions and feelings that he had been unaware of before.

Many of the veterans who seek help at the Veterans Health Administration find themselves working with the evidence-based psychotherapy offered. These have been shown to be effective ways of treating PTSD and corresponding symptoms up to a point. The work with Mr. J demonstrates that body psychotherapy may be another way to help veterans cope with the traumas they have endured and help to instill a new way of thinking about the body and emotions. If approached properly the body's messages can become insights into why a veteran responds a certain way to situations, and not just something that needs to be ignored so that s/he can keep going.

**BIOGRAPHY:**

Diana Houghton Whiting has worked with trauma survivors of domestic violence, sexual assault, and combat veterans. She received her Master's in Somatic Counseling with a specialization in Body Psychotherapy from Naropa University in May 2013. She completed her internship at the VA Medical Center in Cheyenne, Wyoming April 2013. Diana has received EMDR level 2 training and was a victim's rights advocate at a Northern Colorado shelter for three years. Diana uses cognitive and behavioral therapies in conjunction with body psychotherapy interventions and specializes in trauma recovery and PTSD treatment. She is a member of the United States Association of Body Psychotherapy and American Counseling Association.  
Email: dmhoughton@outlook.com

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## Filling the Holes-in-Roles of the Past With the Right People at the Right Time

*A way to open the door to happiness in the present*

**By Albert Pessa**

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### Abstract

First I will briefly review how we establish the foundation for building a happy life using Pessa-Boyden System Psychomotor (PBSP) procedures that provide a new, symbolic memory/experience of the satisfaction of maturational needs **as if they had happened in the actual past**. Then I'll describe how we go about filling in the Holes-in-Roles in the past, using new, powerful, PBSP concepts and procedures that unlock the hidden neurological psychological doors in our minds and bodies that block our receptivity to happiness and the sweet satisfactions of life.

*Keywords:* PBSP, trauma, family network

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Aristotle, among other fundamental thinkers, believed that it is in our nature to seek and enjoy happiness.

My own reading and clinical experience has led me to believe we are hard-wired to anticipate happiness.

If the expectation of happiness is so natural, then why does happiness elude so many people so much of the time?

We come into this world as infants, primed to expect and experience a pleasurable, satisfying life, full of meaning and a sense of connectedness to others (Bowlby, 1969). That is why, when life fails to provide that innately anticipated outcome, we are deeply disappointed and feel cheated out of a fundamental right. So do we give up that longing for satisfaction of those deepest desires and hopes? Not very easily. Though we may have endured a lifetime of unhappiness, we are under the never-ending pressure from our remembered, needy, inner-child-self to complete and satisfy our maturational needs, which serve as the necessary foundation for the experience of happiness. Without that foundation in place, we may ceaselessly knock on the metaphorical doors of all with whom we are in contact — friends, mates and teachers — in search of a reassuring, “Yes!” to our unspoken question, “Are you that someone who will finally give me what I desperately needed back then and despairingly feel I still need now?” Too often, we doubt we will get what we long for, no matter how much people genuinely care for us in the present moment.

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### What can make the present feel that awful?

It is a biological/neurological as well as psychological fact that the memory of frustration of basic needs during our developing years, i.e., the past, fundamentally colors our experience of life now in the present (Edelman, 2000).

Since it is our memories of a deficit-ridden or traumatic past that are running (or ruining) our experience of the present, what if there were a way to create a better past without having to invent and climb into a time machine? We, the founders of Pesso-Boyden System Psychomotor PBSP, Al Pessa and Diane Boyden, found a much simpler solution. We have learned how to access those brain-based memory banks using precise micro-tracking techniques so that the client, assisted by the therapist, can construct positive, maturational need-satisfying virtual memories to offset the negative experiences of the past, endlessly waiting for their completion and consequent relief.

Following the micro-tracking process, we externalize that interior neurological stage in the mind, upon which both memory and imagination play, and have those images of people and events visually represented in the therapy room. This is done in tandem with what is being addressed and thought about, moment-by-moment in the “present”. On the symbolic simulated stage that we have evoked in the therapy room, we carefully and precisely organize—with the full participation and control of the client—new, healing, alternative, need-satisfying events, as if they had happened at earlier times and in other places. We accomplish this with the additional help of role-played, “Ideal” human figures—parents, grandparents, etc. who, had they been in the client’s actual life, would have been capable of providing him or her with those developmentally necessary interactions.

In this ritual arena, clients can emotionally re-live a new past, one now organized to be full of pleasure, satisfaction, meaning and connectedness. Just as real memories influence and effectively run peoples’ experience of the present and future (Damasio,

1999; Edelman, 2003), so do these new symbolic/artificial memories. With these new, positive memories firmly implanted in body and mind and masterfully linked with the real, negative, long-term memories of the past, clients can experience and respond to the present with far more success, hope and happiness than was available before.

### Does it matter that it’s artificial?

I have an artificial hip that allows me to overcome the reality of an arthritically ruined hip and it works more than just fine. Why not artificial memory then? It took surgeons a long time to learn how to make a workable artificial hip and indeed so has it taken a long time to make a successful artificial memory.

This is our rationale for why we make new symbolic memories of the satisfaction of those needs at the appropriate age and with the anticipated and appropriate kinship figures. If we didn’t create new, albeit artificial memories, the only ameliorating effort available would seemingly be a reality-based solution, i.e. how best to cope with the exigencies with which life has presented us. Had there not been a new way to develop an artificial hip, I would then be best assisted by learning to improve my handling of a wheel chair or crutches.

Though this “new memory” process has certainly been a boon for a great many deficit-ridden and traumatized clients, we have found that there are a significant number of people, who, even when provided with the possibility of new memory consisting precisely of what they have apparently needed and longed for, simply cannot absorb it or take it in — much

to their disappointment and their therapists’ surprise and astonishment. Of course, their unaccepting response appears incredibly contradictory, for isn’t this newly designed, interactive, maturational satisfaction exactly what they had endlessly longed for? This phenomenon is often simply described as resistance. However, we have developed another far more useful rationale and effective solution to the problem of inability to receive what has been missing.

### We call that procedure: Working with Holes-in-Roles.

There are many theoretical elements to put in place in order to fully grasp this process in all of its dimensions. To do so, we will have to pose some fundamental questions such as:

- What moves people to act/ behave as they do in the first place?
- What are the basic connections in life that need to be clearly differentiated and firmly established?

Our answers will provide insight into the dilemma of resistance and inability to receive.

To answer this first question properly we simply have to go back to an even earlier question: Why do we have a body to act with in the first place?

The answer to this can be found in the “evolutionarily-remembered (recallable)” data stored in our genes. Through evolution, we humans have become designed/adapted to live in a physical/material world with a physical/material body that is made to want passionately to keep on being alive in that material body in that material world.

Over the eons our ancestors — one-celled creatures on up — developed sensory equipment that supplied information regarding what was around them and developed ways of responding with their material bodies in ways that would ensure their continued existence. Something very primitively similar to pleasure might have been registered in the interior of those simple, life-pioneering creatures that would reinforce behavior that supported the continuation of existence. Certainly we humans respond to pleasure as a reinforcer of positive, satisfying existence.

To address this phenomenon on the human level, I use the shorthand term, **see-do**. In the sense that humans **see** (or taste or touch or smell or hear) a situation, and humans do what is necessary to live well based on what was **seen**. This process is absolutely automatic and extremely rapid and therefore not brought to consciousness unless it is necessary for survival. Every time we **see**, we automatically recall what we have seen before like that, which is stored in our learned database of visual memory to enhance our resources in the present. And every time we **do**, we recall what we have **done** before like that, which is stored in our learned database of motor memory in order to enhance the success in the present circumstance (Edelman, 1999). We use the term mind’s eye to mean what we have stored in our learned, visual memory and can actually “see” interiorly if we set our mind to do it. And, we use the term mind’s body to mean what we have stored in our learned, motor memory and can actually feel in our “real” body if we set our mind to do it (Erikson, 1964; Stern, 1986). For instance, most of us can recall/see our mothers in our mind’s eye and recall/feel how to ride a bike in our mind’s body.

An interesting example of the unconsciousness and automaticity of this process is evident in the neurological condition known as “blindsight” as studied by Nicholas Humphrey (Humphrey, 1986). This phenomenon occurs in individuals who are cortically blind and literally cannot “see” because the neurological pathway of visual information has been severed by a stroke or other unfortunate condition. But the neurological pathway of visual information to their motor system is still intact and therefore their body is prepared and dynamically organized to move appropriately to what it “sees”! Further on, we will extrapolate from this when exploring normal

human responses to family, cultural and mythic stories which promote internal, unconscious, mind's eye (blind-sight type) seeing of the events described in those stories and the unwitting, totally unconscious responses which often include mind's body attempts at satisfying solutions to the dilemmas presented in those stories. Briefly stated, the words we hear in stories promote images in the mind's eye which then provoke actions in the mind's body. All this happens automatically, with profound effect and with little to no conscious awareness.

So to return to the question, **“What moves people to act/ behave as they do in the first place?”** The answer is simple: the past. The **evolutionary past**, stored in our genes, is the primary source of survival behavior in the present. And the **personal autobiographical past** of satisfactions or frustrations of life-needs stored in each individual's memory banks is the secondary source of behavior in the present. One might say that our genes anticipate an optimum satisfaction of basic needs and the possibility of pleasure as a response to the satisfaction of those needs (Bowlby, 1969). The source or root of discontent for those unfortunate individuals who have suffered so many deficits in their maturational process is that their interior requirements are sorely at variance with their personal histories.

Let's now examine the interface between what is seen and what is done or not done about what is seen, using the notion of **shape/countershape**. The easiest way to conceive of shape is to think of the actual shape of an external object that is perceived. Shape in this example could be the visual outline of a tree that is immediately recognized as a tree, and then all the appropriate behaviors that we have internally stored (genetically and personally) regarding trees would become available as potential countershapes. Do you begin to see the matching-quality to the countershape? In this example, the outside world presents the shape while my interior world of potential behaviors regarding that shape would be the jigsaw-puzzle countershape.

Say I wanted to climb that tree to get a better look at the countryside. My body and its parts clambering up the shape of the tree would then be a perfect countershape to the outline of whatever parts of the tree my hands and legs clung onto. Thus, the “sensory” part of sensorimotor would be the shape and the motor part of sensorimotor would be the countershape. The principal of shape/countershape is to be found everywhere else as well.

Now let's say I was hungry, and I was looking for a specific tree that I knew bore delectable fruit. In this example, the shape is my interior feeling of a specific hunger. That hunger also happens to be in conjunction with an interior picture of a specific satisfaction to that hunger, i.e. a delicious peach. Thus, the peach actually seen on the tree is a countershape to both the picture of a peach I have already conjured up in my mind's eye, and quite interestingly, a perfect countershape to the felt longing and feeling of hunger I have experienced internally. Yes, the look of that peach in that peach tree perfectly matches my interior expectation: delicious!

Now comes the moment of reaching for the peach: My hands grasp and perfectly configure the shape of the peach. I bend my arm and place the peach in my mouth, which countershapes the delectable fruit with tongue, lips and teeth. Such a lovely shape and such a satisfying countershape. And further, the exquisitely anticipated shape of the flavor of peach pulp and juices cascades down my welcoming countershaping throat and gullet, and the rainbow of flavors and textures perfectly match my salivating expectation of satisfaction. Heaven on earth.

Looked at in this way, shape/countershape is an endlessly circular process, with shape/countershape interchanging between objects, expectations, and actions. See-do, sensory expectation, and the motor action in response combine to give satisfaction. And, following the pleasure of the satisfactory conclusion, there is a “click of closure”, the sense of a fully completed circle, ready for another round. By the way, when we get that sense of satisfaction at the moment of the closure of the loop, we call that sweet, rewarding feeling a “pleasure-pop.”

The click of closure signals the sense of a **rightful**, you could even say **just** ending that is so pleasurable and so appealing that it is tirelessly sought after in many different aspects and levels throughout our lives.

It is clear that there is an innate tropism and pressure for a complete gestalt that is central to life and is a central principle in all of PBSP and especially in the work with Holes-in- Roles. But for now let's acknowledge that there is an expectation of cycles of completion and when any completion is achieved there is pleasure. Conversely, when it is not achieved there is displeasure and frustration. And if the incompleteness is postponed indefinitely there is despair and hopelessness combined with an inclination to seek alternative arenas of pleasurable existence.

I will give one more example that highlights how basic and fundamental are the inner expectations of shape/countershape, and pleasure. Instead of the peach and the peach tree, think of a newborn with an inbuilt sense of what should come into its mouth and an inbuilt sense of its flavor and texture. Pan the camera of your inner eye on your own internal stage of memory and imagination and “see” in your mind's eye a lactating mother with her newborn infant and you are seeing shape/countershape par excellence as the baby's eager mouth finds the perfectly countershaping nipple and breast. Then share a protoplasmic thrill with all the waiting cells in that child's mouth, throat, and gullet, resonating in expectation of nurture and replenishment.

Obviously, shape/countershape has to do with interactions with people as well as with things. It is this idea of shape/countershape that served as the impetus for our invention of the kinds of figures we call Ideal human figures. They are a perfect, human, external countershape to the shape of our human internal hopes and expectations of what we should find and experience through significant others, when we first arrive on this planet.

Next, let's consider: **what are the basic connections that need to be accomplished in order to experience a satisfying life?** At first glance, this sounds like a matter of shape/countershape and in a way that is true, for that interactive notion is indeed included in the answer to this question. The answer I have in mind is: **connection to the self, connection to the other, and connection to the ultimate** (the seemingly inborn need for or sense of the ineffable, transcendent source of all things).

Let's start with connection to the self. That would seem to be an obvious easy step to accomplish, but it is not. Think of being in that kind of state where you don't really know what's going on inside you. You have to search for “feelings” perhaps in your body or in emotions that roil in you to find an answer to that dilemma.

Those parts of the self that show up as a shape (desires or impulses from childhood) and which are not given the validating countershape of our caregivers go into hiding and show up as symptoms or bodily sensations or unconscious impulses and ideas that might possibly surface in dreams. That is why it is so important to have a life filled with people and circumstances that allow the positive, loving self to emerge into the light of day. That is exactly what we attempt to provide in PBSP sessions with the help of what we call the “possibility sphere”. The possibility sphere is the psychological, emotional countershaping space that we train therapists to offer, in which they make “room” and a safe accepting atmosphere where it is possible for clients to become more of themselves.

As for **connection with the other**, this concerns the fact that in order to become who we really are, we first have to be conscious of as well as deeply connected to our inner, bodily felt, emotional states, and in that condition be deeply connected to a richly satisfying interactive other. This **other** is necessary for the maximum development of one's fullest self and capacity for satisfaction in life (Bowlby, 1969). So if we look at this kind of interaction from the angle of

shape/countershape, the validating acceptance of the significant other is a countershape to the shape of the burgeoning, evolving self. This validating interpersonal interaction then becomes the template for our own internal countershaping of our conscious cognitive image of ourselves with the shape of our “felt” or “limbic selves”.

Lastly we have the connection to the ultimate. If we are deeply connected to ourselves and deeply connected to the other, then we are more likely to feel deeply connected to the universe at large and therefore part and parcel of a vibrant, cosmic network of meaning and order. This state of being produces that longed-for experience of pleasure that comes from the experience that there is justice, order, and rightness—all with a sense of a completion of what is to be achieved throughout time and eternity, during which, in our lifetime, we each play our human part.

What happens when we lose the connections that we so desperately need with the **other** in order for us to literally, physically, emotionally mature and become happy generative adults? Who then is going to countershape us, satisfy our needs, and validate us? With the three connections we have postulated, the answer is simple. We can turn to ourselves and become our own satisfiers with the result that we then look upon the presence of **others** without that deep feeling of connection, love, and meaning. In that case, the **other**, seen as a non-provider for the needs of the self, is experienced without hope, color, or emotional value. Autonomy is to be desired, but it is best if it is developed following a developmental stage of benign and satisfying dependency with the good, satisfying countershaping of the appropriate **other** at the appropriate developmental age (Bowlby, 1969).

If the other has failed us, what could be a next possible solution? Having a healthy spiritual sense is good as long as we don't turn to God as the replacement for the people that we should have had the good fortune to experience and grow up with. The point of having these three connections elaborated is so that we keep clearly in the foreground that each connection should be accomplished “correctly”. Simply put, we should not become our own other and not turn to God as provider of that which should have come from other humans. A child needs concrete nurture, substituted with symbolic nurture when the child is older from the other before becoming autonomous.

### What are two of the most basic drives/instincts in all living things?

We refer to Darwin's tenets of evolution:

- The survival of the self
- The survival of the species

But let's look a bit deeper at two seemingly opposite inclinations, for survival of the self implies self-interest and survival of the species implies interest-in-the-other. Indeed, it is a reality that during our childhood we are mostly absorbed with accumulating all the information and skills we need — that which would give us a good foundation in our developmental process — ultimately preparing us to become providers for others. As we reach that stage of generativity, most of us become the agents for the survival/continuation of the species, i.e. we become capable and more interested in satisfying the needs of the other. In our maturity, we become invested in creating children who will go through the same process. So is there a “switch” that gets turned on at some point when we stop thinking about ourselves and we start to think about the other? To accomplish interactive closure there has to be great awareness of what is perceived outside ourselves, which means the other person and other objects as well. That means that

though we are essentially focused on self-interest in our childhood, even from the start, the fundamentals of interest in the other are operant.

Recent research with human infants at age 14-18 months highlights the points made regarding shape/countershape, the need for closure doing justice, and interest-in-the-other (Warneken & Tomasello, 2009). In this program, a research assistant was situated in a room full of 18-month-old tots. She hung a clothesline in the room and then went through the process of hanging some washed clothes on the line using clothespins. The tots watched as she “accidentally” dropped one of the pins as she was hanging a piece of the laundry. Invariably the children clambered over, and one reached down and picked up the clothespin to hand it back to her. Shape/countershape, click of closure, doing justice, and caring for the other, all in one fell swoop.

Thank goodness that such goodness is ingrained and so early evident and able to be evoked. I am sure that both the tot and the research assistant had the feeling of pleasure that comes from the click of closure. Incidentally, if the research assistant threw down the clothespin the kids made no effort to retrieve it. They could immediately evaluate the difference between the two different behaviors and the internal needs and states they broadcast.

I will now address the next question which is really a subset of the first question.

### What are the three basic motivators which propel most human behavior?

- Work
  - Endeavor to do that which leads to the survival of the self
- Love
  - Endeavor to do that which leads to survival of the other
- Justice
  - Endeavor to make things just and right in a world full of order and meaning. Or as some would say, to do God's work.

The first two are easily understandable and acceptable — Freud himself subscribed to the motivating power of work and love — but justice? What I have already written clearly supports the place of work and love in this list. The see-do process is about work. What we **see** awakens what we have to **do** to maintain existence and that is to hunt, to forage, to plant, and to do whatever else is necessary to survive and thrive. To love has to do with survival of the species. We must first be able to experience being loved and then to experience and express the impulse and wish to give love.

Justice has to do with fairness, to make things right or complete in a gestalt sort of way. Clearly, these matters have a flavor of shape/countershape to them. For there to be justice, things have to fit, to be balanced, complete, and even. Justice is important as a follow-up and consequence of loving. Loving can produce children, and the mature part of us that desires children is invested in helping them live good, just lives.

To deal with the topic of justice, we have to attend to the notions of **intake** and **output**, for they will shed light on the topic of resistance. While we are going through the maturation process, we are mostly concerned with **intake**. During our maturational period we busily ingest and take in that which will allow us to develop and become successfully generative. When we are mature enough to be interested in creating life for others, we are more concerned with **output**—to give to the others we have created those things and behaviors that would provide them with what is necessary for their development and will help them become successfully

generative. If we attend to **output**, i.e. doing justice for others too early in our lives, we become incapable of receiving what we need, i.e. **intake**.

A missing click of closure is readily evident in just reading or hearing the words “Holes-in-Roles”, a feeling of incompleteness. The Holes-in-Roles concept and theoretical/technical constructions that come out of that have to do with both the concept of shape/countershape and the need to do justice, both of which we have shown are inextricably entwined. It also has to do with intake and output and along with that the explanation for the inability to receive, or in other words, to allow **intake**.

Lastly: **What are two of the underlying, genetically available, primordial energy systems which are among the root sources for many of the actions needed to successfully maintain life?**

- Aggression
  - Ability to destroy
    - material (also ideational) forms or living beings in the service of one’s own continued existence.
- Sexuality
  - Ability to create
    - people, art, community and social programs in the service of those others who will continue to be alive after one’s own death

These two polar opposite drives underlie most essential actions. During the developing years, those explosive forces must be effectively limited, defined, countershaped, and nuanced with loving, justice-minded parents and other caregivers to result in the increasing capacity to experience heaven on earth. When those forces are not limited or bound properly all hell breaks loose.

Why do we have to look at the topics of aggression and sexuality in this discussion about Holes-in-Roles? Because one of the unexpected consequences of filling Holes-in-Roles is **the loosening of the bounds and limits of those brute, root forces, resulting in unconscious though systemic, life-stifling defenses against the unharnessed expression — murder and uncontrolled sexuality — of those forces**, just as Freud had posited about the ego’s role in bridling the base nature of the id.

### Finally, Holes-in-Roles in the flesh.

What holes and what roles are we referring to? First of all, by holes we mean gaps in the fabric or network of family roles and relationships. Whenever there is a gap in something that is supposed to be organically whole, the perception of the hole produces a sense of incompleteness in the viewer (see) and an impulse to make it complete and unified again (do). The click of closure and pleasure pop are the result when the network is made whole again.

What is a whole family network and how do we know what a whole family network is anyway? Though the modern era has shown us that many alternate family structures can work, human life begins with the union of sperm and egg and is thus contingent upon a father and a mother respectively. Readers may have noticed how curious children are about their family histories. They seem to have come to earth with an innate hunger to know the shape of their family backgrounds and the history of those that came before them. They “know” what a complete gestalt a family structure should have, just as they know how to complete things and

bring dropped clothespins to adults in need.

As a kind of corollary to this implicit knowledge of family kinship relationships and structure, I believe all children come to earth with roles, stem-selves. By that I mean that we all have within us the capacity to take on each and every familial role. After all, one day we will all become adult men or women. And one day maybe husbands or wives. And mothers or fathers, and aunts and uncles, and grandmothers and grandfathers. We have the seed of each role inside us, which will spring into flowering in response to outer and inner events that call forth the need for those roles.

Kids play out these possibilities when they play house. By their play, it is clear that all those stem-selves are just sitting inside the developing child waiting for the appropriate releasers into the outside world. But more insidiously, they are capable of springing into action in the non-conscious, automatic background on the stage of the mind’s eye and mind’s body.

Now here’s where stories come in. Let’s imagine a little girl who is all dressed up for her birthday party; today she is four years old. But her mommy is crying. She looks up at her mommy’s face with little-girl concern and compassion. See-do is already operant here. She wants to do something to make mommy feel better. Mommy is not dropping clothespins; she is dropping tears.

“What’s the matter, Mommy?” she says. Now here comes the interesting part because mommy begins to tell her something about her own past, which the child has never seen or heard about (but maybe “smelled” or “gathered” or “intuited” in some non-conscious way). Remember that words make images or pictures in the mind’s eye that the child “sees” without consciously knowing she is seeing anything at all (**see**). And that those pictures produce “actions” in the child’s mind’s body without the child knowing that anything of the kind has happened inside her (**do**). Let’s see what happens in that child’s mind’s eye and mind’s body as she listens intently to what her mother is saying.

The mommy says, “You’re such a lucky little girl. When I was four years old . . . .”. I put the ellipses here, not because the mommy paused, but because in that very instant the child has begun to make a “movie” in her mind’s eye theatre. This “movie” (made of “internally seen”, moving, acting-feeling figures) will become part of her long-term memory and therefore influence her experience of the outside world in her next moments of the immediate present and anticipated futures. It’s a bit strange to call this a “memory” for that child doesn’t consciously know that she is seeing anything at all and has no conscious knowledge that she has constructed an internal image of her mother at age four. But as far as her nervous system and neuronal firing and coding is concerned, she has absolutely and irreversibly made a memory! More importantly, the memory of that image will become part of her future destiny (Damasio, 1999).

Let’s look at the inside of that child’s mind at her “movie screen”. There, in front of her mind’s eye, she is “automatically/unconsciously” looking at a little girl that she has never seen

— her mother at age four. That is an instantaneous reaction to what her mother just said, “When I was four years old . . . .”. Now look what comes next as her mother continues speaking, “. . . my father . . . .” “Oh, my mommy had a father, just like I have a daddy”, might flash across the little girl’s unconscious mind.

And you know what? Her automatic-unconscious **see-do** process flashes a picture of a daddy beside her picture of her mother as a four-year-old child, neither of which she has ever actually **seen** before! The strange and important thing to note here is that the theatre of **imagination** shares the same neurological stage upon which memory presents us with mind’s eye images of what has been recorded as having happened in the past (Edelman, 2000). To “see” something in the mind’s eye and to see something in reality is to activate the same occipital lobe of the brain.

Now all this is going on in seconds and fractions of seconds. Let's take our finger off the pause button and push the play button to see what the mother says next after, "... my father ...". And now the next word is a killer, literally, for she says, "... died." That picture of a complete Gestalt: her mommy at age four with a daddy beside her, suddenly has a break in the circle of completion — a huge hole. This is not a clothespin dropping to the floor. This is a daddy dropping dead! And if a toddler will automatically strive to bring the dropped pin back to the person who needed it, just think of what a compassionate, albeit a bit older, tot will do about this loss to her dear mommy. What does she have available? She knows how a little girl needs a daddy for, in having one herself, she can imagine how bad it would feel to lose one. Here is a classic example of Holes-in-Roles.

Next, I think she automatically and totally unconsciously (not unconscious as in repressed, for it was never conscious in the first place) reaches inside herself where her cluster of stem-selves is stored and plucks out that stem-self which could have become a father some day, thrusting it into her mind's body. (Yes, little girls have father stem-selves and little boys have mother stem-selves. I have gone into the topic of integration and unification of polarities in another article that addresses the integration of maleness and femaleness, yin and yang, animus and anima, etc (Pesso, 1997).

That stem-self goes right into action and, in her mind's eye and body, that child extends to the image of her mother at age four. Out of her father-stem-self, a father-for-her-mother is created. That Hole-in-Role-fulfillment makes for the click of closure. The internal, eternal insistence for justice has been accomplished, even if it's only completed in the interior of the mind's eye and mind's body and not consciously registered. Also felt is a kind of body-relief and a pleasure pop of reinforcement that is registered somewhere inside.

So now that child, all too soon, has energies in her system directed to the care of the other, long before her own developmental needs have been fully met. Alas, they would also be more likely to remain unmet, as her own mommy had not even, until now, become a fully developed provider, but that's another story.

Let's continue with the shift in energies to note that this kind of "switch" to the premature interest in caring for the other before the prefrontal lobe has sufficiently developed begins to turn down or even turn off receptivity to care coming toward the self from others. The beginning of resistance to having one's own needs met is being put into place.

The mother then sees the look of compassion and concern on the little girl's face and is touched by her heart-felt interest. So she goes on to say, "You're such a good little girl. You listen to me when I am crying and sad." Of course the child glows with this compliment and that feeling of conscious pleasure simply reinforces the unconscious pleasure pop of having completed the gestalt of a needed father in the first place. But look what the mother says next. "But your father ...". Hit the pause button here. The little girl conjures up in her mind's eye a composite picture of her father in many different states — suspended, waiting to see exactly what picture to consolidate as her mother keeps talking. And sure enough her mother does give her more information to work with as she says, "... is such a rat!" Wow, a rat father image is registered. Clearly a disturbance in the gestalt picture of a mother-daddy, wife-husband compatibly partnered.

But there's more coming to break that gestalt and present another Hole in a Role. Now push the play button, to hear the mother going on to say, "... Because when I cry he laughs or gets irritated and walks away." A big hole is beginning to yawn here. Mommy has no compatible, satisfying partner when she is in this state! Of course the little girl has seen some of that behavior of her father before, but now she is hearing mommy's pain and displeasure about it.

You can tell what's coming next. The little girl reaches inside her store of selves and plucks into life the husband-stem-self. This pseudo pod, powered by her mind's body, extends out into virtual space and becomes the countershape-husband to fill the empty space beside her mother where a "husband" should "rightfully" be. This emphasis on rights may seem to be just a literary/verbal allusion on my part, but the compulsion for doing justice, making things right and complete, is incredibly powerful and busily at work at this moment. Further, the story produces a neurological process in her mind's eye and mind's body, which has an incredibly powerful effect on the energy dispositions in her actual body. The memory of those stories powerfully distorts the organization of her destiny — in other words, her experience of the present and anticipations of the future.

Let's now jump forward and imagine together what this little girl looks like as a grownup. She may have become an effective, compassionate adult who has spent much of her life taking care of others with little time and energy spent on her own emotional needs. She has too little expectation or ability to receive, though there may be lots of offers from caring people outside of herself. She is a bit of a martyr perhaps. She might also have become a leader, albeit one who has some conflict about using her full power or perhaps some difficulties in delegation. Also, maybe she has an explosive side to her personality which erupts now and then that produces pain and fear in her staff, much to her consternation. It's possible she has noted that sometimes she puts off completing necessary tasks, wondering why she so often feels depressed and depleted of energy.

What I am listing here are some of the problems that might show up from her past of insufficient satisfaction of maturational needs. I'm also listing some of the systemic defenses that arise regarding the handling of the two primary forces of life, aggression —X in its unbound form to destroy/kill/murder — and sexuality — in its unbound form to rape and commit incest. Why bring that up now? Because when we fill Holes-in-Roles, it has the unexpected and startling consequence of loosening the controls over those forces that are frightening and dangerous in their unlimited form, much as with Freud's envisioning of the unbridled id (Freud, 1910). So our psyches, in their systemic attempts to hold off emotional and physical upheavals that result in such disasters, provide us with a number of different, automatic interventions to keep things from getting out of hand. Some of those are:

- Depression
  - Turn the thermostat of all energy expressions way down
- Dissociation
  - Turn off the connection to the self so as not to be in touch with what is interiorly stirring
- Avoidance of Completions and Closures
  - Turn off the capacity to complete even simply ordinary closures
    - If one completes things it might open that Pandora's box of ungodly completions of murder and rape
    - Some passive aggressive behaviors of frustrating one's own and others' completions
    - Obsessive-compulsive behavior
    - Rigid and desperately repetitive control of simple behaviors
- Retroreflection
  - Feeling pursued by external dark forces
    - It's not me that's so dangerous, it's what's coming after me that is so dangerous
      - Self-destructive tendencies
        - Don't destroy the other, destroy the self

- Guilt
  - The powerful feeling of guilt holds down other internal dark energies

Before we address the therapeutic procedure we would go through with her, I would like to introduce the notion of what I call the “entity”. That is the name I have given that fragment of the personality that is set loose and perfectly eager to express unbound aggressive and sexual forces and which Freud saw in his practice and labeled the id. He understood the id to be the source of instinctual and raw-emotional energies that required the constraints of external culture (Freud, 1910). In PBSP theory, we understand our quintessential emotional nature to also include a yearning for satisfying interactions and justice. Indeed we take into consideration the instinctual capacity to kill and the capacity to create. Those primordial forces run all of life beautifully in their integrated and unified form — the consequence of the loving interactions of our parents during our maturation process.

The three categories of memory which result in people behaving in an “animal” and brutal way are:

- Memory of deficits
  - When our maturational needs have not been met at the right age and with the right kinship relationship, especially the need for limits
- Memory of trauma
  - Traumatic events awaken uncontrollable survival mechanisms which include
    - Fight — unbridled aggression
    - Flight
    - Freeze
    - Appease
      - In appeasement there is a powerful but hidden, unconscious impulse to provide rewards and pleasure to the attacker (including unbridled sexuality) as one of the strategies for survival
- Memory of filling Holes-in-Roles
  - When we fill Holes-in-Roles, we automatically and unconsciously become the “one and only” answer to the problems we hear about in family stories and cultural myths
    - Whenever we are the only, we become omnipotent and God-like for then there is no other, i.e., no countershaper who can influence us

We all have those demonic forces which lurk, grinning and deadly, out of sight of our conscious minds and that drain energy from our more conscious processes. That entity force wants to be the “only” — God-like in that respect. It would be the only ruling power in the universe, albeit, unlike most images of God, a cruel, cold, and heartless one. Should our internal “entity” be presented with any other authority than itself, it would immediately and endlessly attack it in an attempt to dethrone it. Any other authority would be an affront to its imperial, omnipotent self. Regime change is one of its major strategies and inclinations.

The Oedipal theory addresses what happens when Oedipus blindly marries his own mother, i.e. becomes the man besides the mother when the father is not there, and fills a Hole-in-a-Role. But Oedipal completions of missing fathers are only a small fraction of the incompletions that we all see and hear about. Just think of all the cultural stories of injustice: Israelites in bondage in Egypt; the agony of Christ; and the cruelty to the early Christians; stories of imperial dominations of one’s clan, tribe and country; stories of the horrors of slavery — all the historical wrongs that children around the world grow up hearing about. In our mind’s body, each of us

has plugged into all the gaps and become the messiah to all the dispossessed and abandoned we have heard about. Every one of us has a stem-self for every familial figure that had been missing in the past and that should have been there to make things right. You might say that the whole collection of selves is the basis for a universal messiah complex embedded in each one of us on this planet. I guess that has evolutionary value because if only two people were left on earth they could be the foundation for the human re-population of the planet as they would have within each of them the blueprint for every role needed to keep things going.

Now everything is in place to describe how PBSP theories and techniques are used. So let’s return to our little girl who has now become an adult. Though she is successful in her profession, she is presently concerned about those parts of her personality that rub her colleagues the wrong way and cause friction in her work team. Besides that, she is chronically discontented with the quality of her personal life. Therefore, she finally decides to do something about it or has been encouraged by her superiors to do something about it and then goes into therapy or coaching in the hope of finding some kind of resolution.

Let’s say she has now been a participant of a PBSP group for some sessions and is acquainted with the essential theories and techniques. I will construct a hypothetical session to demonstrate how things might proceed, leading toward a satisfying and life-enhancing end.

### Back to the beginning.

The therapist simply and calmly waits to see what organically arises in this woman’s present experience of emotions and thoughts, knowing that present consciousness is a tapestry woven of threads of memory. The therapist then micro-tracks those moment-to-moment shifts of affect and thought, knowing that what is actively arising in the present moment will inevitably awaken the historical events associated with those states of mind and feelings.

When the client begins to speak about her present state regarding her discontent with the quality of her life this week, the therapist can see the expressions shift on her face which are registering, instant by instant, the impact of her own words on her psyche. Though her actual body is in the room with the therapist and the group, a part of her is emotionally reactive (see-do) to what her mind’s eye is seeing because fleeting images of scenes of prior similar states are unconsciously, but instantaneously and automatically, flashing by. The therapist can take that moment to say, “If a witness were here the witness would say, ‘I see how resigned you feel as you recall how discontented you are about the quality of your life.’”

If the therapist’s choice of words describing the immediate emotion of the client plus its context is on the mark and verbally accurate, the client will instantly and automatically nod her head vigorously in assent. In that moment a number of things have already happened and a number of other things are beginning to happen. First, what makes her nod that way? That motion is an indicator of her receptivity to the accuracy of the emotional word “resigned” chosen by the therapist and the use of the client’s own words, “discontent with the quality of her life this week,” as the context for her feelings that particular moment. If the therapist had chosen a different and perhaps less accurate word, for instance, sad or bitter, the client would not have nodded at all but glanced first at the therapist’s face and then perhaps narrowed her eyes, trying to forge a neural link between the word the therapist chose and the feeling she actually experienced. But if the therapist was indeed right on the mark, the satisfaction of shape/countershape is experienced and that results in a click of closure and its concomitant pleasure pop is registered. Here, the emotion is the shape and the accurate word is the countershape. Because of the simple accuracy of the right word used to describe her interior, emotional felt-

state, the client is now in a condition of greater connection to herself. Recall the three basic connections: her emotional “self” is now a bit better linked to her cognitive “self”.

Now, remember the therapist had said, “If a witness were here . . .”. And in that instant, the client registers an image of such a witness present both in the room and in her mind’s eye. When she registers that statement, she feels she is being seen by another figure, a witness, that has earlier been described to the group and postulated as a benign, non-judging, observing and naming figure — no qualities or functions other than that. Thus the witness is a perfect template for one’s own observing ego, i.e. a pre-frontal lobe function of executive judgment and decision, as well as sense-making. In addition, in that instance, before the witness statement is internalized and used as a way to see one’s self, there is the feeling of being “connected to the other.” So the client is not only resonating with her self but is beginning to feel the comfort of being in resonance with an external figure. She is not alone in her feeling, she is being seen accurately in a way that she sees and knows herself. That is a very good feeling.

But where is the therapist in this configuration? The therapist is not the witness; the therapist has simply described and is narrating what the witness is seeing and saying. What a difference it would make to the client if the therapist had only said, “*I see* how . . .”. Then the therapist him/ herself would be the viewer and something far different would occur in the client’s interior. When an external, benign witness is postulated, the client is free to review her own process — under the permission and quiet oversight of the Witness Figure without the inclusion of the personality, history, and emotional state of the therapist. With the Witness Figure there is a feeling of possibility and a sense of space and time for self-review. As I have seen in innumerable sessions, as soon as the witness is the therapist him/herself, the client is forced to include the therapist’s feeling and relationship to herself and that produces another range of feelings entirely, which in unpredictable ways constricts the client’s range of possibilities. In the PBSP system, healing happens at the exclusion of transference.

However, something very important does happen between the client and therapist at this moment. The client feels seen and assisted by the witnessing process and that produces a feeling of gratitude and appreciation for the therapist, which supports and enhances the therapeutic alliance. This feeling of alliance is quite other than a “transferential feeling” whereby the therapist is seen as the actual provider of what has been missing in the past. Here it is the hypothetical Witness Figure who is providing the right words and context. The therapist is merely the reporter/narrator/stage manager of this event.

The client might then go on to say, “Yes, I am resigned, but that’s just the way the world is and there’s nothing I can do about it.” That is immediately registered by the therapist as an example of a value statement or internal belief system. So the well-trained PBSP therapist then prepares to deliver what is called a Voice Figure who will repeat back to the client, using the client’s own words, but spoken in the imperative, as if those words were a command coming from the outside. For instance, the therapist can say, “If there was a Voice Figure here, the Voice Figure would say, ‘That’s the way the world is, and there’s nothing you can do about it.’”

Here we are not following the client’s emotional state but attending to her thoughts, the other part of consciousness that we parse in the process of micro-tracking. Using the Voice Figure, the therapist has externalized the client’s own cognitive viewpoint/description of her life. This cognitive evaluation and viewpoint has been developed and cultivated over time as the client has assessed innumerable situations and become convinced that these were the laws and controlling ideas governing her world. Now, with the conscious inclusion of the information coming from the Witness Figure and the world-describing words coming from the Voice Figure, the client’s database of memories and recollections of specific illustrative events are now also

resonating in pattern-recognition of that combination of feeling and thinking. The events that produced that viewpoint are hovering on the threshold of the inner stage of the theater of the mind’s eye and mind’s body.

Upon hearing the voice statement, the client might react by saying, “Yup, you said it, that’s a fact.” The therapist can then postulate a Witness statement, saying, “If a witness were here, the witness would say, ‘I see how accepting you are of that viewpoint.’”

Of course, if “acceptance” is the right word, the client nods and the very scenes that are the foundation for that viewpoint are about to pop into consciousness. And indeed, the client might choose that moment to say, “My mother was always unhappy and there was very little anyone could do to ever change it.”

Here it comes. The client has now consciously mentioned her *mother* in this context of helplessness, and you can be sure that the moment she says mother, her own mother’s image is lit up and registering on the screen of her mind’s eye. Of course, the therapist will offer a witness statement. But I want to highlight another technical intervention that would follow that witness statement; the therapist might say something like this, “Whenever a figure comes up in one’s mind that has an emotional impact on clients, we ask them to choose someone in the group to represent that figure in the room, so that the figure can be simultaneously seen by you with both your real eye and your mind’s eye.”

Now the client chooses someone in the group and that someone formally takes on the role by saying, “I will role-play your image of your mother.” Then the client is asked to place that figure in the room where she can project that image of her mother. Thus the space in the room becomes the matching externalization of the theater in the mind’s eye. The client is seeing her “real” mother in her mind’s eye, all the while also seeing the real role-player in the room designated as the symbol of her mother. She can now project on this role-player the kinds of images and feelings that she is seeing in her mind’s eye and feeling in her mind’s body. She is not hallucinating her mother, nor does she believe for a moment that it is her real mother in the room. She is perfectly aware that this is a role-player; however, all the associations she has with her mother can be played out in the room with this consciously acknowledged projection/stand-in. It is therefore important that nothing be done in the room that is counter to what is going on in her mind that may destroy the resonance and synchronicity of those two theaters. For this reason, we instruct role-players never to initiate any action or words not supplied by the client.

In the past, we used to develop a highly articulated “historical scene” in order for the client to feel and process what had happened in the past. Nowadays, we are more inclined to mostly *hear and register* what had happened in the past and then to construct in the room the antidote/healing counter-experience. By antidote we mean the staging of what would have been a more satisfying alternative to the actual history. This is done as early as would be believable by the client. Repetition of negative memory reinforces the power of that history — a tenet of cognitive behavioral theories — and is now thought to be best avoided or minimized.

The client looks at the role-player in the room while at the same time “seeing” images of her mother in her mind’s eye; the two theaters are linked. Therefore everything she sees consciously or unconsciously in her mind’s eye — which will produce changes in the organization of action in her mind’s body, her thoughts, emotions, and her actual body feelings — will be linked to, and influenced by, everything she sees in the room. In this way, the room becomes a highly-charged ritual space where new positive memories can be crafted and linked with the original, real, negative memories. The client is no longer in the ordinary present; she is in an altered state, somewhat akin to hypnosis; but, in contrast with hypnosis, in this structured procedure,

her consciousness of the real setting and her control over it is never lost.

Therefore, it is important that the therapist be extremely sensitive to what is going on in the client moment-to-moment via the micro-tracking process and also acutely aware of the long-term therapeutic goals and strategies of the client. The interventions and instructions given by the therapist have to be highly precise and carefully chosen. The role-players must be instructed (and sometimes have to be reminded) **not** to identify with the role or attempt to influence the state of the client by behaviors that they *think* would be “good” for the client to see, hear, or feel. They learn to be there as supportive figures, who are willing to be present and offer themselves as human superstructures upon which the client can safely project her powerful internal images.

The client sits staring at the figure representing her mother in the room, deep in thought while unconscious memory processes are very likely presenting to her mind’s eye fleeting, fragmented, rapidly shifting images of her history and experiences with her mother. These internal images will awaken a multitude of sensations, emotions, and impulses in her mind’s body, which show up as mercurial and rapid changes of expressions on her face and marked shifts in the rhythm of her speech and breathing. If she was connected to appropriate instruments, they would show heart rate and blood pressure changes in synchrony with the emotional quality of the scenes her memory presents.

“What’s going on inside?” the therapist asks. The client shifts her awareness back into the room in the present and says, “I was remembering how unhappy and unavailable my mother was when I was a child.” The therapist would continue to micro-track with a witness statement that would underline the emotion the client was experiencing at the moment she answered the question.

The client then recounts innumerable occasions on which her mother left her alone to take care of her little brother while she went out at night. These memories produce body-wrenching sobs as she vividly recalls the terror she suffered and perhaps didn’t express at those times. As she tries to control and stifle those impulses, her chest heaves, her shoulders shake, and her stomach muscles spasm under the influence of the conflicting goals of expression and suppression.

The therapist says, “When people struggle with their feelings, and their bodies show the agitation and strain that yours is showing now, we suggest that they enroll a contact figure who would help them handle how much they feel. Would you like to choose such a figure?” The client does so; a role-player is then chosen, enrolled, and instructed to hold the client in a way that supports all the surfaces mentioned above that are so agitated and under stress. That figure is instructed to say, “I will help you handle how much you feel.” This communicates to the client that this figure is not there to quell the feelings but to give an “envelope” of containment, like a membrane to a cell, which would keep the cell and self from spilling out of its bodily container. In that way, with that help, the turbulent emotions can now be expressed physically, without constraint or fear of them erupting out of control.

This figure is postulated in the present, though the emotions that are being felt and expressed have to do with the past. However, as the client is crying now with even more heart-wrenching sobs, one can hear the tonality and rhythm of a child’s expression of grief combined with fear. Thus the client is in two states simultaneously. One is in the present room with a helping volunteer from the group enrolled as a containing figure, and another is remembering and feeling herself as miserably and terrifyingly alone as a child with no one present to hear or hold her.

The client, after some diminishment of sobbing, shouts out at the figure representing her mother in the past, “Why did you leave me that way?” Clearly she was in desperate need of a mother who would be constant and supportive and not leave her in charge of her sibling when

she was such a child herself. Her maturational need for support and protection was clearly unmet. Now would be the time to experience a new memory of what we call an “Ideal Mother”, who would not have left her alone at night with the responsibility of taking care of her younger sibling. Here is a perfect example of a crying need for the internalization of an experience to match her sense of longing for what she should have received as a child.

The therapist offers a picture of a need-gratifying scene by suggesting that the client consider choosing someone to role-play an Ideal Mother with those characteristics which would have enabled her to be more maternal. The client, instead of being open to such an offer, goes through a remarkable transformation. A moment ago, she was the picture of a child in need; now, suddenly, her entire demeanor and gaze depict another kind of figure. She looks up in disbelief at the therapist, no child-longing look here, and says sarcastically, “Do you think I would believe that? You have to be kidding or just naïve.”

We have already spoken about the two different stages or theaters that we are dealing with. One is the ritual stage in the room, and the other is the inner theater of imagination in the client’s mind. Now I would like to use the metaphor of the client’s body being a stage for the appearance/emergence of her child states and also for the appearance/emergence of what we call the “entity,” by which we mean the omnipotent, unbounded fragment of personality that is produced when one has been the healer, caretaker, messiah figure for one’s fore-bearers too early in one’s life. That figure has some of the demonic, satanic qualities I spoke of earlier. For whenever someone has too early in life taken on those justice-fulfilling roles that have been unfortunately left vacant, they do tend to leer, jeer, jibe at, and mercilessly attack all other authority figures as if they were mortal enemies of their imperial right of ruling the universe.

So in one moment the child is on the stage, and the next moment the entity is on the stage. The entity is not the true self. However the child part that appears now is a remnant of the true self that has lacked satisfying maturational care by the appropriate other, i.e. a mother who was fully mature and therefore perfectly capable and desirous of taking care of the other, i.e. her child.

Here is the way we see the equation: When one has put out too much too early to take care of the other, one effectively loses the capacity to receive what one has wanted and sorely missed. The way we have found to offset this seeming “reflex” is to present images of a more appropriate filler of those roles other than the self. This intervention shuts down the outflow of interest-in-the-other energy via the pseudo-pods stem-selves which then allows the client to automatically redistribute her life energies on her own behalf. Self-interest and the capacity to receive then becomes a possibility.

Now to return to the therapeutic intervention at hand —when such a moment of sarcasm occurs, it highlights the client’s unreadiness for precisely what was missing and she has just spoken about longing for. The therapist can underline the lack of receptivity at such moments and teach that this can be seen as a sign of having put out too much too soon. This is when the therapist might say, “Whom did you take care of?” In other words, who was the object of her too-soon interest-in-the-other?

A frequent reaction to this question is a humorous and ironic, “Everyone!” Indeed, that is often the truth, for many people in this state feel like they have carried the world on their shoulders for a lifetime.

The therapist could retort, “Pick out one person.”

The client answers, “Well for instance, my mother,” as she points to the figure representing her mother in the room.

“What did you do for her?” the therapist asks.

“She was always unhappy,” the client answers. You can be sure that when the client says those words that images of her mother’s unhappiness are consciously and unconsciously flashing through her mind (*see*). You can also be sure that her mind’s body is automatically responding to those images (*do*).

“Why was she so unhappy?” the therapist asks.

“Well, her father died when she was only four years old, and she had to pitch in and help her mother take care of the house.” As she describes this scene it is surely being played out in her mind, though she has never “seen” it but only “heard” about it. To repeat, stories make pictures, and pictures, in the mind’s eye, make movements in the mind’s body to resolve and bring justice and countershape-completion to what is seen. Though this process is totally automatic and unconscious, it nevertheless has tremendous consequences for the disposition of the energy in both mind and body. From what the client has just said, there are now two Holes-in-Roles represented here. One is the hole where her mother’s father should have been, and the other is where her mother’s husband should have been. Both holes have to be filled appropriately or the vacuum they create will “suck in” the compassionate, justice-desiring “instinct” in the client.

The therapist suggests the following. “Why don’t you pick someone or something to represent the image of your mother as a four-year-old?” The client looks about the room and picks someone from the group upon whom to project that image of her mother. Let me highlight a critical issue that has to be attended to at this moment. After the role-player is instructed to officially take the role, saying, “I will role-play your image of your mother as a four-year-old,” the therapist says to the role-player, “For the rest of the time you are in the role, do not make eye contact with the client.” Then the role-player takes the role and is instructed by the client where to stand or sit. It is crucial that even during this stage-managing moment, the role-player does not look at the client. For we have found that any instant of eye contact with the client awakens an immediate, reflexive response to once again take on the role of the giver and provider for those internally imagined, needy figures. Any moment of eye contact is interpreted as a request for help and that possibility has to be scrupulously avoided as it would affix in the client’s mind that she is once more the one and only answer to her mother’s needs. The therapist’s task at this juncture is to present the client with the satisfying “movie” or “scene” of that child-image of her mother in the presence of an ideal father who would not have died — the exact opposite of what had actually occurred. It is that Ideal Father figure whom the “mother” is instructed to look at and receive satisfying continuity of support from.

So, after the role-player is appropriately placed, the therapist says, “Now pick someone to role-play your mother’s Ideal Father.” The client does so and the role-player is instructed to say, “I am role-playing your mother’s Ideal Father and am no part of your mother’s real father.” This clarification and distinction is very important for we have found that people often unconsciously awaken in their mind’s eye a picture of those who had actually been or not been there. In other words, we have learned to monitor and track clients’ internal images as the role-playing contracts are assumed so that a truly new figure is presented and not the original figure, who in fact did not fulfill the genetically anticipated role of fathering for her mother.

The reader must surely have noted that the therapist is being very directive and active, which is in contrast with the therapist’s style up until now. When making Holes-in-Roles interventions, the usual rule of following only the impulses, emotions, and thoughts that arise in the client’s body and mind as in traditional client-centered therapies is suspended temporarily. The client, if left on his or her own to stage a Holes-in-Roles situation, would immediately re-construct it according to how it had been fulfilled in the unconscious imagination, thus unwittingly reinforcing the client’s role as the savior and provider of justice. Freud has described this as the

“repetition compulsion” (Freud, 1975), and this outcome should be strongly avoided. That is why the therapist takes the lead whenever this repetition pitfall appears about to be played out.

Once the Ideal Father is on the stage or established in this “movie” (what we call the Holes-in-Roles constructions), the therapist asks the client to place him in relationship to the figure representing her mother as a four-year-old. In this event, the client does not have a role to play but is a viewer in the “audience”. Those procedures are in contrast to those moments in the structure when the client is on center-stage and the receiver of needs.

The client, with the therapist’s overview, proceeds to do this. The therapist knows that in this arrangement the client can be safely licensed to use the information arising from her own emotions, feelings, and thoughts as a guide for what the Ideal Father should do. Now, in this symbolic, positive reconstruction of the negative past it will be her mother’s Ideal Father who will carry out exactly what she would have liked her mother to receive — and very likely had endlessly/ tirelessly tried to provide her with, in her unconscious, mind’s body, see-do imagination.

It is moving and impressive to watch this sequence. She takes the hands and arms of the role-player and places them around the shoulders of the figure representing her mother as a child. The therapist instructs that role-player Ideal Mother to look up at the face of the group member representing the Ideal Father and to smile at him. The client, having choreographed the arrangement, steps back to look at it and then nods her head to the therapist indicating that it is right.

The therapist then instructs the Ideal Father figure to say to the child figure, “If I had been your Ideal Father, I would not have died when you were four years old, I would have been there with you all the time as you grew up.” Hearing and seeing this, the client nods her head in assent and glances at the therapist, tears in her eyes. The therapist says, “If a witness were here the witness would say, ‘I see how touched you are as you imagine how this would have been for your mother.’”

The client nods in agreement, then heaves a sigh of relief and makes a gesture that indicates a shift of feeling in her back and shoulders. She says, “I feel as if a burden was lifted off my shoulders — I feel lighter.” I have heard those exact words hundreds of times in structures like this. It is as if there was a universal script and a universal effect that goes along with it. It is stunning to see the shift in energy and alertness, the change in gaze and posture that comes with this satisfying intervention. In my imagination, the pseudo-pod part of the client that was acting as a virtual father to her mother all these years — draining energy resources that should have been available for her own life — has now been retracted and those energies have immediately been made available to her own personal self. She now has the pleasure and privilege of feeling the aliveness that accompanies this shift of energy.

The client says, “If my mother had been fathered like that, my whole life would have been different.” Once again, this phrase is typical. Change one’s history and then the perception of the future begins to change. At once, the client’s gaze reflects this change. She appears to be looking out from eyes focused further into the space around her and not so limited by the walls in the room and definitely not turned inward. The future has opened up a bit, and there is the appearance of hope on her face and probably an increased sensation of hope in her body feelings.

Accompanying the client’s exclamation is an emerging picture of how her mother would have been able to become as an adult had she been fathered like this in her childhood. That emerging, maturationally evolved mother-image could also be understood as an embodiment of the principle of an Ideal Mother, i.e. someone who had been raised to maturity and who was

now able and ready to raise the next generation effectively. With that image in mind, of her mother being satisfied by a living father, the client is moving closer to becoming receptive to the possibility of experiencing an Ideal Mother for herself. The therapist, noticing this effect, can now say, "What do you think of enrolling an Ideal Mother for yourself now, who had been similarly well raised by her own Ideal Father?"

No rolling of the eyes and cynicism now from the client who simply says, "That's a good idea." The shift to acceptance is so pronounced that it could seem as if she never had her earlier dismissive attitude and response to the same offer just some minutes ago.

She looks about the room and chooses one of the females in the group who then says, "I will role-play your Ideal Mother and no part of your real mother." Then the group member adds, as is customary at this point, "Where do you want to place me?" For at this juncture the client is no longer making a movie that she will be the audience of, but she will be the central figure about whom the rest of the cast will assemble.

The client arranges the role-player in a way that epitomizes a child-mother relationship. The client snuggles into the mother and asks her to say that she would never leave her alone at night to be in charge of her little brother. The role-player then says, "If I had been your Ideal Mother, I would not have left you alone at night to be in charge of your little brother." The client reacts at once to that statement and feels the relief of that responsibility, which shows on her face and in the way she releases her breath. This is witnessed appropriately but then tears well up in the client's eyes, and she cries once again but this time without terror but with grief at knowing how much she had missed this relief.

This is a typical pattern seen in many sessions, the shift from relief to grief as the contrast between the experience of safety that has been so endlessly longed for and the terror and insecurity of the past are literally side-by-side in her mind. Relief and grief cycles of this kind can continue for several minutes.

Then the client sits up and says, "I've had enough, now I'm worried about my brother, who is taking care of him?"

"What would you like to do here?" the therapist asks. "You can have someone role-play him, and he would be with you and your Ideal Mother, or we can make another movie and give him his own Ideal Mother. Which way would you prefer to go?"

"Let's give him his own Ideal Mother," the client decides. That scene is then set up with the client choosing one person to represent her brother when he was a little boy and another person to represent his Ideal Mother. The client choreographs the setting and settles back with her Ideal Mother once again. A scene is played out where the Ideal Mother, at the client's request, says that she would never have left him and his sister alone at night, and she herself would have been there to take care of him and put him to bed.

Upon hearing this the client relaxes further into the arms of her own Ideal Mother, but then looks back at the role-player representing her brother and says, "I feel like I should be there to hold him, he really needed me, and part of me can hardly believe that she would really be there for him."

The therapist asks, "Who are you seeing in your mind's eye as you look over there?" The client answers, "You're right, I'm trying to imagine my real mother saying that and it is just not believable." Then the therapist asks the group member enrolled as the Ideal Mother to restate her role and its corollary. The role-player then says, "I am role-playing your real brother's Ideal mother and no part of your real mother."

"Yes," the client says, "You're right, I was trying to picture my real mother doing that. Let me get it straight in my head now." She closes her eyes and assembles a different picture in her

mind's eye and then opens her eyes and says to the role-player, "Say what you said to him again now." The role-player repeats the same sentence that she would never have left him alone at night with his sister and would have been there to take care of him and put him to bed herself.

The client says with relief, "Then I wouldn't have had to do it." At this point it is sometimes useful for the client to experience a cinematic illusion called "breaking the 4th wall" as seen in Woody Allen's *Purple Rose of Cairo* where the actors leave the screen and speak directly to the members of the audience. Remember, the client is simply the audience watching the dual screens (the one in the room and the one in her mind's eye as she reconstructs it interiorly). But now the Ideal Mother role-player/actor on the screen outside her is instructed to look away from the role-player representing her little brother and direct her gaze to the client and then say, "That would have been my job, not yours," then she returns to being in the movie by turning her head to look at the role-player representing the client's little brother.

"What a relief," the client says and snuggles deeper into the arms of her own Ideal Mother, relishing even more the experience of being simply a child and not a surrogate parent.

Structures follow an organic process, and when they are over it is evident to the outside viewer as the indicators of wholeness and completion become evident. The client seems to be at that spot for she shows subtle changes in gaze, tone, and words that the story is over and that she is finished. She may close her eyes and nod her head in reaction to her inner scenes; her breathing may change; she may take a long breath and exhale it with a sense of closure. But something of symmetry is missing at this particular juncture, and the therapist notes that by saying, "What about having an Ideal Father as well?"

"Who wants him here anyway," the client says cynically. "I'm perfectly comfortable with just me and my mother. He was never around enough when I was little, and he wasn't very kind to my mother either."

Being conservative and noting the client's resistance to take in or receive fathering, the therapist says, "Why don't we bring in someone to represent your mother as a young woman and give her an Ideal Husband. Not a second husband but an ideal first husband who would love her and give her the time, attention, love, and respect you always knew your mother deserved."

"Okay," the client says with rising interest, "I would like to see what that would look like."

That scene is then set up. The therapist says, "Pick someone to role-play your mother as a young woman." The reader might ask, "Why her mother as a young woman?" That choice is made so that the next step will be clearly a scene of a first marriage for the mother and not a picture of what her mother would have looked like following the possible divorce of her father. For indeed, it is possible and likely that she fantasized how things would have been for her mother if her mother had divorced her father and married a different man. So, to offset that much-later scenario possibility and to offset the reproduction and representation of her mother's misery with her actual father, this route is taken. In this case, we are endeavoring to create a new history for her mother, prior to the remembered painful, actual history. This will be a movie of a new beginning for her mother as a wife and this time with a perfect partner to counter-shape her mother's need for partnering as a young woman.

The client picks a woman from the group, and the therapist instructs that role-player to make the contract for the role, by saying, "I'm role-playing your image of your real mother as a young woman", and then, once again, this role player is told to never look directly at the client or make eye-contact with her from that moment on. For if she did, as I underlined before, the client would immediately respond to a seeming request for interaction and unwittingly, automatically, and instantaneously fill the Hole in the Role of a partner for her mother. Indeed,

she has most likely unconsciously fulfilled that function her entire life. In this representation, she is released from partnering responsibility and burden, and thus that negative history is not reinforced.

The therapist says to the client, "Place her." The client does so as the therapist alertly watches the role-player to make sure that she doesn't look at the client in order to ascertain where to stand and where to face. The client places the role-player at what seems to the client to be the appropriate place, and then the therapist says, "Now pick someone to role-play her Ideal Husband." The therapist might add, "Not her second husband, but an ideal first husband, so that she could be happily married in the first place."

In passing, the client might nostalgically reminisce and say, "My mother was such a beautiful young woman, with so much promise and talent. She would have flowered if she didn't get married at all." This is okay, but in this moment the client may be holding off the possibility of a happy, fulfilling marriage for the mother — still leaving open that no one other than herself would have allowed her mother to be fulfilled and still be partnered. In this circumstance, the therapist would add that this Ideal Husband would have supported her mother in fulfilling her own dreams about her future and not have hindered her development or the realization of her potentialities. In other words, justice would have prevailed.

Going on, the client picks someone from the group to role-play her mother's Ideal Husband, and he is instructed to enroll by saying, "I am playing your real mother's Ideal Husband and no part of your real father." The therapist then says, "Now place him." This is an important moment, fraught with potential pitfalls, for in all of the client's history it has been replete with images of distance between her mother and father, and she would most likely place these role-players far apart as a realization and representation of those actual memories. Seeing them far apart would simply underline and reinforce the history as it was and thus draw the client into the empty space once more as a Holes-in-Roles filler. In the event that the client makes such a choice, the therapist should be a bit directive and remind the client that this was the ideal partner who would have loved her mother and been there as a support for her dreams and ambitions and that he was carrying no part of her real father's history and qualities.

Let's imagine that those pitfalls were dealt with appropriately, and the client has now placed the two figures together, side-by-side. The therapist can once again be directive here and instruct the role-player representing her real mother to look into the eyes of the role-player representing her mother's Ideal Husband. Such a moment is important and has an immediate effect on the client for she is seeing what could be for the first time her mother engaged in a positive interaction with a partner. It is also important that the role-player representing her mother as a young woman smile with pleasure as she looks at her partner figure. In fact, it has often been the case that some role-players, intent on doing a good job for the client, unwittingly communicate their preoccupation with doing a good job with a look of grim determination on their faces. So it is important that the therapist monitor such moments that might unintentionally represent a replay of the past.

If all goes well, the contented smile on the client's face shows how positively she is reacting to this imagined scene of compatibility. That could be witnessed by the therapist saying, "If a witness were present the witness would say, 'I see how much pleasure you feel as you imagine how it could have been for your mother to have a loving ideal husband.'"

"Yes," the client might say and add, "Now I would like to see him put his arm around her shoulder and tell her how much he loves her." The role-player representing her mother's Ideal Husband then places his arm around the role-player representing her real mother and says, "If I had been your Ideal husband I would have told you how much I love you." The client might

say, "Never mind that. Just tell her you love her very much and that you would never walk away from her when she was crying." The role-player then says simply those words, "I love you very much, and I would never walk away from you when you were crying."

The client's reaction here is interesting. First she feels the relief of imagining her mother being cared for, and in the next instant the grief that is evoked by remembering just how painful her mother's life with her father had actually been. Once again, this is a very natural cycle, which regularly occurs the moment a longed-for alternative is experienced. This new image of satisfaction presents a very vivid contrast to what she had actually seen in her mother's life and often the pain of that history results in clients welling up with tears. But now, she is not feeling a hopeless grief but a grief coupled with relief at seeing a more just closure. This scene provides a different conclusion to what was before an endless sense of loss with no expectation of relief in the future.

Following those sequences the client might eventually say, "Wow, I never saw my parents together like that. If I had, my whole life would have been different." This would be the time for the therapist to say, "How about choosing someone to role-play your Ideal Father so you can experience how it would have been to be the child of a similarly contented couple."

"Yes," she says, "I would like to feel how that could have been like." Remember how resistant the client had been to the suggestion of an Ideal Father before this scene was provided? Now, in marked contrast, she is primed, ready, and eager to explore and experience how that previously offered possibility would feel. And here we come to the crux of this article. **Only when the web of family networks is complete are people fully ready, willing, and able to receive for themselves.**

"Pick someone to role-play your Ideal Father," the therapist says. The client looks about the room and chooses one of the men. He is instructed to say, "I am role-playing your Ideal Father and no part of your real father." The client, still in the arms of the Ideal Mother says, "Sit beside her and put your arm around my Ideal Mother like he did with my real mother," indicating the figures in the scene in front of her.

She looks up at the two of her own Ideal Parents with satisfaction and pleasure, and says, "What a wonderful feeling to look up and see the two of them together like that." To be safe, the therapist might say, "Make sure you are not seeing the faces of your real parents in your mind's eye as you look up at your Ideal Parents."

"You're right," the client might say. "I was trying to imagine it was them, and they immediately became less believable." Then, after some moments of internal sorting and shifting, she might say, "Yes, now I have it clearer in my mind; this is the way it should have been and could have been with my picture of what Ideal Parents could be like."

With relief and contentment she might then snuggle between the two of them and then reach above her and pull the arms of the role-players around her. "Hold me like this," she might say.

The therapist might say, in order to place a time line on the scene, "Perhaps the Ideal Parents would say, 'If we had been your Ideal Parents, we would have held you like this when you were a child.'" The client agrees, and they deliver that message.

"This is wonderful," the client might say. "I feel so safe and cozy now," a look of innocent bliss coming over her face.

To underline and anchor this moment, the therapist might say, "If there was a witness present the witness would say, 'I see how contented you feel as you experience how it would have felt to be in your ideal parents' arms when you were a young child.'"

"I could stay here forever," the client might say. The therapist could say, "Would you like

the Ideal Parents to say, 'If we had been your Ideal Parents you could have stayed like this with us forever?'" This is not to say that this is a realistic wish but in fact to suggest that if the memory is internalized it is indeed there forever to be tasted and re-tasted endlessly. Also, to children, a long, long time is forever, so this statement is an exaggeration, but it is not emotionally false.

The client says, "Yes, I would like to hear that."

The therapist says, "They will say that, but before they do, imagine that these feelings of contentment and snuggling that you are feeling in the present moment would be precisely what you would have felt as a child. So deliver all your bodily sensations — the contact of their arms around you, the feelings in your back as you snuggle into them, the look of their faces, the feelings of cozy contentment you feel inside — all of those feelings, link them to your sense and memory of yourself — in your mind's body — as a child of three or four."

The client closes her eyes and sinks into the sensation of how it would have been at that age, a relaxed look of pleasure and relief glowing on her face. There is silence for some minutes as she anchors those memories and sensations in her mind and body. Slowly her breathing changes and after a sigh, or a marked exhalation, the client opens her eyes, looks at the therapist, now clearly as an adult in the present — for there is a totally different look on clients' faces when a structure is over. This phenomenon indicates to me that a structure is an organic process, with a beginning, a middle, and an end. And now the end has arrived and so has the client, returned from an immersion in the deep memories of the past into the present with the past now more in the background.

This is not to say that the client has been out of contact with the present, for she has known all along that she is in the therapy room with her fellow group members, choosing among them to role-play for her various figures. She has been on two levels simultaneously throughout. She was certainly in an altered state but fully aware of the present, while also deeply connected and resonating with memories of her past. But now the structure is over, and she has put the event into the past, and we have made a satisfying, symbolic, new memory, which will powerfully influence how she lives in the present and anticipates the future. The therapist says, "It looks like you are finished, is that right?"

"Yes," the client says, nodding.

"Are you ready for the de-roling?" the therapist asks.

"Yes," says the client, "I am." Now the ritual of enrollment is about to be reversed, and the room cleared of all the artifacts of the past in order for the arena to become once more simply the group room

The therapist says, "First let's take out of the air the Voice Figure that we had posited before." The client makes a gesture of wiping away that area where that image of the Voice Figure had been located. "Then what movie shall we de-role first?" the therapist asks. It goes without saying that it is important that the last figures to be de-rolled should be the client's Ideal parents. Usually the client de-roles each scene in reverse order, so it is likely that the client says, "First my little brother with his Ideal Parents." Those role-players then say their appropriate de-roling statements such as, "I am no longer role-playing your brother as a little boy, I am" and then they say their own name to end their contract as that role-player. Each role-player in each scene in turn follows that procedure.

Then the therapist says, "Let's de-role the Witness Figure that was in the air," which the client accompanies by making the same wiping move as was done for the Voice Figure. The therapist then says, "Are you ready to de-role your Ideal Parents?" Often, in partial jest, the client might say, "No, I'm not letting go of them." The therapist might then say, "Do you

want a few more moments to anchor that feeling?" Or, the client might say, "No, I've really got it inside of me now." The Ideal figures then make the de-roling statements and return to where they had been seated in the room before the structure began.

The therapist says, "Let's take some time for sharing." Sharing is the usual procedure following a structure that allows the group members to express what happened in their own process as they watched or participated in the structure.

So there it is. At the beginning the client was simply unable to imagine any figure who could have provided her with what she needed. Her own capacity for receiving was blocked. The interventions and movies that were made gave her the opportunity to see those network holes filled by the appropriate persons, which had an immediate effect on her ability to receive. With those new memories firmly in place, the client is able to return to her real life with more hope and optimism, as well as a readiness to receive the rewards and love her personality and talent deserve. She is no longer the omnipotent healer of her family network. The entity energies have become reduced and bound, allowing her to feel strong emotions without the consequence of depression, dread, doom, or disaster. Happiness is indeed an attainable possibility.

## BIOGRAPHY

Albert Pesso, co-founder with his wife, Diane Boyden-Pesso, of PBSP, Pessa Boyden System Psychomotor, and President of the Psychomotor Institute, Inc. was formerly Associate Professor and Director of the Dance Division at Emerson College, Supervisor of Psychomotor Therapy at McLean Hospital in Massachusetts, and Consultant in Psychiatric Research at the Boston VA Hospital. He has conducted training programs in PBSP in the US, Brazil, Israel, and in many countries in Europe. He and his work with PBSP for the German GTZ Mission in The Democratic Republic of Congo have been featured in a documentary film, "State of Mind" distributed by Icarus Films. He is the author of many books and articles on PBSP, and a frequent lecturer at universities, hospitals and clinics in the US and Europe. At present, he continues his intensive training schedule in the US and Europe and also leads programs and sees individuals in Boston, Massachusetts.

Email: apesso@pbsp.com Website: www.pbsp.com

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## A Review of Barnaby B. Barratt's The Emergence of Somatic Psychology and Bodymind Therapy Christina Bader-Johansson, MSc

Barnaby Barratt's *Emergence of Somatic Psychology and Bodymind Therapy* contains three sections: "Introducing a New Discipline" (5 chapters), "Sources: Ancient and Contemporary" (7 chapters), and "Current Challenges: Possible Futures" (5 chapters). Each chapter starts with a presentation of the themes discussed and theories presented, giving the reader a good overview before delving into the content. Barratt, collecting themes pertinent to the new discipline he calls "Somatic Psychology," quotes many well-known body psychotherapists and unites aspects of history, philosophy, culture, neurobiology and energy medicine to grasp a broad conclusion for somatic psychology. Barratt's book takes a wide stance on the theme of psyche and soma, giving an excellent overview of both Western and Eastern attitudes toward therapy. Underlying it all, he pleads for new considerations of what it means to be human and to heal human suffering. His book is also political when considering the implications it could have for really working with spiritual healing of the body. In that light, the values we hold today of high margins of profit and possessions are no longer possible to maintain.

More and more disciplines of psychotherapy and psychology are realizing that philosophical, cultural and neurobiological evidence can bridge the reductionistic dichotomy between psyche and soma. Barratt argues that the disciplines are at a crossroads at the present, trying to get away from representations "in the head" about the body. He predicts that psychoanalysis will no longer be much in evidence and cognitive behaviourism no longer credible as a science, and that psychology will become *somatic psychology and psychotherapy bodymind therapy*.

Barratt defines *somatic psychology* as follows: "the psychology of the body, the discipline that focuses on our living experience of embodiment as human beings and that recognizes this experience as the foundation and origination of all experiential potential." As for *bodymind therapies*, he encapsulates them as: "the healing practice that is grounded in the wisdom of the body and guided by the knowledge and the vision of somatic psychology" (p.21).

He gives an historical survey of the end of the 19th and 20th century as the time in which the male, Western, white, Christian, dominant power structure governs and manipulates the views about *the other*, considered to be nature, as well as women and people of the third world and people of color. Along these lines, the body is also treated as other to the mind. These polarizations had progressively been seen as the "natural order of things" (p. 25): civilized, indicative of modern values, and well accepted in the spheres of capitalism and globalization.

This has gradually changed as advances in the physical sciences, awarded Nobel prizes, tell about a universe of interdependency (quantum physics: theory of entanglement, relativity of time, particle-wave-duality, the uncertainty relation, correlations rather than causality), where the observed and the observer can no longer be seen as totally separate

entities. Already foretold in the Vedic, Buddhist, Taoist and many indigenous teachings in which there are no dichotomies of subject/object, man/nature, or mind/body, nonduality has been confirmed by modern theories of nonlinear dynamic systems and complexity theories. Barratt also honors the Dalai Lama's exile as a gift to the North American and European world which has further enabled dialogue about Western science and Buddhist thinking.

In this new-to-the-West line of thinking, the quality of a material event is determined before the matter comes into existence. Intention comes before action. This is the context in which the emergence of somatic psychology and bodymind therapies is to be articulated. Barratt gives some vignettes of therapeutic interaction to illustrate this. Ninety percent of what is known about the brain's functioning has been discovered in the past decade. In the chapter on neuroscience Barratt briefly describes the polyvagal theory, mirror neurons, vascular communication and memory that is encoded in every cell, all of which certainly do their part in offsetting the Cartesian image of a cerebral mind that governs the bodily machine (p. 123). He makes the point that character change — which is invariably a complex and gradual process — involves the somatic expression of a person's internal conflicts as much as it involves the verbalization of mental representations. Therefore, an approach to treatment that focuses solely on one of the aspects is doomed to be limited in its potential to heal (p.45). In some chapters he exhaustively continues the discourse around the *zeitgeist* shared by Freud, Rank, Reich, Ferenczi, Balint and others, and puts it in a modern, critical and constructive context, as exemplified by the thoughts of Gallagher in his book, *How the Body Shapes the Mind* (2005).

The significance of the emergence of somatic psychology is that it establishes, or re-establishes, human experience as the primary subject matter of any inquiry into the psyche and that it acknowledges the primacy of the embodied experience. Barrett mentions philosophers like Habermas, Husserl, Bergson and Merleau-Ponty and their influence on the increasing interest in bodymind therapies. Such diverse disciplines as anthropology, sociology, and cultural studies demonstrate how an increasing interest in the body indicates an important shift towards a broader understanding of the psychology of the body.

Instead of manipulating the body from the outside, Barratt sees healing as an inherently spiritual potential of the bodymind components. Healing the psyche is an ethical and spiritual process which presupposes safety, trust and intimacy. He describes some requisite factors for healing: a) the importance of honoring-by-listening to all aspects of the individual and his or her ecology, b) mobilizing energies by intentionally breathing and moving with awareness, and c) the appreciative connectivity of touching with awareness: touching in the sense of ethical, physical palpation and respectful, emotional engagement. Healing is not the avoidance of pain. Healing is not the avoidance of death. Healing is not a procedure of political or sociocultural adaptation. Healing is inherently a celebration of the liveliness of life itself!

Barratt describes some Western traditions of bodywork, such as osteopathy, chiropractic, massage, dance therapy, and free-form expressionist dance, which liberate the body and stimulate self-expression. He presents some principles or empirical laws that he finds widely applicable to many modalities of bodywork. These principles include:

- The body and the mind interact in and as one unit.
- The structure and function of the body are reciprocally interrelated, as well as the flow of subtle energies.
- The body possesses self-regulatory mechanisms.
- The movement of body fluids is essential to the maintenance of health.

<sup>1</sup> Barnaby Barratt is a psychoanalyst, sexuality educator, sex therapist and somatic psychologist. As a former professor of family medicine, psychiatry and behavioural neuroscience at Wayne State University, he has directed several graduate programmes in clinical and somatic psychology.

- Movement reflects personality.
- Movement improvisation allows the patient to experiment with new ways of being.
- Dance movement therapy allows for the recapitulation of early destructive object relationships towards more constructive, less fearful iterations in a contemporary relationship.

Barratt then presents the influx of Asian healing disciplines with detailed descriptions of yoga, prana, chi, nadis, meridians, chakras and kundalini. He values the teachings of the Tibetan tradition in the diaspora after 1949 and in particular the work by D.T. Suzuki and his lectures at Columbia University. It is well known that Jung, Fromm, Watts and Merton were influenced by Suzuki, Barratt informs us. He concludes with a brief description of shamanic practices and transpersonal psychologies. In shamanic soul-travels, dissociated parts of our personality are emotionally contacted and brought back to the embodied being.

The Eastern religions all include yoga teachings as a pathway to spiritual growth and increased awareness. Currently, Western science is being challenged to acknowledge that our embodiment is not merely physical. It also has a “supra-physical” double in that there is an “astral body” or subtle energy body which yogic science has known about for millennia (p. 107).

Barratt has a deep knowledge of healthy sexuality and sexual therapy, which he presents in the chapter “The inherent Sexuality of Being Human”. He points out that very little has been done within the study of phenomenological sexuality and he criticizes modern books on body psychotherapy for completely avoiding the subject. Instead, sexuality is mentioned in its deteriorated forms, such as abuse, incest and other traumatizing experiences of sexuality. He describes the Western culture of embodiment in three alienated and optimized “products”: the media ideal, the medical ideal, and the economic ideal, all of which need to be critically discussed and deconstructed. He champions a bodily path to spiritual awakening which includes a playful, joyful experience of sexuality freed from social oppression.

In the chapter “Oppression and Momentum of Liberation”, Barratt discusses the issue of identity in a universe of non-linear dynamic interdependence. Indeed, nothing less than global cultural change is required for human beings to evolve on this planet, he argues. This is still a challenge to mainstream psychology and medicine. The question is in what way the discipline of somatic psychology could have a vital role in the elaboration of the psychology of liberation and thus contribute to radical political and economic transformation in the world. Are we aware of the immense impact we could have?

This book is a must for all body psychotherapists. Reviews of it so far have been outstanding, but the dense 234 pages of content admittedly are not easy to digest in one go. My suggestion is to read it in the form of a Scandinavian study circle, with one person presenting one chapter and the group reflecting and discussing it in depth, then another person presenting the next chapter and the group again reflecting.

I highly recommend this book!

## BIOGRAPHIES

Barnaby B. Barratt PhD, DHS is a practicing psychoanalytic healer and teacher, internationally recognized for his contributions to psychodynamic philosophy, theory and practice, as well as for his work as a sexuality educator, sex therapist, somatic psychologist, and practitioner of Tantric meditation. In addition to his 35-year career as a psychotherapist,

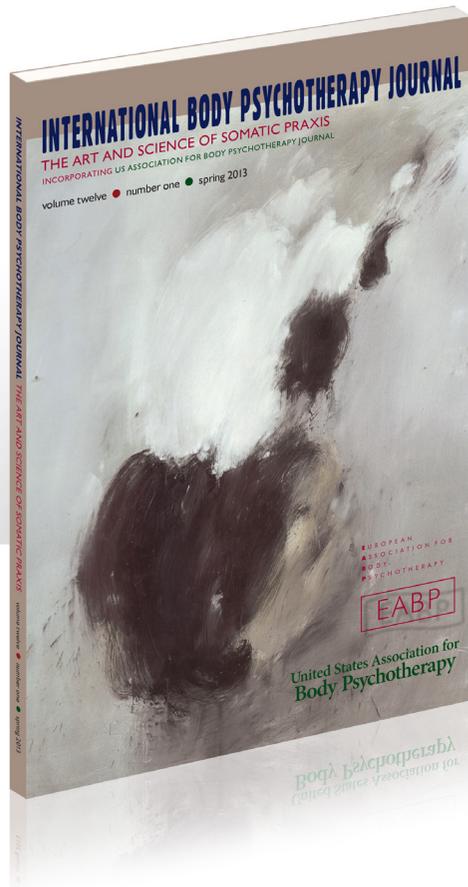
he has a distinguished history of teaching in higher education, teaching at such institutions as Harvard University, the University of Michigan, and Wayne State University. Currently practicing in South Africa, Dr. Barratt was most recently Provost (Chief Academic Officer) and Professor of Psychology at Northcentral University.

Dr. Barratt is the author of eight books: *Psychic Reality and Psychoanalytic Knowing* (1984), *Psychoanalysis and the Postmodern Impulse* (1993), *The Way of the ‘BodyPrayerPath’* (2004), *Sexual Health and Erotic Freedom* (2005), *Ten Keys to Successful Sexual Partnering* (2005), *What is Tantric Practice?* (2006), *Liberating Eros* (2009), and *The Emergence of Somatic Psychology and Bodymind Therapy* (2010). Additionally, he has published over seventy professional and scientific articles, reviews and book chapters. He is currently working on a book about the nature of freedom.

Email: BBBarratt@Earthlink.net

Christina Bader-Johansson, MSc, is a psychotherapist (ASP), body psychotherapist (EABP) and President of the Swiss National Association of the EABP (CH-EABP). She is the author of *Movement and Interaction* (Studentlitteratur 2012) which is currently only available in Swedish.

Email: bader.johansson@bluewin.ch



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## TABLE OF CONTENTS

- 4 **Editorial**  
Jacqueline A. Carleton, PhD
- 7 **The Present as Morphogenesis**  
Stanley Keleman

## ARTICLES

- 9 **Idealism & The Goals of a Psychotherapeutic Process**  
Michael C. Heller, PhD
- 39 **Body Image Disorders**  
Bernhard Schlage, MA
- 50 **Military Culture and Body Psychotherapy: A Case Study**  
Diana Houghton Whiting, MA
- 63 **Filling the Holes-in-Roles of the Past  
With the Right People at the Right Time**  
*A way to open the door to happiness in the present*  
Albert Pessó

## BOOK REVIEW

- 88 **A Review of Barnaby B. Barratt's**  
*The Emergence of Somatic Psychology and Bodymind Therapy*  
Christina Bader-Johansson, MSc

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