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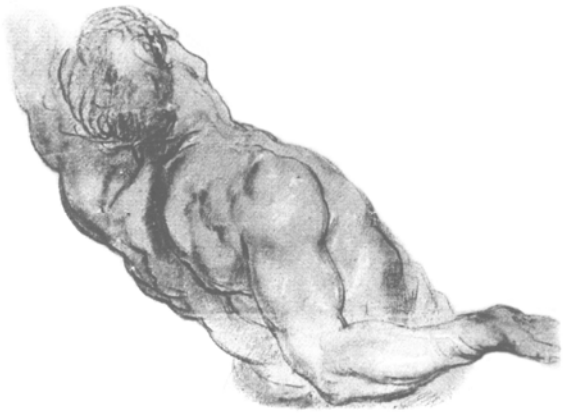

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USABP Mission Statement
The USABP believes that integration of the body and mind is essential to effective psychotherapy, and to that end, its mission is to develop and advance the art, science, and practice of body psychotherapy in a professional, ethical, and caring manner in order to promote the health and welfare of humanity. (revised October 1999)

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A palpable synergy is building in our organization and spilling over into your commitment to the USABP Journal. With this issue, enough members have volunteered their time and expertise to put all Journal articles through a formal blind peer review process. A minimum of three reviewers read each submission and returned their thoughtful written comments and suggestions to the editor. Based on these reviews, articles were accepted provisionally and reviewers' comments were forwarded to the author along with recommendations for final edits. A willingness to face the scrutiny of peers is an indication of commitment to excellence and professionalism, but it is, nonetheless, daunting. Many of you have expressed your appreciation of the professional interchange involved in this procedure. I commend each of you who submitted an article for publication, whether accepted or not, and encourage more of you to open yourselves to this process.

Each of the papers contained in this issue integrates some aspect of clinical body psychotherapy with either theory or research. All are written by practicing clinicians in the field who are also concerned with teaching and training body psychotherapists. Each weaves a tapestry of a different design.

Peter Fernald, trained in both psychoanalytic and bioenergetic psychotherapy, takes a fresh look at Carl Rogers' client-centered approach as an essentially body-oriented psychotherapy. He analyzes Rogers' attention to the somatic aspects of experience as catalytic for change, quoting numerous examples from Rogers' sessions. He then goes on to compare certain more general aspects of Rogers' thinking about human nature with those of Wilhelm Reich, thus typing him into the body psychotherapy lineage.

Alexis Johnson, on the other hand, uses two contrasting cases as a focus for an exploration of the uses of an integrated approach to early childhood development therapy through particular attention by the therapist to his own bodily sensations and emotions and facilitation of that same awareness in these two clients. She illustrates how the combination of seeing wholeness, body awareness and astute questions offer an exciting therapeutic map for the pre-personal world.

Penelope Best focuses on the relational shaping between the body of the client and the body of the therapist and explores that relationship in the relational shaping between the body of the therapist and the body of the supervisor in a dance therapy supervision research project. She uses the concept of Interactional Shaping as a frame for her creative integration of dance therapy, movement observation and social constructionist discourses and discusses its connections to other theoretical perspectives. She illustrates her work with examples from supervision sessions.

Cynthia Price, honored at the last USABP Conference for her research proposal which was subsequently funded by the National Center for Complementary and Alternative Medicine at the National Institutes of Health, describes the process of her research design and implementation. As she points out, intervention research in the field of body psychotherapy is crucial to its advancement. To this end, clinicians and researchers must be familiar with each other's language and methodologies, preferably embodying both.

Thirty years ago, this editor participated in a psychiatric epidemiology training program at the College of Physicians and Surgeons of Columbia University (also funded by NIH) which introduced residents in psychiatry and advanced PhD candidates to each other's fields. We spent two years taking courses together and in each other's fields and went on to formulate cross-disciplinary research projects. My own became a dissertation on Wilhelm Reich's ideas on child rearing. I eventually refocused my goals and moved from research and teaching into further training and ultimately the practice and teaching of body psychotherapy. I am very grateful, in the course of editing this journal to come in contact with those of you who share my passion, not only for the work itself, but for the advancement of research and building of theory. It is exciting to see this kind of interdisciplinary approach utilized by body psychotherapy.

Jacqueline Carleton, Ph.D.
Editor
New York City
Spring 2003

Body Awareness in the Pre-personal World: Working with Strain Trauma

Alexis A. Johnson, Ph.D.

Abstract

This article explores an integrated approach to early childhood development and therapy with two different clients. While one client dissociates and the other is hyper-vigilant, both suffer from strain trauma and its consequences. This integrated approach involves the therapist paying particular attention to his own bodily sensations and emotions and facilitating that same awareness in the client. The healing journey is delineated by the kinds of questions the therapist can ask the client. Clarifying questions allow the therapist to mirror the client's immature narcissistic needs. Leading questions narrow the client's focus and allow the therapist to have more of an agenda. Relational questions address what is happening in the present and in the relationship. Even though these clients gather the capacity to trust and change only slowly, the therapist must hold hope and see the client's wholeness. This combination of seeing wholeness, body awareness and good questions offers an exciting therapeutic map for the pre-personal world.

Keywords

Body awareness – Body awareness in the pre-personal World – Child development – Moving clinical work into research

You have to be very concentrated while you listen. You have to focus on the practice of listening with all your attention, your whole being: your eyes, ears, body and your mind. If you just pretend to listen, and do not listen with one hundred percent of yourself, the other person will know it and will not find relief from his suffering.

Thich Nhat Hanh

Introduction

I am writing this paper to integrate many theories with two different, slow to change clients – Bob, a wealthy businessman and Mary, a successful professional. Both are in their late forties, married, have children and social networks. From the outside they appear very successful.

When I first met Bob, I saw a bio-energetic structure of upward displacement with some orality in his eyes and slope of his shoulders. His style of speaking and self involvement quickly suggested a lot of narcissism. He came into therapy because of depression. He had tried several of the medications both for depression and for the bipolar disorders, with no relief.

Bob sees himself as a spiritual person and truly longs for wholeness in his career and to be in a more intimate relationship with his wife, yet struggles with both. On the outside, he is tall, attractive, broad shouldered, very intelligent, wealthy, and well-educated. On the inside, he often feels lonely, dependent, and defective.

When I really look at Bob, I notice the longing in his eyes. His eyes are big and round and soft. In spite of his many outer successes, internally Bob is overwhelmed much of the time because no matter how much positive mirroring he receives, he is never convinced that others perceive him as valuable. He feels rejected by the slightest stern tone or questioning gaze and always assumes it means he did something wrong. When he falls out of balance, he regresses into one of two states. He will do something grand and inappropriate like give you something valuable because you admire it or act like a goofy pre-teen to attract attention. Or, sometimes he will retreat to his 'cave', even his bed, and become totally withdrawn, depressed, and out of touch with his surroundings.

Mary presents herself as both strong and self-effacing. Her body is sturdy in appearance but her eyes are very withdrawn. She is of medium height and weight, attractive in part because of her quick smile. She is shy and finds eye contact difficult. In spite of her professional and personal achievements, Mary came into therapy because she found herself loosing track of time, feeling lost in old memories, and fearful of being discovered as incompetent at work.

Mary is very active in her church, volunteers at a local hospital and is an advocate for the homeless. However, the inner dialogue she shares with me is*: "If the people I work for really knew me they would see what a pathetic, incompetent person I am."* No amount of external praise has shifted Mary's self image. One time Mary found a mistake on her paycheck that docked her salary. Her first response was *"They found me out. They know I'm not really worth this high salary they are paying me. And now they're going to fire me."* She fell into what felt like an altered state of intense shame based on personal rejection. She contemplated not going back to work the next day, a place she had worked for almost 20 years.

Mary also falls into an altered self-state when she becomes the center of attention. Whenever someone gives her heartfelt, well-deserved praise she becomes overwhelmed with humiliation and self-rejection. During these episodes she cannot relate to anyone, not even her husband. Amazingly, she is able to hide these responses completely. It is important to her that no one knows how bad she feels.

As I got to know both Bob and Mary I discovered how much they each suffered with a sense of incompleteness, debilitating loneliness and fear. I also realized that their issues required a particular sensitivity or attunement on my part as both were very vulnerable to hints of rejection, emotional abandonment, or inattention. It became apparent that the relationship between us was crucial and that body work was ineffective if anything was unresolved between us. As Johnson (1987, p 77) writes: "Through your attention, understanding, patience, prizing, compassion, and yes, even love, your client will learn that he is worthy and lovable." Johnson was referring to narcissistic issues but I have found that stance applies to individuals suffering from early strain trauma. The following is my cognitive map of their inner world and how I try to model what Johnson describes.

A Cognitive Map of The Pre-personal World

- Client falls into altered self-states triggered by rejection, loss or humiliation (real or imagined) These altered states are characterized by strain trauma where feelings predominate and linear time does not exist
- The inner world is plagued with feelings of worthlessness and self-hate sometimes defended by entitlement; behavior is characterized by extreme withdrawal or defensive anger
- The capacity to split reality and perceive a "good one" and a "bad one"
- Inability to initiate in the outer world or self-soothe in the inner world

Bob and Mary's issues stem from the earliest months of life, from what I refer to (following Wilber) as the pre-personal, pre-verbal stage of development (Wilber, 1979, pp 7-21, Wilber, Engler and Brown, 1986, pp 65-105) and what the bioenergetic therapists refer to as oral and schizoid issues (Lowen, 1958, pp 161-193 and 368-391; Johnson, 1991, pp 28-41). During this time, the infant strives both to attach and differentiate herself from her primary caretakers and each attempt becomes embedded into the felt-sense of her body-self. This unconscious, pre-personal, pre-verbal memory of self and relationship is carried through to adulthood (Lewis, 2000, Klein, 1987). For Bob, his childhood was experienced as total loneliness and abandonment as his mother was often deeply depressed or striving for upward social mobility, his father worked long hours, and there was no extended family. For Mary, there was more obvious abuse and neglect. In both cases, the match between caregiver and child was deregulating. Their brains do not contain the healthy limbic patterns of dependency leading to trust (Lewis, 2000; Schore, 2002). Neither can contain the internal rhythm of falling apart and coming together when life has its 'downs' (Beebe and Lachman, 2002; Chodron, 1997). Instead, each continuously plunges into the pre-personal reality of falling forever (Winnicott, Chapter 4, 1965 p 57-58) or of being consumed with intense self-hate (Krystal, 1988.)

When Bob and Mary decided to enter therapy, neither needed to 'uncover' a 'repression' or to learn a new way of seeing the world. Each needed to create a sense of self by connecting with his or her body and by the container of the therapeutic relationship. Like Ogden and Minton, (2001), I want to help clients like Bob and Mary regulate affective and sensorimotor states through our relationship, and allow them to self-regulate by mindfully contacting, tracking and articulating their sensorimotor processes. My experience is that this combination ultimately generates the missing structure.

My first focus is on the body. Moment to moment, I pay attention to how each of us expresses ourselves through our body language. I establish a strong positive connection with the client through empathic immersion, the ability to see the world strictly through the client's eyes. I make it very clear through my attention, my tone of voice, and my posture that I am interested in what is going on inside of her.

All of us are able to 'read' faces for cues. Innately, we know what caring eyes look like and we know what support sounds like. This kind of care, support and genuine Presence- the willingness and ability to simply be in the situation -are imperative in order to enter the client's world. But care and Presence are not enough. My words are very important and have the power to help and to harm. I use my words to support each client to find the answers within her by asking genuine questions, and listening hard for the answers that come in both body language and in words. There are various types of questions to be asked and this article addresses some of the most potent ones. Each session is an exercise in trust on two levels. First I must trust myself as a practitioner and know that I have a general map of what needs to happen. Second, I need to create trust between us. I never know exactly what will unfold, yet I trust something will happen to support the growth of this person during the time we spend together.

Impact of Rejection, Loss and Humiliation

Perceived rejection, loss or humiliation throws this kind of client into an altered state where he is at the mercy of his destructive internal reality. I emphasize the phrase "perceived rejection, etc." because the client is hyper-sensitive and waits for the next event to validate his inner instability, anxiety, and even panic. He is extremely defensive to any challenge to his sense of self. Any dialogue holds the potential for rejection, loss and humiliation.

For Bob, if his wife doesn't want what he wants whether it is sex, disciplining the kids, or going out to dinner, his deficit response can be triggered. Internally he feels: *"There's something wrong with me. I'll never get the respect and contact that I need because I'm such a loser."* He recognizes that she has the capacity to honor his opinion and pay attention to him, but he literally doesn't experience her giving this to him, even when she does. It

is as if his capacity to receive and internalize new, positive information has frozen in old, "*can't get the contact I need"* patterns.

This response is linked to Bob's history. Bob experienced his mother as only interested in herself, in money and in her social ambitions. She was cyclically depressed and we know from his bodily feeling states that she often didn't attend to his basic needs as a baby and small child. She could not attune to Bob because she was too preoccupied with her own thoughts (Stern, 1994). This internal preoccupation affected her ability to put Bob's needs first. So her face and her eyes didn't reflect to Bob *"I see you and your upset"*. Instead her face and her eyes reflected *"I am too overwhelmed with my needs to attend to anything beyond changing your diaper. I don't want to engage with you because I just can't deal with you."* She may have done the right thing by picking him up to change his diaper but Bob was treated as a thing to be changed, not a person to be cared for. In these types of exchanges, Bob was not given the healthy care necessary for him to gather more bits of himself. He grew up feeling neglected emotionally and never knowing the safety of relaxation and trust. His first attachment was very insecure (Fonagy, 2001).

Mary often talks of perceived conflicts both at work and in her marriage, but in her telling of the story she is always in the wrong. She is deeply humiliated by the conflict itself. From her point of view, there should never be conflict because conflict endangers. Like pushing water uphill, she is constantly trying to prevent typical human exchanges.

When I sit with Mary, she is frequently very tense, unable to make eye contact and holds her body in various closed postures. Her body language and clothing reflect her desire to never be seen. Even during the summer she wears turtlenecks and baggy pants and pulls her long sleeves over her hands. This dread of being seen as competent and this need to be invisible stems from Mary's history. *"If Dad's attention turns towards me, I am endangered."* Mary's first few years with her mother were uneventful but when her successful father returned he hated her and abused her both physically and verbally. He considered her an intruder, taking his wife away from him. Her passive mother never protected her. As an adult, she is unable to accept positive feedback without feeling terrified.

Strain Trauma

As I hope is clear from the above examples, the experience of falling into this altered state is extremely painful, disorienting, and truly unbearable. Subjectively, it is not experienced as a personal feeling. It just is. It takes up all their inner space.

Increasingly, the consequences of trauma have become meaningful in clinical discussions. It is not the purpose of this article to give an overview of that large and diverse body of literature but I do want to include some of the concepts and research coming out of that field. I am indebted to Krystal (1988, p 142ff) for introducing me to the idea of infantile strain trauma as I have found it very useful in understanding and being with clients like Bob and Mary.

As human beings we can process our experience through our cognitive abilities, or sometimes our emotions predominate, and sometimes sensorimotor functions are most important. We move among these states without conscious thought. Feeling alive and creative requires a flow among these inner possibilities. Functionally, these states are totally intertwined, but clinically and experientially it is useful to pay attention to the differences.

We all have moments where we lose our adult perspective, become terrified when no danger is present or berate ourselves for not being more competent. But for the client with pre-personal wounding, the phrases *"falling apart"* or *"having a meltdown"* better conveys this dreadful experience. The flow among the three states is lost – in particular cognitive functioning is impaired and either the emotional or the sensorimotor modes predominate. It is a place of feeling completely alone and not having the skills necessary to reach out for support. When strain trauma is triggered, the person loses the capacity to witness and take a step back to ask: *"What just happened? I was feeling OK and then she said I made a mistake and suddenly, all I feel is miserable."* The self does not know time and place. "Now" collapses into "then". Instead, the client's emotional experience destroys adult functioning (van der Kolk and McFarlane, 1996). There is no self-reflective ability, no transitional space (Winnicott, 1971, Chapter 1, p 13), to return to for a reality check.

Both Bob and Mary free-fall into hell; there is no ground and no end in sight. Once they regress into that sensorimotor state, they can't get out. It is hard for someone who seldom or never enters this experience to grasp this overwhelming hell. When an infant is overwhelmed in every sensation, if his body is in spasm, his limbic circuits are registering overwhelming danger. If you have ever tried to soothe a baby who isn't able to stop crying no matter what you do, you know how distraught this baby is. The infant has two choices – hyperarousal and dissociation (Schore, 2002, p. 450). This bodily sensation is of un-speakable horror where the psyche is threatened with complete disintegration and collapse. If there were words they might be: *"I can't", "I can't stop feeling bad, I can't soothe, I can't cope."* The client's experience is that he falls into this altered state, like hunger comes over a tiny baby. For the infant, these physiological experiences have the impact of a 'thing' in the body, like a blow to the solar plexus. When the adult regresses to the traumatic state, feelings are facts, they are full body states, and they are always negative.

Bob wakes each and every morning in an altered state of hyperarousal, dread and depression. His entire psyche-soma operates as though it is 1960. His heart pounds, his breathing is shallow, and he can't lift his head off of his pillow. Bob is fused with the past trauma of waking up in his parent's house and wondering if his mother will humiliate him or his father that day. At the first moment of waking, he doesn't realize that he is an adult in his own house and that his autonomy will not be threatened and undermined. Through our work together, Bob has learned that the way out of this altered state is to get out of bed and move his body, to leave the 'then' and return to 'now'. Sometimes he just can't.

Bob finds it difficult to create the internal space to acknowledge: *"I feel disappointed because my wife doesn't want to go out to dinner with me tonight, she's too tired."* His frozen, traumatized self state is: *"She/Mommy hates me, she's always hated me and she will never take care of me or want to be with me again."* He doesn't 'feel' disappointed; rather he 'knows' he is unwanted.

Mary dissociates whenever she is startled. She can be startled by a sudden motion, a loud noise, any emotion she didn't expect, or by praise when she expected rebuke. If her husband slams his fist at his desk because his computer crashed, she falls into this altered state. Her immediate response is*: "I did something wrong and now there's going to be hell to pay."* She withdraws energetically, makes herself as invisible as possible, and constricts her breathing. She can remain in this dissociated state for the rest of the day. She is lost in her old story. She is terrorized both by the fear itself and because she can't find her way out (van der Kolk and McFarlane, 1996).

Worthlessness, Self-hate and Entitlement

When a client has healthy self-structure it is clear that as an infant he received consistent attunement from his primary caregivers. (Bowlby 1969; Stern, 1985, Fonagy, 2001) Through them, his inner world developed a sense of "going on being" (Winnicott, Chapter 4, 1965 p 60) and basic trust (Erickson, 1950, pp 247-250). His body was held with love; hurts were repaired with touch. He moves through life's difficulties by relying on these healthy body sensations and memory traces, through a resilient sense of self. He has internalized that things change and that he can make things change.

However, for the client with pre-personal wounding, his inner world is founded upon the experience of having been inconsistently attended. He both dreads the return of the traumatic state and fully expects it. When Bob and Mary fall out of adult functioning, they experience themselves as endangered, unlovable and without value. For them, inner stability or "on-goingness" is unattainable because it is always based on how someone else views them. Bob can sometimes defend against his dread with entitlement while Mary can be stuck in a fairly steady state of self-hate.

Each has an unconscious demand to have his limited self-image reflected back to him. Bob longs to be seen as only good and Mary expects to be seen as only bad. Bob is thrilled and filled by praise, even though it doesn't last long. Enthusiastic praise can send Mary into her traumatic state because she assumes she is being mocked. There is no room within her psyche for praise to be warranted, there is only room for self-hate.

While business is a place of great self-esteem for Bob it is also a place of potential worthlessness. When he thinks he might have made a mistake, he fears a humiliating reprisal. He monitors which phone calls to return in order to avoid people and situations where he may feel humiliated. If someone calls who might be angry with him, he doesn't return the phone call. The inner berating voice suggests to him*: "Oh my God, she's angry. What did I do wrong?"* He is so desperate to be seen as all good that he can't afford to take the chance of someone seeing his human failings. This behavior then creates an angry client who feels disrespected by never hearing back from him. He unconsciously sets himself up to recreate the dreaded state of someone being angry at him.

Bob often defends against his worthlessness with a sense of entitlement. He demands that others pay exquisite attention to his feeling state and to his personal needs. A *'No'* is devastating because he unconsciously believes it means he isn't good enough to get his needs met. If he takes the risk to expose his longing and says to his wife *"Do you want to go out to dinner tonight?"* he is entitled to receive only a *'Yes'*. If he receives a *'No'*, he lashes out or withdraws. Mary's stance is that she is entitled to nothing. She tries not to have any needs and not to make any demands on anyone. She fully expects the external world to reflect her badness. Mary never attacks or lashes out at another, but she is capable of harming herself.

Mary's inner voices berate her without mercy, even when all appears to be going well on the outside. Mary was promoted to the Head of the Department and there was a dinner arranged to honor her achievement. For her, this public recognition was profoundly upsetting. Somehow she made it through the evening and then cried all the way home. She spent the rest of the night recycling the voices of hate while she walked around her apartment hitting herself over and over again. All of the terrible things that her father ever said to her rushed in at once as though they were happening right then. All of this was in total silence for fear of awakening her husband. The energy behind her total withdrawal, self-attack, and private despair seemed equal to the level of praise she received during the dinner.

The Good and the Bad

Herman (1992, p123) has proposed that when the mental health system does not recognize the complex range of symptoms that follow childhood trauma, people often end up being called borderline in a rather pejorative fashion. Bob and Mary do share some characteristics with that diagnosis, the most obvious being their capacity to 'split' their inner and outer worlds when under stress of any kind. They lose perspective and the ability to remember a more whole picture of themselves and others. Although they both 'split', they do it quite differently. Bob is all -OK when he is seen by a valued other as OK. When things are going well with a new client who praises his product or his creativity, he and the client are in the glow of 'all-good'. In his fantasy life, he expects them to become friends. He no longer recognizes that this is a client situation and that he must take care of his business in appropriate ways. If that same client disagrees with him, criticizes his product in any way, he falls into his personal hell. Suddenly, that same client is no good, has lousy taste, is hypercritical, and he hopes to never sees him again! It is very hard for him to continue the "working-client-relationship" because he puts both himself and the client into the world of 'all bad' or 'not OK'.

In Mary's inner world, all adults are better than she is. Her 'split' is that others are 'good' or 'OK' and she is 'bad' or 'not -OK'. For Mary, splitting offers several possibilities. She can dissociate when she feels endangered. That is, she can place her emotions into an impregnable strong box where no one can touch her, and act 'as if' everything were OK. She can also *'not hear'* positive information coming towards her. She puts that information into a compartment of *'not to be believed'* for soon *'humiliation will follow'*.

How is it possible for clients like Bob and Mary to 'split' the world in these ways? The inner life of an infant is filled with undifferentiated physical sensations that form the foundation for future feelings and thoughts (Stern, 1985, pp 97-99; Beebe and Lachman, 2002 p 67). For the nurtured infant, these islands of sensation become linked through repeated experience and are 'recorded' at the neurological level (Lewis, 2000 pp130-140; Schore, 2002). As the abilities to feel and then think slowly mature, the child learns there is 'me' who has feelings (infant cries when hungry, toddler says "me hungry" or "me want"). For Bob and Mary, these undifferentiated sensations never became linked because there were not enough good and soothing experiences throughout their infancy (Fonagy, 2002, p100). As adults, they both lack resilience. They each have gaps in their self-structure. These unconnected aspects of their personality allow them to 'split' the world into "good" or "bad".

Bob splits his world between "good" and "bad" and Mary splits her world between "inner world of collapse and hate" and "outer world of competency". Their behavior reflects the gaps in their inner structure. Bob expands and is over-indulgent when in the presence of a praising other whom he values. When criticized, he completely contracts and withdraws (Johnson, 1987, p84ff). He bases his self-value on how he is perceived in the moment. Mary never displays her split to the outside world. She stays totally competent at work and in social situations while falling apart on the inside. There is no continuity between her inner experience and her outer affect. All of these strategies reflect the incomplete development of the self. A false self is created to keep the true self alive (Winnicott, 1965, Chapter 12 p142-143).

The Person Can't Initiate or Self-Soothe:

Neither Bob nor Mary has a soothing inner voice suggesting *"It's all right, everything is going to be O.K."* or *"You can take a risk, you can do that"*. Instead, safety lies in doing what is familiar, repeating the known, no matter how many times it has proved not helpful. New people and new situations are always potentially re-traumatizing. Like many traumatized people, the repetition compulsion is often stronger than the impulse for growth and consciousness (Herman, 1992, p 41).

Bob finds self-care difficult. One week he will exercise two hours a day; then he won't exercise at all for a month. One week he will get to work on time and the following week he can't get out of bed. He is unable to self-soothe when upset because he falls back into the pre-personal dependency of his infancy and demands that someone else take care of him. His capacity for self-agency (Stern, 1985 p 76-82) is mixed. He excels in the business world but he struggles in the world of emotional connectedness. He needs others to reach out to him and initiate personal contact.

While Bob was neglected, Mary was abused. Her mother took care of her basic physical needs, but did not defend her from her father's attacks. She internalized this cruelty and abuse and now turns the energy onto herself. Her inner abuser kills off her immense capacity for growth. It has taken Mary years of therapy to stop colluding with this destructive force and take the initiative to even accept a promotion or to look around for a more satisfying, better paying job.

Mary is able to take care of others but not herself. She does for them what was never done for her. She joins causes and volunteers. But she can't demand proper pay for her work, create a home that nourishes her, or deal with any conflict in her relationships. When she is upset, she is only able to withdraw, dissociate or beat herself up either verbally or literally. She is unable to take a warm bath, call a friend for support or nurture herself in other ways.

Components for Healing Personality Deficit

The pre-personal healing journey only can take place in relationship with another person. The initial trauma or wounding occurred at a time of life when a caregiver was essential for survival. Now the client must re-enter this two-person system and risk dependency and humiliation in order to heal (Klein, 1987; Herman, 1992). Much courage is required! Instead of falling into the altered states of dissociation or hyperarousal, the client must develop a witness self.

I create a safe emotional atmosphere by using mirroring, empathy and attunement. I become an energetic "container" who pays attention to the feelings being expressed, listens for emerging themes, and holds the space of open ended possibility. I wait for cues from my client and let go of any pre-determined agendas. I stay open to every possibility because I don't know exactly what needs to happen or what will happen. I do know from experience that once we co-create the safety of transitional space (Winnicott, 1971 Chapter 1 p 13), the client shares more of his inner truth and wholeness. I also know that this is vital to create a stronger sense of self and greater consciousness.

At the beginning of our work, my one and only intention is to establish safety and trust (Herman, 1992, p133). I want the client to discover his own sense of agency and empowerment from within his body self but the trust must come first. After all, why should the client trust me if he's had early experiences where the other person didn't attune to his needs? My trustworthiness needs to be proven. I can harm a new client by giving good advice. To say to Bob at the onset of our work*: "Don't you see your wife said 'no' to dinner because she was just tired?"* makes him *"bad"* and her *"good"*.

I understand my clients' inner reality by reading body language, listening to metaphor and finding ways to put words onto emotional experience. I listen deeply and use words only to clarify my understanding of their experience, not to inject myself into the situation. Over time my face, eyes, tone of voice, body language and words validate their emotional reality allowing them to experience me as an ally, not an invader.

I have learned that most of us can only process a few comments at a time. We learn the most by hearing ourselves speak. This is particularly true for someone whose early years were much disrupted. Our work together may be his first experience of enough time and space to express what he feels, thinks and wants. Insight is only useful if it comes from within and is not given. Because of this, I ask a lot of questions.

My Inner Dialogue

I rely on my internal felt sense and intellect to determine whether or not to ask a question. Before I say any question out loud, I check with myself:

- *"If I ask this question, is it likely he will have an answer?"*
- *"Will this question upset him and disrupt his on-goingness?"*
- *"If I ask this, will it cause shame?"*
- *"Can he use this question to deepen his understanding or emotional connection to himself?"*

If I'm not sure, I know it is not the right question to ask at the time. I focus on what will strengthen safety and trust between us. Later, I might find the right time to ask this question.

By slowing down enough to listen to my own inner cues, I am more available to perceive the subtle cues of these extremely sensitive and intuitive people. When Mary first began working with me she often turned her head to the left, looked down at the rug and clearly left the room. At first I would say:

Alexis: "*Where did you go?"*
Mary: *"I don't know."*
Alexis: *"What do you see or hear?"*
Mary: *"I don't know."*

After a few sessions like this, I realized we were in a rut. I wanted to talk about what was happening at the sensate level but Mary had no idea. She had no answer to my question so it was not helpful to continue asking. I needed to change my type of question in order to meet her. I began to ask questions that identified her absence:

Alexis: *"Are you ready to come back and resume our conversation?"*
Mary: With a shudder and a glance at me, *"Yes."*

This last question acknowledged that she was "gone" but did not insist that she be specific about where she went. I finally found a way to talk to her without shaming her by exposing her not knowing. The new question

supported her to reconnect with me and later, with herself. Much later in our work we have been able to explore where she "goes".

Repairing Mistakes

I can't prevent all mistakes; I can only repair them. Mistakes are inevitable because I cannot read his or her mind to always know what is needed in the moment. In the mending process, two useful things happen. First, the client builds self -structure. Second, we build deeper trust between us.

I made a mistake with Bob when he talked about his wife's *"No"* to sex. I asked him: *"Did you hate her right then?"* This question was much too much for him to acknowledge. I could see him physically recoil and wince as though I had hit him. I said: *"I'm sorry, that word was too big."* Bob's gaze relaxed and reflected his relief. If Bob were to acknowledge his capacity for anger and hate, he would fall down the helpless, worthless, despicable side of his deficit. His inner voice would say: *"She's such a good person, how could I hate her?"* My apology was needed to restore the bond, to let him know that I had made a mistake and that he was appropriately self-protective from such a question. Only later could he experience and express anger and hate.

Mary is much harder to read. For example, she appears very compliant to any changes in our routine. At the beginning of our work, when I would tell her of an upcoming vacation, her only response was, *"Have a good time."* Her adult remarks were genuine, but there was more going on. Over time, I realized how quick she is to comply in order to avoid anticipated rejection. Eventually, I decided to inquire more deeply.

Alexis*: "Mary, even though you say 'Have a good time' I sense it's hard for you that I'm going away and we need to talk about that."*

She softened, became smaller and looked away.

Mary: *"I know you need to get away from me."*

Alexis: *"Why would I need to get away from you?"*

Mary*: "Because I poison anyone who gets close to me."*

I was shocked!

Alexis: "*I'm so sorry that I underestimated how hard it is for you when I leave. I didn't appreciate that a part of you thinks I need to get away from you. Do you have any idea where this idea came from? Do I do things that suggest I want to get away from you?"*

Mary and I have spent a lot of time on the notion that I want to get away from her and that she is poisonous. Slowly she has come to experience, and then believe, that my vacations have nothing to do with her inherent 'badness'. This is not to make the claim that this sense of being poisonous has been fully integrated and transformed in Mary. It is a self-state that stays with her and our work continues to lessen its impact.

It is the lived experience of small inevitable mistakes and small repairs that are most helpful to re-wire unhealthy patterns and to build healthy self-structure. If I were a perfect mirror then I would be idealized, we would be fused, and there could be no individuation. Using these mistakes is critical to my way of doing therapy.

Clarifying Questions

One of my goals in therapy is to create dialogue and genuine exchange between us. Since these clients avoid their inner life, because it is unbearable or they are too ashamed to reveal what they do know, I ask a lot of questions to initiate a conversation. My questions come from a lot of listening. I ask clarifying questions to increase body awareness and to generate meaning. At the beginning of therapy, my questions are informed by reading my client's body and hearing his personal story, early childhood development and object relations.

The onset of our work is an important time to ask body-centered questions. Typically, a client with pre-personal wounding is disconnected from his bodily sensations and feelings. These questions bring awareness to the frozen places*. "Something just happened. What are the sensations in your body?" "Did you notice that your jaw just tightened?" "So just close your eyes and take a deep breath. What are the sensations you are experiencing right now?"* Body awareness is the first and essential step to form self-structure. This form of awareness for me precedes any efforts to get more flow in the body itself. For clients with strain trauma, flow means feelings and feelings mean overwhelm and danger. This can precipitate the very symptoms and discomfort we are trying to investigate and heal.

I use clarifying questions with Bob when he is unable to put words onto his own experience. When Bob falls apart to his wife's *"No"* I have come to understand that for Bob, this *"No"* means he is unworthy of her and he is worthless. I mirror his altered state, validate it and put words on it*. "The look on your face tells me that you must have felt awful when she said 'No'."* When Bob is able to resonate with this comment, I ask more detailed questions.

Alexis: "*What is awful like?" (trauma physiology)*

Bob: *"It's this knot in my stomach and this constriction in my breathing."(body sensation)*

Alexis: *"When you breathe into the knot in your stomach, do any images or colors come up?"(more sensations)*
Bob: *"The first thing that comes to mind is the brutal fights my parents used to get into late at night." (association connecting to feelings and meaning)*
Alexis*: "Does this sensation come up any other time?"*
Bob: *"It can come up when I'm afraid I've made a mistake at work." (Linking feelings to various experiences)*

I ask these questions to slow Bob down so he can sink into the sensate experience of "awful". Over time, Bob has learned that some of his sensations and feelings are bearable because he has lived through and survived experiences of "awful" during our sessions. Each time Bob lives through his sensate experience rather than fleeing from it, he creates self structure.

When Mary clearly 'leaves' the room I can now ask her sensate questions.

Alexis: *"Are you seeing or hearing something not in the room right now?"*
Mary: after a long silence *"Yes, crashing and banging."(trauma physiology)*
Alexis: *"Is it happening to you or around you?"(sensations)*
Mary: *"Around me."*
Alexis: *"What can we do to make you feel safe in this situation?"*
Mary: *"It helps to talk about it. Talking makes me realize that what is going on in my body is noise and anger going on around me and inside me."(feelings)*
Alexis: *"What do you need to feel safe in this emotional, angry situation?"*
Mary: *"By talking about it, I can feel more separate from it."(words moving the pre-personal to the personal))*

In this example Mary moves from overwhelming sensations of crashing and banging to emotional language about the feeling of anger. As my client becomes adept at answering body-oriented questions, I then focus more attention on what her world means to her. I want to help her make the links between her inner experience and being in relationship. I ask a range of questions:

- *"Does that sigh have something to do with your inner world or with something I just said?"*
- *"I don't quite understand what you mean when you say you can't deal with her, could you help me?"*
- *"What made you feel sad…confused…angry? Did something happen between us that upset you?"*
- *"I don't understand why that exchange made you feel so bad. Does it remind you of something from your past?"*

These questions help to unpack her emotional response and give it meaning.

Leading Questions

As the work deepens, I ask a leading question when I have a sense of where we ought to go next or what feeling is right below the surface**.** A leading question narrows the field of exploration rather than expands it. It is focused, specific and contains some agenda on my part. By asking a leading question I become a separate person, whereas with a clarifying question I am more of a function. As a function I have the job of mirroring my client's feelings as exactly as I can while as a separate person I can have a different perspective on the situation.

My client's ability and readiness to answer leading questions signifies a shift in our relationship. Our interactions are more dynamic, relational and co-creative. The client trusts me more, which enables me to have a different point of view without being perceived as dangerous. He knows I'm his ally and we are a working team. I only ask a leading question when I feel confident that he is close to internalizing a more complex sense of himself.

Both of the clients in this article are wary of eye contact and the connection it offers. Therefore, when they make more eye contact in a session I assume they feel stronger and more separate. At these times I ask leading questions to support them to take the next step in their healing. I focus on a specific feeling or perspective rather than leave things totally open-ended.

The timing of asking a leading question is crucial in order to avoid compliance. I want the client's authentic response or spontaneous gesture (Winnicott, Chapter 12, 1965, p 145). If I sense compliance I ask about that and let go of my previous agenda.

Now I can coach Bob with leading questions. This would have been impossible a few years ago because Bob experienced me, like all others, as potentially dangerous. Now, he usually trusts that my agenda is to support him to take the next step of self-inquiry. Leading questions include my hypothesis of what is helpful. For example:

- *"We both know you're very jealous of your wife's attention toward your children. Could this really be the hidden anger you still hold at your mother's neglect?"*
- *When your breathing changed, what or who were you thinking of? Maybe you were you thinking of your boss, or authorities in general?"*

- *"Maybe your intense anger has other roots. The current situation just doesn't seem as important as your feelings suggest. Could your feelings be connecting this incident to the story about your Mom?"*

I ask questions like these when I think I am close to being right, when I think the client is close to seeing it, and when I think he will follow me with just a little push. If I ask a leading question and he resists, I back off and return to more open-ended clarifying questions. For the person who collapses into a black hole (van der Kolk, 1996) I may ask*: "Is it possible that you were not only feeling withdrawn, but also sad, or even angry?"* or with the person who falls into sadness all the time*: "Could it be possible that you were also feeling anger?"* I want him to tolerate the complexity of his inner life, to hold the tension of the opposites and I hope my questions will focus him in that direction.

Mary has always been open to leading questions. I always make sure she is connected to her authentic self and not just agreeing with me. She is too quick to own the negative part of her self and too slow to consider her talents and strengths. It has been important to underline Mary's positive qualities with my leading questions rather than to support her negative self-image.

Mary: "*I don't know how I'm ever going to earn enough money."*
Alexis: "*I wonder if you should get business cards printed. It sounds like you are getting ready to go out on your own."*
Mary: *"What would I put on them. I don't know anything!"*
Alexis:"*How about starting with your three degrees and then some words like 'experienced in emergency response'."*
Mary: "*Well, I suppose that's true at least."*
Alexis: *"Can you feel how your body just relaxed?"*
Mary smiles at this question.

Another type of leading question encourages the client to take another person's point of view. I 'push' Bob to see the world from a more mature place, but I can only do this if I feel he is ready to give it a try. The deficit spaces of Bob's psyche need his point of view honored first. The ability to receive these types of questions indicates tremendous growth in problem areas.

Alexis*: "Is it possible that your wife didn't want to go to dinner on Tuesday because she was feeling tired from working overtime last week?"*
Bob: (in a very angry tone of voice) *"So I suppose you would say that it would be wrong to tell her that I'm not going to do something with her the next time she asks me because she refused to go to dinner with me."*
Alexis: *"I don't know if it would be wrong, I just don't think you'll get what you want. How do you think she is going to feel with your refusal?"*
Bob: *"I guess she's going to feel mad at me."*
Alexis: *"Where do you think the cycle of punishment is going to end?"*
Bob: *"But I don't know what else to do with how hurt and angry I am at her. I'm frightened, too. She just doesn't get it."*
Alexis: *"Can you imagine telling her what you feel rather than withdrawing and later punishing?"*
Bob: *"I see the sense in your suggestion and it might be a better way to handle it. But I can't do it. When she rejects me I just feel terrible. But maybe I can think about it."*

As we explore the details of Bob's potential response to his wife, he is able to reflect in a new way. Through the repetition of this kind of dialogue, Bob slowly has begun to internalize a witness self. This creates more space between a trigger and his response, develops more flexibility around "the truth", and includes the other's legitimate voice.

Relational Questions

Relational questions address what is happening in the "here and now" between us. They address the pragmatics of our relationships and explore transferential issues between us. They are very potent, when used at the appropriate time, because they elicit present-time emotion from the client. The discussion is not about something out there; it's about what's here. It is immediate and we both sense it. The intention behind asking relational questions is for the client to connect with his strength to be in the here and now and know what he feels and what he wants. These questions also enhance his aliveness and his ability to be in his body. It is a practice space. It is potential space (Winnicott, 1971, Chapter 3, p 47-48). When used well, it deepens his sense of being cared for, even cared for enough to be confronted.

Relational questions necessitate delicacy because this kind of client is terrified to be in the present and talk about his feelings. Any real relationship represents a danger to his fragile self-esteem system. He fears exposure

and fears dependency on the therapist. From the clients' perspective, these questions have the potential to harm because of the intimacy and vulnerability involved.

I begin to ask relational questions when there are enough positive links between us and enough healing has taken place on the pre-personal level. The foundation of trust and compassion needs to be well established and is essential before attempting to ask these types of questions. As the pre-personal needs mature through time spent asking clarifying and leading questions, I am able to enter the relationship more often as a person rather than a function. The use of relational questions implicitly acknowledges the transition to an I-Thou relationship (Buber, 1923,1970).

Before asking relational questions, I assess that my client has integrated the following:

- There has been major healing of early developmental misses.
- The client has the ability to embody "going on-being" during a challenging period.
- The client has strengthened his sense of self and self-agency.
- Healthy, co-created attachment has taken place between us.
- He has enough of an adult present to sometimes self-soothe.

Lately, Bob and Mary have been able to utilize relational questions. Each has learned that the feelings he or she has during our sessions are welcome by me even if unpleasant. This epitomizes a major accomplishment. Whether these feelings originated from childhood experiences or belong exclusively to our relationship, Bob and Mary have more capacity to sit with them.

Alexis: *" I am taking off the last two weeks of August."*
Mary: (in a playful tone of voice) *"You're just doing that to get away from me!"*

Mary is 'playing' with how things used to be. Now she has enough witness self to hold several realities. Sometimes she is poisonous; sometimes she is not; sometimes both are true. We discuss our relationship in all of its complexity, including her hidden desire to be dependent on me as well as her belief that she could kill me. In this example, Mary's feelings come more from transference and less from our relationship.

In spite of all his changes, Bob still hates to deal with our relationship directly because of his terror of being attached to a woman and then dropped. He acknowledges his dependence on me in indirect ways, mostly through his eyes, but can't use words because it would be too humiliating. The areas he is able to work with me on are the issues of money, payment and time – all very potent for him!

Bob discusses our relational dynamics when it comes to his payment for our time together. We have clashed in two different arenas. He often needs to reschedule due to business travel and he hates to pay his bill on time. Sometimes he forgets to cancel our appointment and still expects a makeup. If I 'get my back up' and address his entitlement with an annoyed tone of voice, rather than being straight with him, he becomes confused and then combative. He is very sensitive to my annoyance and doesn't like it one bit particularly when I don't confront him directly!

We have had many discussions around money: how important it is, what it means, and how he hates to pay his bills and deplete himself of his hard-earned wealth. It has been hard for Bob to develop the ability to see our relationship beyond a business service (i.e. a function). He struggles to accept me as a real person with real needs to be paid and to be paid on time.

Alexis: "*I have a bill for you. It's the end of the month."*
Bob: "*Oh no, not already! I just paid you. Could you wait a few weeks because I am expecting a payment soon?"*
Alexis: "*I wonder if paying my bill will really make any difference in your lifestyle this month. Does it have more to do with not wanting to write the check and see the money leave the account?"*
Bob: *"Probably. I really have plenty of money in the account, but I would much rather wait until this next check comes in and builds it up before I have to take anything out of it."*
Alexis: "*I think it would be better to pay me and see how it feels to subtract the numbers and notice that you survive, nothing bad happens, no one humiliates you…."*
Bob: (reluctantly) *"I suppose so."*

Bob complies with my request grudgingly. This is not the unconscious compliance I worry about. This is required adult behavior between two equals!

By the time I am focusing on relational questions, my client has traversed many pre-personal gaps and made crucial links in his understanding and strides in his healing. A new level of intimacy is created through asking this type of question. It is during this stage that many pieces come together and much of our previous work integrates. The client and I work through our dynamics within the co-created transitional space. This space supports the

client to strengthen his sense of self and offers an opportunity that did not exist in his family of origin. Clients like Bob and Mary are able to take risks because of the trust that exists between us and the chances of a healthy outcome are greatly enhanced. As we navigate our relationship, Bob and Mary have become increasingly skilled to do this type of exploration in their other close relationships.

Conclusion

> To the degree that I've understood the teachings, the answer to these questions seems to have to do with bringing everything that we encounter to the path….This path has one very distinct characteristic: it is not prefabricated. It doesn't already exist. Pema Chodron

The above quote captures the essence of my work – to bring everything to the path. For me 'everything' starts with the body, its sensations, its feelings, and its defenses. Words are critical, but they must be grounded in felt experience. I encourage a client to pay a lot of attention to his own body and what it is communicating. And we both must surrender to the fact that the path is unknown. This form of therapy is a mystery and is created moment by moment by the two participants. It is hard for a client to bring everything to the path when so much of life is out of awareness and has never been felt, let alone reflected upon. It isn't easy, but with time, it works!

I have found my map to be helpful and rewarding to my clients as well as to myself. I hold the client's wholeness and his deficits as well as my own. I hold hope for a client to come back to himself, even when he falls apart over and over again. At the beginning of our journey, I am more of a function than a true companion. I must mirror, listen and ask those questions that ground him in his body and clarify his reality for him. As trust grows, I ask more direct, leading questions without impinging on his space and his way of being in the world. We navigate challenges together and the relationship survives.

When our work has matured, our dynamic shifts to a true two-person system. I confront an issue, am supportive, use humor and all of my aliveness to help generate the intimacy he both longs for and dreads. Our connection evolves toward an I-Thou relationship. We become two true subjects brought together to facilitate the journey of the client and know that both of us will be changed by the encounter.

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Biography

Alexis Johnson, Ph.D., trained traditionally at Michigan State University, then in humanistic and transpersonal philosophies and methods at Esalen Institute, Big Sur, CA. She has studied and taught Core Energetics, family systems, self psychology and object-relations. She is a co-founder of the Center for Intentional Living and teaches Integrative Psychology in New York, California and Europe. Alexis enjoys many roles: student, teacher, therapist, spiritual seeker; wife, mother, step-mother, friend and gardener and is always looking for ways to balance them all.

Interactional Shaping within Therapeutic Encounters: Three Dimensional Dialogues

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Abstract

This paper suggests that within therapeutic encounters, and explicitly within body therapies, there is relational shaping between the body of the client and body of the therapist, and between the body of therapist and body of the supervisor. This mutual shaping is both active and passive and takes place both consciously and unconsciously in the spaces in between individuals and between individuals and contexts. This improvised relational 'dance' consists of interactions in which the players influence each other, and each other's stories, over time. The present paper introduces and defines the concept Interactional Shaping, as a frame for conflating dance therapy, movement observation and social constructionist discourses. It presents supportive qualitative data from a dance therapy supervise on research project. It also locates the concept of Interactional Shaping within other related theoretical perspectives and gives a rationale for offering another viewpoint for observing relationships. Whilst the context for this paper is set within dance therapy, the focus upon mutual influence within relationships is relevant for any professional working within therapeutic, caring or education sectors.

Keywords

Interactional Shaping within therapeutic encounters – Mutual influence – Non-verbal interaction – Shaping - Supervision

Dance Movement Therapy

Dance Movement Therapy (DMT) is defined by the professional association in Britain as ' the psychotherapeutic use of movement and dance through which a person can engage creatively in a process to further their emotional, cognitive, physical, and social integration.' (ADMT UK, n.d.). DMT is based upon a core belief in the interrelationship of body and mind. Body processes and both verbal and non-verbal communication are central to the work (Meekums, 2002). However, within the field there is not one agreed definition of self, or of what constitutes a therapeutic relationship. When dance therapists write about their work, there is usually a division between descriptions of the movement behavior and ways of understanding the therapeutic relationship (Levy, 1995). Arts therapists tend to borrow language, and constructs, from established schools of psychology and psychotherapy, e.g. psychoanalytic, humanist, object relations, systemic, to understand what happens between people (Best, 2000). Each of these approaches brings with them a set of values and beliefs which are integrated into, and influence, the therapist's practice. Within this paper the reader will notice an allegiance to systemic and social constructionist ideas within descriptions of relational material. The construct being presented, Interactional Shaping (I.S.), is one attempt to synthesize observed movement phenomena and psychosocial theory.

Interactional Shaping

The majority of this paper will be presented from a first person position to be coherent with the experiential nature of the concept being presented, as well as, with the qualitative research data. My colleague and I have, both as educators and supervisors within a postgraduate Dance Movement Therapy training in the UK, wished to offer our students an adaptable framework for creatively understanding relational phenomena. Within the training we are intensely curious about how people 'do' communication. Social constructionist and systemic ideas inform our practice as they locate communication within wider interactive systems. We privilege constructionist and artistic discourses which encourage trainees to be curious about meaning making within verbal and nonverbal social dialogues (Anderson & Goolishian, 1990; Pearce & Cronen, 1980; Pearce, 1984). Within dance movement therapy literature relational events are often described either in object relations terms (Meekums, 2002) or using transferential language informed by a psychodynamic approach (Dosamantes, 1992). Within our training programs we needed ways of locating systemic and constructionist ideas, of mutual and contextual influences within movement language for use within dance therapy. We, therefore, devised the term Interactional Shaping (I.S.).

Foundations for the term, I.S., exist within many fields researching communication and relationship. Related terms used within non-verbal communication research, developmental psychology, movement observation analysis and social constructionist therapy will be indicated in this paper. Other fields offer conceptual, and in some cases empirical, support for the centrality of relationship in creating experience i.e. neuroscience, social psychology, body psychotherapy, psychoanalysis, feminist, narrative and systemic therapy.

Through microanalysis of conversations Condon (Condon 1980.56) coined the term 'interactional synchrony' to describe the complex, complimentary movement process between listener and speaker. Quite separately within developmental psychology, Winnicott (1965), when describing the relationship between mother and infant, wrote of 'mutuality, 'mutual influences', and rhythmic 'interactional synchrony' as being essential for healthy

communication. Another developmental interactionist, Stern, spoke of 'intersubjective relatedness' and the importance of the mother's use of 'shape' when attuning with her infant (Stern, 1985.27 & 146).

At a similar time within the world of dance and movement analysis, choreographer Rudolph Laban devised a systematic movement observation system, Labanalysis (Laban & Lawrence 1967; Laban, 1992). The system was divided into 3 areas: the use of the body (actions), where the body moves in space (shape) and how the body moves (qualities or rhythmic efforts). The system, originally designed for use within industry, choreography, and dance education, is now used within dance therapy for diagnosis and description. The method of observation has become known as Effort/Shape and is based upon the premise that even within functional actions motion and emotion are linked (North, 1972; Davis 1995). The system locates all movement qualities, or Efforts, along 4 continua - Flow (binding to freeing), Space (unifocus to multifocus), Weight (increasing to decreasing pressure), and Time (increasing to decreasing speed). For the purposes of this paper it is the other aspect, Shape, which is most relevant, as it pertains to relationships in environmental space, between body parts, objects and people (Bartenieff & Lewis 1980). Pupils of Laban, Warren Lamb and Irmgard Bartenieff, went on to support psychoanalyst Judith Kestenberg to further develop Laban's ideas for use within therapeutic settings In particular the concept of 'Shape Flow' was developed to describe individuals' relational experiences, or their physical responses to environmental influences (Kestenberg & Sossin 1979).

Connections between the environment, relational experience and physical adaptation are also found within other fields. Researches within neuroscience write of "neuronal plasticity" in which neurons are dependent upon, and adaptable to, experience (MRC, 1999), while social psychologists study the phenomenon 'emotional contagion' or mood exchanges between people (Wild et al, 2001). Neuropsychoanalyst Schore investigates 'synchronized energy exchanges' between mother and infant within the development of attachment behaviors (Schore, 1994), while research into memory and neurodynamics suggests a possible neural basis for adult behaviors within psychotherapeutic transferential phenomena (Grigsby & Stevens, 2001). Similarly within body psychotherapy praxis there is acknowledgement of the interconnected nature of bodily, psychological and environmental processes both in past and present interactions between people (Carroll, in press). Some somatic psychologists acknowledge the effect of wider cultures as shapers of experience. Practitioner Johnson uses the term 'social somatics' to describe 'the constant shaping of bodily experience by institutions of our various cultures' (Johnson, 1998.9).

Many fields studying human behavior note a paradigmatic shift towards an increased awareness of complex interactive systems in which there is mutual relational influence and co-creation (Gergen, 2003). The concept of Interactional Shaping is coherent with this shift towards understanding how people are shaped by, and in turn shape, their experiences. This is especially evident within the field of psychotherapy. Postmodern psychoanalysis is now seeing some analysts disclosing personal material, positioning themselves differently, and focusing more upon interactive relational processes (Goldberg, 2001; Jacobs, 2001). Feminist therapy continues to locate the therapeutic relationship within an interactive frame of connectivity, mutuality, and related awareness, especially within the relational-cultural model (Jordan, 1996; Stiver et al, 2001). Social constructionist and narrative therapies focus upon the interfaces between individual and social 'stories', or narratives, and how these shape, and are shaped by, joint actions (Epston & White, 1992). Social constructionist Pearce suggests there is 'a reciprocal, causal relationship between forms of communication and ways of being human' (Pearce, 2001.11). Within systems thinking and systemic therapy attention is paid to 'feedback loops' (O'Connor & McDermott, 1997), mutual influences, and the observer's effect on the observed system (von Foerster, 1981).

While all of the theorists above acknowledge the effect of environmental influences, not all focus upon the idea of interaction as being a two-way, or even multi-way, dynamic process which shapes all parties moment to moment. My intention in using the proposed term, Interactional Shaping has been to draw students and supervisees' attention to a more active sense of shaping their environment, as well as their being shaped by it. I am curious about how this shaping occurs between bodies and how it is affected by the context, the qualities of the movements, and the beliefs and expectations of participants. Through drawing attention to I.S. within supervision I encourage supervisees to become curious about all the other possible conversations which might have been made had they acted differently (Pearce, 1994). Every encounter contains a rich mixture of influences from past, present, and imagined social exchanges.

Methodology

The research material which informs this paper arises from a supervision pilot project I ran in 1998-9 with qualified dance therapists. Qualitative methods were used consisting of extensive field notes, post session questionnaires filled in by participants and supervisor, and an open-ended group interview. The present paper is based upon one aspect of the data – fieldwork notes that I wrote, as supervisor, during and after each session. The results from the full data are to be presented within another paper (Best, 2003). For the purpose of illuminating the concept of Interactional Shaping, I have selected extracts from one session (8th out of 10) for examination.

The project was the beginning of my research developing a model of supervision in which the therapist's creative processes are central and act as a means towards understanding what gets created when relating to client material. I call this RCPM, or Relational Creative Processes model of supervision. Within the RCPM model

participants shift, not only between their personal and professional material, and between therapist and client positions, but also between modes of reflection and expression e.g. moving, sensing, drawing, writing, listening, playing with props, and talking. The RCPM is informed by other supervisory models which use creative activities to reposition the therapist in relation to the clinical material (Lahad, 2000; Lett, 1993). Moving between expressive modes facilitates distance and opportunities to re-engage with the material from a new perspective (Best, 1999). There are other relevant models of supervision, which, whilst not employing creative arts, do make use of positional shifts to create fresh perspectives. Within systemic therapy the use of the 'reflexive team' listening and feeding back, facilitates distance from the clinical relationship, while within narrative therapy the idea of 'collaborative supervision' repositions the therapeutic narratives amongst the supervision group, sometimes also including the client's responses (Andersen, 1991; Crocket, 2002). A metasystems perspective is offered by Gilbert & Evans (2000) within their 'integrative relational model' of psychotherapy supervision which is inclusive of person position shifts and 'multi perspectival views' (p.11).

In the spirit of Interactional Shaping, I ask the reader to take note of my language in the transcription below, and consider how it may have influenced the session. Note also the structure of the sessions, which begin with improvised movement arising out of a warm up section, which I led, based upon my observations and intuitive responses. In this I shape and am shaped. In my role as group supervisor I rarely arrive with a planned task; I allow the events in the room to influence the unfolding of the session. My one repeated strategy is to ask participants what connections there might be between what happens in the room and the supervisees' clinical work. I ask the reader also to consider possible subtexts within supervision, such as expectations, judgments, support, desires which influence both my actions and those of the supervisees. Also note the possible effects of the hypnotic or 'indirect suggestion' of my language and/or interventions and how this might shape events (Furman, 1992.9). I overtly take responsibility for my part in the creation of meanings within the sessions.

Case Material

The transcript below comes from my contemporaneous fieldwork notes, which included some descriptive comments and thoughts written immediately afterwards. I have put direct quotes in italics, and any additional comments for this paper in parentheses. I have condensed the transcript of the introductory warm- up section below, while keeping the overall structure, so the reader can get a sense of the language I was using.

The group was in the room when I arrived carrying all sorts of props and paper and tapes etc. The participants were all sitting on the theatre seats rather than within the movement space and I suggested they walk around the room as a transition into movement. From this came the theme- Walk and Pause. I then said 'The pause can be filled with stillness or attentiveness. You can leave the pause suddenly rushing, or loosely lingering. ... Check how the body feels. What kind of movement does it need to warm up- big / little / heavy /light? Breathing, as you go.' I put on oboe music which to me felt light and spacious allowing for range of movement options. The task then became stop /go, pause/move. The warm up continued as I observed their bodies moving, and then chose ways to support their transition into the space, into a sense of their body weight, physicality, and personal rhythm. I added a suggestion of three dimensionality to encourage a sense of both themselves and others. 'Sometimes putting yourself in places /positions and not knowing how you got there. Pausing and disentangling.' As a cue to ending the warm up section I said 'Begin to settle in to where you are at the moment and move towards a pause '.

The next task was 'Let the mind conjure up stories, pictures, words, associations from your movement. Then out of these associations create a sculpture. It can be a moving one or a still one...' Individuals slowly went into shapes.' Imagine where this sculpture is? Inside a building? On a landscape? Perched on the edge of something? Build a picture of what is round you. How much detail can you see? Is it important to this sculpture or could it be anywhere? (I am trying to deepen the felt experience by establishing a sensed context). 'When ready, let go of the sculpture and share something of your experience with another one or two people.' Then I said shortly afterwards 'go back to the sculpture and see if it can move. If it were able to move, how would it do so? ... 'What does it know about you? Especially, what does it know about you as healer, therapist, clinician? What message does it have for you'

I wanted then to add another shift of modality. They had moved physically, gone into imaginative associations and an internal focus, then out to verbal dialogue with others. There had then been a shift back to the kinesthetic, combining sensation and imagination ('how might the sculpture move') and cognition ('what does it know about you?') The next task shifted to another mode that of drawing, of externalizing from the felt sense, towards a concretizing form. 'When ready get some paper, and write a sentence, a word, an image about the sculpture and something you found out or maybe didn't find.. Once again I felt the need to move on, not yet knowing quite where we were heading, yet sensing that further integration was now needed with clinical work. I gave a temporal cue, 'One more minute and let yourself finish. We can come back to the picture later.' (Notice the language of permission which I used and then the shift of person from 'you' to 'we'. These language structures may serve to shift subtly the relationship between myself and them and between themselves and the image /word they are working on.)

It now felt it was time to bring in explicitly the participants' clinical work. I said 'Nominate,' (at the time I noticed this was a strange word which had come to me, so I reflected upon this out loud and that I was going to stay with this word because it had come to me). I then continued, 'Nominate a client or a group, someone who stays with you, or jumps out at you. Make a mark on the paper to represent this person or thing that you have chosen.' We then went back into movement. Now move this person or an aspect of the group. Put them into your body. Get something of it in your body'.

The next task arose as I watched them move. I wondered what might happen if while 'being' inside the body of the remembered client, the participants could reflectively switch to reversed second person position i.e. an empathic sense of the other. I was in effect asking them to jump twice, once to second person position of understanding and then to look back at themselves. I said 'While in the body of this person, imagine what this person makes of you. Imagine/sense what this person thinks of you? What do they feel about you? After a moment to allow them to feel and move this I went one step further focusing the quest. 'What does this client think is your main concern as a therapist? What do you keep saying or doing as therapist? What do they notice about you? What would they say is your favorite movement? What do they see as your main intervention and does it help?'

As participants became still, I said. 'Go into 2 small groups and talk about your therapist (yourself) while in role as the client. The others in the group are also other clients with other therapists listening to you talk about your therapist. Help each other by asking questions. I had not used this specific embodiment and role reversal task before, though I have used, as have others, role-play in supervision and training (Lahad, 2000). As in most of my work I respond to what I observe, through a bodily felt response, intuition and tacit knowledge (Nikolitsa, 2002). My writing is one way in which I externalize and assess my processes as being valid. I became very excited by the task, as I observed the eagerness with which the participants entered the role-play.

This appeared to be a very powerful task, as participants had moved through several stages to reach a potential new level of understanding, of embodiment. I noticed the participants were particularly engrossed in the task, with very focused eye contact, high intensity in their muscles, and total attention being given to each speaker. My sense of the powerfulness of the task became confirmed later, when the participants reported on their experiences. I visited the two groups while participants remained in role talking to one another, as if in a self-help group for people trying to understand their therapists. They were speaking 'as if' the client, being curious about why their therapists (actually themselves) behaved as they did. As I watched I was in awe of the way they were inside their clients. It appeared they had really noticed things about themselves. It was hard work and rewarding. Below are two small cameos from these self-help groups.

One supervisee, whom I shall call Jane, who is wanting to do more work with refugee children, and who already works with refugees was speaking 'as if' a refugee child saying to the others in a bemused, and somewhat confused, manner, "She (Jane) keeps wanting me to make a house. I don't know how to make a house! My house burned. I can't make another one. She gave me string and I wrapped it around me. But I couldn't make a house. She says we will dance. I don't know how to dance, but I can jump. Jump up and down, up and down." Another group member asked, "Does she move, too?" "Yes, she spins, round and round, round and round". Another person asked, " why does she do that?" The child answers, "She is making wind, and wind will blow out the fire". I will come again to jump up and down, and to try to make a house." Jane was almost in tears and had to stop her role-play, as it was such a powerful experience. In the sessions this child had not spoken. Jane now saw what a distance there was between what she did as therapist and how hard the child had worked to make sense of the therapist's actions. Jane felt enormous respect for the child's ability to continue working on the relationship. Jane became very excited about forging ahead with her work and stated at the end of the sessions that she now had so many new ideas.

A second supervisee, whom I shall call Sue, was in the other small self help group and was 'being' a severely learning disabled adolescent without speech, whom I shall call Sam, with whom Sue works in a group. Sue asked me what to do, as the young person did not talk and I suggested that tonight he could speak as she would speak for him. Sam spoke very enthusiastically of his therapist, "Sue does dangerous things. I put the elastic over her head and she goes dangerous. She rushes off and around the room and far, far away from me. I put the elastic over and she goes. She's dangerous". Asked by other members "'Does she let anyone else put the elastic around her?" "NO!" is the emphatic reply. "Does she enjoy the dangerous movement?" "Yes, she loves it, Sue loves dancing. I can be anywhere, in the dining room, in the classroom, in the corridor and if I see her all I have to signal is 'Sam - dance' and she smiles and looks and me and says really happily 'yes, Sam - dance'. It can be anywhere and she gets excited when I say that."

This was told with tremendous enthusiasm and Sue then had to physically shake herself out for a while before returning to the circle to talk. She then showed the group the drawing she had done earlier, which had two dots with an ellipse around them (her and Sam), and then another circle, which was the group. She said that Sam always stayed as far out of the group circle as possible in the dance therapy sessions and only connected when she introduced the elastic. Sue noticed from the embodiment task and the subsequent articulation, how connected this lad actually is, even while on the edge of the group. She noticed that Sam has a special connection and this is his autistic way of connecting one at a time, but very firmly. She only realized the specific kind of pull from the

embodiment. She finished the session by saying that she is always so very tired when she is working, yet is reminded that she really does love what she does, and this gives her energy to return to the work.

We ended the group by going back into movement accompanied by music with a strong rhythm to assist participants to de-role and find their own feet. I mused afterwards about whether they had ever left themselves, as the client was 'as if' an extension of themselves or perhaps an aspect of themselves which became alive in relation. From listening in I was reminded how through reflection upon action we discover what we already 'know'. Through creative, reflexive embodiment we may discover aspects of ourselves and make our tacit knowledge explicit (Nikolitsa, 2002).

Discussion

If one uses the concept of Interactional Shaping as a lens through which to look at the case material above, one might be curious about the effects of the supervisor's language on the participants' experiences. For example how certain phrases influence outcomes, e.g. 'nominate a client'; 'you as healer'; or 'What message does (the sculpture) have for you?' One might also wonder about how shifting between kinesthetic, iconic, symbolic and lexical modes provides different information, and shapes the individual and the material in different ways. For example consider the effect of the accumulated information from Sue's, drawing, then her embodiment, and her role-play. Such shifts facilitate creative, multi-focused views of the case material in which embodiment; externalization and reflection lead to what Lett terms the 'multimodal accessing of the knowing-in-being-self' (Lett, 1993.375). Therefore, Interactional Shaping may pertain to the relationship between parts of oneself, between expressive contexts, and between self and others in the environment.

Therapists' explanations for what takes place within the interactive space between therapist and client have changed over time towards greater inclusion of relational processes (Gergen, 2003). Dance Therapist and psychoanalyst Dosamantes summarizes historical ideas about transferential phenomenon, highlighting the 'trend' away from 'mechanistic intrapsychic explanations of personality in favor of an intersubjective and interpersonal view' (Dosamantes, 1992.360). Dosamantes goes on to say that the ethical implications of this shift are that analysts 'assume greater responsibility for the continual, and close monitoring of their own actions, fantasies, and thoughts' and are enriched by an awareness of the 'subjective interplay between themselves and their individual patients '.

While Dosamantes uses the term 'interpersonal', her description of transferential material appears to emphasize intersubjective phenomena, focusing upon individuals' intrapsychic experiences in relation to one another, as a means of understanding what happens between them. Social constructionist and systemic approaches, on the other hand, emphasize co-creation of meaning and the multiplicity of meanings with an emphasis upon interpersonal communicative processes as the key to understanding what happens in the space in between (McNamee & Gergen, 1992; Pearce, 1994; Best, 2000). There is an assumption that meanings are co-created between selves engaged in social exchanges that contexts are formative and that processes, rather than products, of communication are central.

Psychotherapist Spinelli (1996) speaks of the self as being 'plastic', allowing for the creation and existence of many selves-in-relation. This fits well with the social constructionist perspective being presented in this paper. Barnet Pearce, founder of CMM (Co-ordinated Management of Meaning) focuses upon the 'social worlds that we are co-creating through out actions' (Pearce, 2001.3). The ideas of plasticity and co-creation, of intersubjectivity and the interpersonal may be particularly helpful for therapists working directly with, and in relation to, the body, as these ideas emphasize shared responsibility and the need for self reflexivity of the therapist.

The field of neuroscience offers a different view of plasticity from that of psychotherapist Spinelli, one closer to the Kestenberg Movement Profile view. Neuroscientists investigating learning and memory write of 'neuronal plasticity' referring to ways in which ' the brain is able to remodel its connections in order to adjust the organism's response to changing conditions' (MRC Co-operative, 1999. para.1.) These changes take place over time, rather than moment-to-moment, as in the frame of Interactional Shaping. Body psycho-therapist Carroll (2001) emphasizes the importance of developmental neuroscience in providing a fresh perspective on human processes, embedding psychological and somatic functions within a ' network of relationships' (2001.4). Carroll locates herself within new science, which, along with other disciplines exploring human behavior, is now searching for 'emergent properties of complex interactions between systems' (2001. 1).

Viewing Interactional Shaping as an emergent property of interaction and communication may be useful to the psychotherapeutic practitioner working in the here-and-now, as well as considering previous relational patterns. I.S. as evidenced within my supervisory practice focuses attention upon momentary changes within a dynamic relationship which is being created, and recreated, within a social situation. I.S. refers to somatic, psychological and social narratives which have the capacity to change. In the case material described within the example above, the dance therapist, Sue, became aware in her body, of the excitement and danger of the elastic band and its effect on the behavior and emotions of her client. Sue's bodily 'felt sense' (Gendlin, 1996) was transformed and externalized into a drawing, which was then reflected back as important information about the relationship being co-created between herself and the child. The elastic appeared to wrap together more than their physical bodies; it could be seen also as a concretized expression of mutual influence between social worlds.

From a movement perspective there is a related concept, shape- flow, which is based upon the expanding and narrowing of the body during breathing. The idea of shape-flow initially came from Warren Lamb, a pupil of Laban, and was further developed by psychoanalyst Judith Kestenberg, who with others created a system of movement analysis called KMP (Kestenberg Movement Profile) based upon longitudinal observations of infants interacting with carers (Kestenberg et al 1999). In describing shape-flow dance therapist Loman states it 'expresses plasticity of living tissue… (and) shape-flow patterns provide a means to express and structure internal feelings about relationships' (Loman & Foley 1996. 342). Kestenberg's idea that shaping, plasticity and relationship are connected is supported by recent research in neuroscience, which suggests that 'object relations are embodied' (Carroll, 2001, Part 2, para.1).

The Kestenberg Movement Profile is based upon a developmental premise that, as an individual matures, body movement patterns evolve over time and psychological development can be observed through these 'predictable' patterns (Loman & Foley, 1996). The idea that traumatic and significant experiences are stored in one's body is not unique to KMP. Body psychotherapists acknowledge the concept of somatic memories, and relationship between body and mental states (Johnson & Grand, 1998; Carroll, in press). Within KMP trained observers assess both the developmental issues and age of trauma, and also specific relational issues through body movement patterns. A detailed description of the KMP is outside the scope of this paper, however, interested readers should see Kestenberg and Sossin, 1979.

The Kestenberg Movement Profile (KMP) is divided into two main sub systems: the Tension-flow-Effort system and the Shape-flow-Shaping system. The Tension system is purported to relate primarily to the development and expressions of an individual's 'inner needs', while the Shape system relates to the development of an individual's relationships to people and things in the environment (Loman & Foley 1996). It is the Shape system which is congruent with the idea of Interactional Shaping presented in this paper. 'Shaping is about relationships, about how parts are interconnected' (Kestenberg et al 1999.161). The Shape system follows a developmental sequence. This starts with 'Shape-Flow', in which the infant's body shrinks away when repulsed, and bulges forward when attracted. The next phase is called 'Shaping in Directions' in which the child actively connects with others, and objects, through directional pointing. The final phase is termed 'Shaping in Planes', in which the individual moulds to their environment, including others, using three dimensions, facilitating the most advanced level of relational connectedness (Loman & Foley 1996).

Earlier within the case material in this paper there is an example of three dimensional shaping. I asked the participants to create a body sculpture encouraging use of three dimensional shaping or shaping in planes. My field notes indicate that during the session, while observing the body movement within the room, I decided to introduce overtly three dimensionality in order to open participants' awareness of others. The task arose in what felt to be an organic manner, based upon my 'felt sense' while observing the movement focus and range. It is only in retrospect, after reflective analysis upon my notes, that I noticed the close link between the sculpture task and my next suggestion for the participants to connect to their clients from within the sculpture. Inherent within any person's capability to shape in this way is their experiential history of relating to others both in the distant and recent past (Kestenberg et al 1999). I might assume that in asking participants to think about their clients while in the process of shaping with their own bodies, they might well be connecting to recent clinical experiences as well as more distant memories.

Winnicott (1965) was aware of the importance in early relational experiences of breathing and shape changes when he highlighted the significance of the mother's adaptability to, and synchrony with, her infant's heartbeat and breathing. Winnicott's idea of mutuality within early relationship experience influenced Kestenberg's concepts of the development of 'self-in-relationship' (1999.6 & 124). Stern (1985) also focused upon 'intersubjective relatedness' and the importance of attunement between caregiver and infant. Stern's description of 'attunement' highlights three features: 'intensity, timing, and shape,' which could all be part of the dynamic complexity within Interactional Shaping. These theorists' perspectives provide support for the interactive nature of the body, psyche and the environment. While the KMP (Kestenberg Movement Profile) profile has been based upon observations of interactions between individuals, as an observational tool it also assesses individual psyche-soma development over time.

If followed rigidly the KMP model might be related to the idea of a 'feedback loop' within systems thinking, or a 'closed chain of cause and effect' (O'Connor & McDermott, 1997.251). Within the concept of Interactional Shaping there is an appreciation of ongoing 'balancing and reinforcing feedback 'within the present moment, rather than a focus upon previous 'loops' (O'Connor & McDermott, 1997.32). The perspective of Interactional Shaping draws the attention of the observer (whether therapist, supervisor, or care worker) to the fluid co-creation of realities between individuals and systems through the interaction of bodies in motion in space. The non-verbal influences between people are mutual and take place before, and alongside, verbal interactions. The value of I.S. as a theoretical lens may be that it takes the observer one step beyond ' interactional synchrony' (Condon 1980) and Shaping (Kestenberg et al, 1999) towards a post structuralist ethical position which includes the observer, issues of power, influence, and person position (Stiver et al, 2001). Such a position is in line with feminist, systemic, social constructionist and narrative therapies.

Issues of power can be seen, and deduced, from the case examples provided in this paper. In the position of supervisor I acknowledge the power my physical, verbal, and non-verbal input may have upon outcomes (Fruggeri, 1992). My use of hypnotic language puts me in a potentially powerful position, in which I may be strongly and overtly, or subtly, influencing the experiences, and at times images, of participants (Furman (1992.9). My vocal pacing, breath sounds, and movements at the side of the room may also affect outcomes. There is also the consideration of the therapist's power in shaping clients' experiences. One participant in the example above, Jane, following an embodiment of a non-verbal, relational experience with a refugee child, became aware of what power she may exhibit as therapist. In the subsequent role-play when Jane 'became' the young boy, she experienced how hard the child worked to do what the therapist wanted. Jane, as therapist, could suggest dancing; she could request a house to be built, by offering props. She could spin and spin, perhaps to keep playful movement in the room, as verbal communication was not an option. The child created a different internal story about the 'wind' being created helpfully by the therapist's spinning body. Perhaps he retained some power through this positive interpretation, as well as through his jumping and jumping and jumping.

One rationale for recommending another viewpoint when observing relationship, is a perceived need within the field of Dance movement therapy, to incorporate and relate post-modernist ideas directly with observable movement phenomena (Parker, personal communication). As observers are part of the observed system, and subjects are part of wider systems of movement, meanings, and relationship, adopting different person positions could produce different experiences (O'Connor & McDermott, 1997; von Foerster, 1984). Where you locate yourself in a relationship, theoretically and physically, may influence what you see, the space you have to express yourself, and how you may shape others around you (Best, 2000).

Within the RCPM sessions participants shift person positions repeatedly. They begin in first person position, checking in with their bodies, their 'felt sense' and then move towards second and third person positions within the session. In the case material in this paper there is one instance when I ask participants to try out the body experience of the client (a shift to 2nd person position). Later during the role-play when the 'clients' are talking together, there is an unusual combination of first and second person positions. At other times in the supervision sessions participants may take on a third person position observing the relationship between another couple or commenting on the overall process in the session. Such shifts of person position are frequent within systemic and social constructionist practice, as well as in narrative therapy supervision during 'outsider-witness' practices (Andersen, 1991: Fox & Tench, 2002). The insider, perhaps the therapist within supervision, takes the outsider position or the supervision group takes the insider position and the client takes the outsider position. These shifts encourage new narratives to be created and integrated in a similar way to the exercise within the case example. Further research might look at differences between shifting perspectives via embodied role-play, artistic media, person positions or theoretical frame.

From a poststructuralist perspective we are shaped by the person position we take, or are put into, and mutually we shape others. In practice, while in the role of therapist, or supervisor, or researcher, we might be in any one of the positions. We could be more distant (3rd) with an overview, or in the empathic second person position (I -thou), or even in first person, fully involved in an 'I' position, and responding from our own feelings, responses (O'Connor & McDermott, 1997; Gilbert & Evans, 2000). I suggest that therapists, supervisors and researchers need to consider what they bring to interactions through their bodies and how to maintain curiosity about what gets created between people. From my clinical and training experience what gets shaped within the interaction is plastic and lively, vulnerable and powerful.

Dance therapist Penny Lewis emphases the importance of embodying relational figures and engaging bodily within the 'bi-personal space', thereby connecting to one's 'self-in-relation' (Lewis, 1993.5). Kestenberg's Shape-flow-shaping system claims to assess the 'nonverbal foundations of relational development' (Loman & Foley 1996. 341). Interactional Shaping as a frame may offer a view incorporating both 'bi-personal space' and interpersonal, interactive space. I.S. may help therapists, supervisors, supervisees, (and clients) to appreciate multiplicity and mutual influence within interpersonal dynamics e.g. the variety of modes, expressions and narratives danced, spoken and heard within therapy and supervision processes.

Summary and conclusions

This paper introduced the concept of Interactional Shaping as a creative construct to assist trainees, therapists and supervisors to appreciate the ways in which multiple verbal and non-verbal contexts and narratives shape relationships over time. Connections were drawn with Condon's 'interactional synchrony', 'Dosamantes' 'intersubjectivity', Kestenberg's 'Shape-flow-shaping', Winnicott's 'mutuality', Stern's 'intersubjective relatedness', Laban's 'Effort- Shape', Schore's 'syn-chronized energy exchanges', neuroscientific concepts of 'neuronal plasticity', social psychology's concept of 'emotional contagion', Johnson & Grand's 'social somatics', Lewis's 'bi-personal space', O'Connor & McDermott's 'feedback', feminist therapy's 'relational connectivity' and Carroll's ' embodied object relations'.

Support for the presented model of supervision, RCPM (Relational Creative Processes Model) was drawn from creative arts, narrative, systemic and social constructionist and relational integrative supervision models

highlighting related practices i.e. differing creative media, person position shifts, 'collaborative supervision', 'reflecting team' and 'outsider witness'.

A case was made for the new term Interactional Shaping as a way of focusing therapists' observations and reflections on how not only narratives, but also bodies are shaped moment to moment. The paper provided case examples from qualitative data within a supervision research project. The supervisees considered both active and passive aspects of Interactional Shaping revealing how their body narratives had shaped, and been shaped, by their interactions with particular clients. The reader was also asked to pay attention to the effect of the supervisor's choice of language and task. Connections were drawn between related psychological theories and descriptions of non-verbal interactions. The experience of the author both in private practice and professional training is that this construct serves to promote creative curiosity about what is created between people. It also supports an alternative, post structural ethical position by drawing the therapist's attention to the multiplicity of communications and possible outcomes, prompting therapists to take responsibility for their input. These non-verbal and verbal narratives enrich creative interactions over time, shaping communications and outcomes.

In offering the concept of Interactional Shaping, the author illuminated connections between a number of fields concerned with human behavior, communication and psychotherapeutic relationship. The paper points to a need for further research across these fields. An in depth review of research might critique practitioners' understandings of what happens in the somatic, psychological and social spaces between people. Such research could add another narrative to the interconnecting web of professional conversations, thereby stimulating further curiosity and dialogue.

'Transformation is inherently a relational matter, emerging from myriad coordinations among persons'. (McNamee & Gergen, 1992.5)

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Carl Rogers: Body-Oriented Psychotherapist

Peter S. Fernald, Ph.D.

Abstract

Carl Rogers's person-centered approach is essentially body-oriented. This thesis is considered in four contexts: 1) the moments and dimensions of change in psycho-therapy; 2) person-centered theory; 3) Rogers's activities as psychotherapist; and 4) similarities between Rogers's and Wilhelm Reich's thinking about human nature. . . . psychotherapy is a process whereby man becomes his organism — without self-deception, without distortion ... (It) seems to mean a getting back to basic sensory and visceral experience (Rogers, 1961, p 103).

Keywords

Body oriented psychotherapist – Person-centered approach – Wilhelm Reich – Carl Rogers

Forty-five years ago, while pursuing a master's degree, I was introduced to the client-centered approach of Carl Rogers. I was deeply moved by Rogers's words. Later, I entered a doctoral program which was more eclectic, emphasizing psychodynamic, social learning, and existential approaches. I did not return to Rogers's writings until 20 years later, when for the first time I taught a course in counseling. Once again, Rogers's writings had a strong impact on me. This time his words seemed more like poetry than prose, poetry that elicits new meanings and deeper understanding with each reading.

It was not until recently, however, that I was able to appreciate and comprehend even more fully Rogers's ideas. My enhanced and, I believe, more accurate understanding of his writings came through my study of and training in bioenergetic analysis, a form of psychotherapy having a body-mind focus (Lowen, 1975, 1980, 1990). With its empha-sis on the body, bioenergetic analysis prompted me to see Rogers's approach from a different perspective. As the title of this article sug-gests, I believe Rogers's primary intention as psychotherapist was to facilitate the client's being more in touch with his or her body. In attempting to demonstrate my thesis, I address four topics: 1) Rogers's descriptions of the moments and dimensions of change in psycho-therapy; 2) fundamental questions pertaining to any theory of human nature; 3) Rogers's various activities during a psychotherapy session; and 4) some similarities in thinking between Rogers and Wilhelm Reich.

Moments and Dimensions of Change in Psychotherapy

The essence of psychotherapy is change. Factors that produce change, as Rogers described them, are considered below. The focus is on both the moments and dimensions of change as they occur for the client.

Moments of Change

Rogers believed he could recognize "moments of movement," those instances when change actually occurred. One such moment involved a young man who wished his parents would disappear or die.

Client: *It's kind of like wanting to wish them away, and wishing they had never been ... And I'm so ashamed of myself because then they call me, and off I go -- swish! They're somehow still so strong. I don't know. There's some umbilical -- I can almost feel it inside me -- swish (and he gestures, plucking himself away by grasping at his navel.)*

Therapist: *They really do have a hold on your umbilical cord.*

Client: *It's funny how real it feels ... It's like a burning sensation, kind of, and when they say something which makes me anxious I can feel it right here (pointing). I never thought of it quite that way.*

Therapist*: As though if there's a disturbance in the relationship between you, then you do just feel it as though it was a strain on your umbilicus.*

Client: *Yeah, kind of like in my gut here. It's so hard to define the feeling that I feel there. (Rogers, 1961, p. 148).*

Another moment of movement occurs in a man exploring some previously unrecognized feelings of fear, neediness, and loneliness, which suddenly evolve into an intense physical response resembling prayer and supplication.

Client*: I get a sense of -- it's this kind of pleading little boy. It's this gesture of begging. (Putting his hands up as if in prayer).*

Therapist: *You put your hands in kind of a supplication.*

Client: *Yeah, that's right. 'Won't you do this for me?' kind of. Oh, that's terrible! Who, Me? Beg? ... That's an emotion I've never felt clearly at all -- something I've never been --- (Pause) ... I've got such a confusing*

feeling. One is, it's such a wondrous feeling to have these new things come out of me. It amazes me so much each time, and there's that same feeling, being scared that I've so much of this (Tears) ... I just don't know myself. Here's suddenly something I never realized, hadn't any inkling of -- that it was some thing or way I wanted to be. (Rogers, 1961, p. 149)

Moments of change always involve the body, having, in Rogers's words, "obvious physical concomitants" (Rogers, 1961, p. 130). The latter typically involve physiological loosening, for example, moistness in the eyes, tears, sobbing, sighs, and muscular relaxation. For the individuals described above, physiological loosening occurred as a burning strain on the umbilicus and as a bodily experience of fear and pleading suddenly emerged into consciousness. Rogers believed that over the course of successful psychotherapy physiological loosening occurred throughout the organism. He even speculated that if appropriate measures were employed, improvement in both circulation and conductivity of nervous impulses would be observed (Rogers, 1961).

An individual may subsequently distance him- or herself from a moment of movement, as seems to be evident above in the statement, "Who, Me? Beg?" But, as Rogers points out, such a moment is irreversible, meaning once such an experience has occurred, it thereafter is available for future reference. Feelings and meanings attributed to feelings during a moment of movement may subsequently shift. Nonetheless, a moment of movement provides a point of reference, "a clear-cut physiological event" (Rogers, 1961, p. 150), to which the individual can return again and again until satisfied as to exactly what the experience means to him or her -- or, stated otherwise, until the experience is fully integrated into awareness.

Dimensions of Change

In his process conception of psychotherapy, Rogers details various dimensions of growth: openness to experience, internal rather than external locus of evaluation, willingness to be a process, experiencing oneself as subject rather than as object, and trust in one's organism (Rogers, 1961). Rogers does not explicitly state that one dimension is more important than another. His discussions of the dimensions, however, suggest that trusting one's organism is a, if not the, central and generic process that includes the others.

For example, since all experience is organismically based, openness to experience involves trusting the organism. Similarly, an internal locus of evaluation always involves the organismically-based sense of satisfaction, dissatisfaction, or both. Because all organisms exist in a continuous moment-to-moment process of change, trusting one's organism indicates a willingness to be a process. Lastly, in those moments when one fully trusts and accepts organismic experiencing, one experiences him or herself as subject, not object. In the cases mentioned above, for example, it would be incorrect to say the strain on the umbilicus and the feeling of pleading were perceived, because such a statement suggests these feelings are objects. In such existential moments, one does not have an experience. Rather, trusting one's organism, one is the experience. And accordingly, self is subject, not object, (Rogers, 1961).

> I see constructive outcomes in therapy...as possible only in terms of the human individual who has come to trust her own inner directions, and whose awareness is a part of and integrated with the process nature of her organic functioning...the functioning of the psychologically mature individual is similar in many ways to that of the infant, except that the fluid process of experiencing has more scope and sweep, and the mature individual, like the child, trusts and uses the wisdom or her organism, with the difference that she is able to do so knowingly. (Rogers, 1977a, p.248)

To summarize, the moments of change that occur over the course of psychotherapy are physiologically based, and the fundamental direction of change is toward increased trust in the organism. Rogers's emphasis on the body is evident.

Fundamental Questions for any Theory of Human Nature

Five questions that any theory of human nature must address are the following: What are the units of study, or stated otherwise, the structures of interest? What energizes and directs human behavior? How do human beings develop? What are the various types and causes of human dysfunction? How is dysfunction either eliminated or diminished? More simply stated, the questions pertain to several concerns: structure, motivation, growth, psychopathology, and change. Referring to Rogers's person-centered approach, I shall answer these questions. I do so in a effort to demonstrate that each answer makes clear and direct reference to the body or, more specifically, to organismic experiencing. (Rogers, 1951, 1959, 1961, 1980a).

Structure

Rogers postulates two "structures" or processes, organismic experiencing and self. Experience refers to everything potentially available to awareness occurring within the organism at any given moment. Such experience includes both conscious (symbolized) and unconscious (unsymbolized) processes. Organismic experiencing, therefore, includes all sensory experiences, conscious and uncon-scious (Rogers, 1959).

Self refers to that portion of organismic experiencing that becomes differentiated and contains the sense of "I" and "me." Differentiation refers to perceptions of "I" or "not I" and "me" or "not me." Rogers describes two types of differentiation, external and internal. External differentiation involves identifying oneself as a physical being different from other physical entities. The young infant who alternately sucks his thumb and the mother's breast, for example, soon learns the thumb is "me" and the breast is "not me." Such physical differentiation presumably occurs very early in life and is non-verbal (Rogers, 1959). A second type of differentiation occurs internally. The process is similar to that just described. Accordingly, some organismic experiences become identified as "I" and "me"; other organismic experiences are relegated to the nonconscious, to "not I" and "not me." Consider the young boy who is told, "Little boys are tough; they don't cry!" Organismic experiencing relating to anger becomes identified as "me." Organismic experiencing that pertains to sadness and hurt is "not me."

To summarize, the two basic structures or processes in Rogers's person-centered approach are organismic experiencing and self. Since self is a derivative of organismic experiencing, the latter is both fundamental and primary.

Motivation

What energizes and directs human behavior? Rogers offers a simple and straightforward answer to this question: the actualizing ten-dency.

There is one central source of energy in the human organism. This source is a trustworthy function of the whole organism rather than of some portion of it; it is most simply conceptualized as a tendency toward fulfillment, toward actualization, involving not only the maintenance but also the enhancement of the organism (Rogers, 1980a, p.123).

Noteworthy for our purposes here is that Rogers might have used the words "human being," "individual," or "person." Instead, he refers to the "human organism" or simply "organism," which suggests a close link between the actualizing tendency and body.

Rogers also postulates a need for positive regard, which is both universal (i.e., present in everyone) and persistent. Positive regard refers to warmth, caring, respect, and sympathy. Healthy development requires that significant others provide these qualities (Rogers, 1959). However, a problem occurs with positive regard, namely, that positive regard expressed by a significant other can become more compelling than organismic experiencing. This is where conditions of worth warrant consideration.

Growth

Conditions of worth refer to attitudes that are conditional - i.e. judgmental, evaluative, and critical. A child's self-concept emerges through interaction with significant others who hold and espouse conditions of worth. Accordingly, various positive and negative values are attached to the child's perceptions of self, and organismic experiences are differentiated as worthy (approved) or unworthy (disapproved). The child acts so as to enhance the former and deny, minimize, or distort the latter, which necessitates a split between organismic experiencing and self (Rogers, 1959).

Under ideal conditions, the infant or child, feeling fully prized, introjects no conditions of worth. The child's feelings are fully accepted and respected by caretakers, though certain behaviors are not permitted. The parental attitude, theoretically speaking, might be something like this: "I understand how "when you are angry," kicking your sister (or urinating when and where you please) feels satisfying to you. I am most willing for you to have such feelings, and I love you. I also have my feelings. I feel upset and distraught when your sister is hurt (or when I have to clean up after you)." Both the child's and parents' organismic experiencing are important (Rogers, 1959).

It is a rare and fortunate child who receives unconditional positive regard (i.e., no conditions of worth) from significant others. In the ideal situation no organismic experience is considered bad or denied awareness. The child's self concept includes all organismic experiencing. Such a child, theoretically, develops into a healthy, fully functioning adult.

Psychopathology

The more common circumstance is one in which conditions of worth are present, or often even omnipresent. Such a circumstance is fertile ground for the development of personality dysfunction.

> In the human being...the potentiality for awareness of functioning can go so persistently awry as to make one truly estranged from organismic experiencing. One can become self-defeating, as in neurosis; incapable of coping with life, as in psychosis; unhappy and divided, as in the maladjustments that occur in all of us. Why this

division? How is it that a person can be consciously struggling toward one goal while his or her whole organic direction is at cross purposes with this? (Rogers, 1977a, p.244).

Rogers's answer to his question has to do with conditions of worth, evident in such statements as: "Don't be so scared," "Put on a happy face," and "Little boys don't cry." Through such conditions of worth, parents and the culture reward behaviors that are perversions of the natural directions of the actualizing tendency. The individual becomes alienated from organismic experiencing, behaving consciously in terms of introjected, rigid constructs (i.e., conditions of worth) that define his or her self concept and unconsciously in terms of the actualizing tendency (Rogers, 1959).

Rogers eschewed complex classifications of psychopathology, such as those involved in the various editions of the Diagnostics and Statistics Manual of Mental Disorders (Rogers, 1959). In fact, he believed that diagnosis of any type is not only unnecessary but also unwise and frequently detrimental. Even inadvertent "diagnoses" such as is implied in the statement, "I wonder if this is the best time for you to move," Rogers believed, could undermine both trust in organismic experiencing and ultimately progress in psychotherapy. This is so because any statement that carries with it even an implicit evaluation establishes the psychotherapist as the expert, the one who knows. The locus of evaluation then is in the hands of the psychotherapist, thereby undermining the client's taking responsibility for understanding and working through his or her difficulties and struggles. For Rogers, diagnosis is appropriate only when it is based entirely on the organismic experiencing of the client, not the intellect of the psychotherapist (Rogers, 1951).

Change

A clear statement of Rogers's perspective on the factors that bring about change is evident in his fundamental hypothesis, which consists of three parts (each in italics): If I can provide a certain type of relationship, the other person will discover within her - or himself the capacity to use the relationship for growth, and personal development will occur (Rogers, 1951, 1961). The certain type of relationship, which includes the three qualities for which the person-centered approach is well known-- empathy, unconditional positive regard, genuineness--is considered below. The capacity to use the relationship for growth, which refers to the actualizing tendency, was described above under the question of motivation.

The focus here is on the third part of the hypothesis, personal development. Changes occur when an individual, experiencing the three qualities just mentioned, allows actualizing forces to take over. The learning that occurs through actualizing forces is "...a total, organismic, frequently non-verbal type of thing..." (Rogers, 1961, p.86). Denial and distortion of experiencing diminish and, as change continues, self includes more and more organismic experiencing. With little or no censorship from a conceptual self-filter, the person becomes the full potential of the human organism, including full awareness of basic sensory and visceral reactions.

The person comes to be what he is, as clients so frequently say in therapy. What this seems to mean is that the individual comes to be -- in awareness -- what he is -- in experience ....in other words, a complete and fully functioning human organism (Rogers, 1961, pp. 104-105).

A brief review and summary of answers to each of the five questions is as follows:

What are the basic structures? Answer: Organismic experiencing and that portion of organismic experiencing called "self." What energizes and directs human behavior? Answer: The actualizing tendency, "the central source of energy in the human organism."

How do human beings develop? Answer: Human potential is realized (i.e., personality is fully functioning) to the extent that organismic experiencing is neither denied nor distorted.

What are the various causes of dysfunction? Answer: Dysfunc-tional behavior occurs whenever conditions of worth prompt estrange-ment from organismic experiencing. How is dysfunction modified? Answer: When certain conditions (empathy, unconditional positive regard, genuineness) are present, actualizing forces take over, and the person becomes a more fully functioning human organism.

The answer to each question makes clear and direct reference to the organism or, consistent with my thesis, to the body.

Rogers as Psychotherapist

It is Rogers's extraordinary capacity to listen empathically, his willingness to respond personally and genuinely, and his warmth and non-judgmental caring, I believe, that elicit deep organismic experiencing in his clients. I believe too that a most salient aspect of Rogers's non-judgmental caring, his unconditional positive regard, is his persistent reluctance to offer interpretations or employ techniques. In an effort to demonstrate this claim I shall discuss a film-recorded interview conducted by Rogers in the mid 1970s.

The Case of Mr. J

The interview was conducted with Mr. J, a highly articulate, African-American male who had had leukemia which was in remission (Rogers, 1980b; Rogers, 1977b). Rogers meets with the young man for approximately an hour-long session on two consecutive days. Over the course of the two sessions, Mr. J moves from being a highly talkative, rambling, defensive individual to one who is brimming over with painful feelings and at a loss for words.

Forty minutes into the second session, he is unable to tolerate the intensity of organismic experiencing, and he requests that the session be ended.

In the first session, Mr. J talked about his anger. In the following verbatim excerpts, taken from the second session, Mr. J begins to experience his anger.

Mr. J.: *And there's nobody that I can put my finger on. There's nobody ... the person that started the whole thing, that process. That would probably be a lot better for me that I probably would try to do that person in.*

Rogers: *Yes. If you could pin it on one person, then your rage would be justified and you could really get after that person.*

Mr. J.: *But how do you blame somebody else that's sick? And I think that people who do that to other people are ... they're really sick ... I know there's a lot of anger there. But it's not my nature to be angry. Not my nature to be angry, but I feel angry.*

Rogers: *So I hear you explaining and explaining that "it's not my nature to be angry ... it's just that I am angry right now."*

Mr. J.: *For sure. And to be angry in a productive ... I don't know how you can be angry in a productive way. (Rogers, 1980b, p. 2156)*

Rogers's ultimate interest is to facilitate organismic experiencing, However, he does not push for either greater intensity or particular types of organismic experiencing. Rather, his empathic responses simply acknowledge whatever organismic experiencing is present, including both feelings (e.g., rage and anger) and inhibitions of feelings (e.g., needing to justify and Mr. J's nature). For Rogers the organic movements of contracting or tightening are no less important than those of expanding and loosening. That Rogers's empathic responses track organismic movements equally in either direction, opening or closing, is testimony to his providing unconditional acceptance.

Rogers: *I get what you're saying. And I also feel quite strongly that I want to say, "It's O.K. with me if you're angry here."*

Mr. J.: *But it's hard to know how to be angry.*

Rogers: *Sure. I'm not saying you have to be. I'm just saying it's O.K. with me. If you feel like being angry, you can be angry.*

Mr. J.: *You really do believe that.*

Rogers: *Damn right. (Long pause. Client sighs.)*

Mr. J.: *I'm not sure how to respond to that at all. Because a part of that anger is all the hurt. Maybe what's happening is that, if I become angry and I really let it hang out, then I really will see how hurt I am. And that just came to me as you were talking.*

Rogers: *Perhaps at the deeper level you are afraid of the hurt that you may experience if you let yourself experience the anger. (Rogers, 1980b, 2156)*

Here, in his first three statements we see Rogers being highly personal and genuine, his transparent self. The statements stop Mr. J in his "emotional anger tracks," catalyzing him into a deeper level of feeling, his hurt. By itself, Rogers's next response may appear to be an interpretation, yet it is simply an empathic reflection of what Mr. J just said. Mr. J subsequently goes on to acknowledge and explore his deeply buried hurt.

Mr. J.: *I'd really like somebody to tell me how to let out that hurt ... in about 5 minutes and be through, and it'd be like living the rest of my life in peace. You know what I mean?*

Rogers: *Sure. It would be awfully nice if somebody could say, "Now, if you do this and this, all your hurt will come out, and it'll be gone forever."*

Mr. J.: *For sure.*

Rogers: *Be great, wouldn't it?*

Mr. J.: *I have a suspicion that maybe you know some things that I don't know.*

Rogers: *No. I'm not holding out on you.*

Mr. J.: *Yeah, I believe that ... it feels like I'm holding out on myself. (Rogers, 1980b, 2156)*

In his first two responses Rogers again is empathic and in the third response he is genuine. In another psychotherapeutic approach, the psychotherapist's response might have been a retreat to silence, the interpretation that Mr. J. does not trust Rogers to be forthright, or perhaps the interpretation that Mr. J believes Rogers knows more about Mr. J than Mr. J knows about himself. Interestingly, Rogers's genuine response prompts an "interpretation" by Mr. J, an interpretation that amounts to Mr. J's owning his projection of "holding out."

Mr. J.: *My body really must have gone through some changes or whatever because there's something there just keeping it, keeping that hurt ... and I know all those reasons, but I can't seem to muster that power to get that out, to really ...*

Rogers: *Still too much locked in.*

Mr. J.: *For sure. But it really helps, 'cause it's incredible. This is the first time I've ever talked to anybody that I haven't really been in control. To some extent, I've really given up a lot of control ...*

Rogers: *Sort of letting things loose. Rather than keeping them under your control.*

Mr. J.: *For sure.*

Rogers: *That's a new experience.*

Mr. J.: *A very new experience for me. A very new experience. (Rogers, 1980b, 2156)*

Implicit throughout the session is Rogers's warmth and acceptance, his unconditional positive regard for whatever Mr. J says and feels. Mr. J's acknowledgment of giving up control suggests that he has been deeply touched and moved by Rogers's warmth and non-judgmental caring.

Mr. J continues, indicating how very difficult, almost impossible, it is for him to describe how badly he has been hurt. He comments, "... it's like somebody knocking you down... stomping on you and spitting on you ...feeling like garbage ...like somebody took a big god dam tree and just rammed it up ..." (Rogers, 1980b, 2156)

Rogers: *And it's that kind of pain that you've suffered.*

Mr. J.: *Yeah. I just can't let it happen again. I really don't know how to tell you how badly I've been hurt. I really don't.*

Rogers: *Goes beyond words.*

Mr. J.: *Yeah But I know it's there, and I think maybe I should attend to it a little bit more. But God damn it, it just ... Ooooooh! (A groan of pain.)*

Rogers: *You're feeling some of that hurt now.*

Mr. J.: *Yeah. I am. (Rogers, 1980b, 2156)*

Deep organismic experiencing, Rogers suggests, initially is described metaphorically (e.g., garbage and big God damn tree). When fully experienced, it is wordless, in this instance a groan (Ooooooh!) of excruciating pain. Rogers's full acceptance, genuiness, and empathy has initiated an intensity of organismic experiencing that is more than Mr. J can bear, or at least, wants to bear.

Mr. J.: *I think that, if I show you how much I've been beaten or whatever, like I'd probably become nothing in this chair, you know.*

Rogers: *You might practically disappear, if you really let me know how hurt and beaten and awful you feel?*

Mr. J.: *For sure. I could tell you some things that would just maybe blow you away. Funny. It's really too much for me.*

Rogers: *Too much. I think you feel like, "I've gone about as far as I can go at this point."*

Mr. J.: *Yeah, really. When I start smiling, I know I have ... But I'm being truthful about it anyway.*

Rogers: *Yes. I feel that, too. You've walked around that pit of hurt and pain and beatenness, and you've felt some of it; and perhaps that's as far as you can go right at this moment ... even though you know there's more there. You know that you're keeping some of it down. And to know those things may be helpful too.*

Mr. J.: *(Sighs and groans.) Phew! ... Oh! ... Whew! I have to stop. O.K.?*

Rogers: *O.K. All right. You've gone about as far as you can go.*

Mr. J.: *That's right. (Rogers, 1980b, 2157)*

In this excerpt all of Rogers's responses are empathic, though one ("Yes, I feel that , too") involves Rogers being genuine too. Both Mr. J and Rogers know there are more painful feelings to be explored. However, Mr. J clearly states that the process has become too much for him. He must stop. Agreeing to end the session, Rogers acts on his conviction that the best guide for Mr. J's therapeutic process is Mr. J.

Interpretation and Techniques

Throughout the two sessions Mr. J provides Rogers with numerous opportunities for offering interpretations. Never once, however, does Rogers offer an interpretation. For example, when Mr. J struggles and puzzles over his inability to express his anger Rogers neither suggests nor probes for former experiences or current circumstances that might contribute to Mr. J's difficulty. Perhaps the most opportune instance for interpretation occurs when Mr. J says, "I have a suspicion that you may be holding out on me." A classic interpretation here would make reference to Mr. J's transference, possibly transference based on childhood experiences with a withholding parent. But Rogers's response involves no interpretation. Rather, his response is person-to-person, genuine, and straight forward: "No. I'm not holding out on you."

Suppose Rogers had made an interpretation of transference, stated tentatively perhaps in the form of a question: "Do you recall either of your parents holding out on you?" Very possibly Mr. J's response would have been one of resistance, resistance that Mr. J and Rogers then would have to address. But such a circumstance, as the following statement clearly indicates, would never occur.

> To deal with transference feelings as a very special part of therapy...is to my mind a grave mistake. Such an approach fosters dependency and lengthens therapy. It creates a whole new problem, the only purpose of which appears to be the intellectual satisfaction of the counselor - showing the elaborateness of his or her expertise. I deplore it. (Rogers, 1987, pp. 187-8)

Rogers notes that many counselors working with Mr. J might have introduced a technique (Rogers, 1980b). In an effort to help Mr. J experience his anger or hurt, for example, Mr. J might have been asked to hit a pillow or let out a scream. Rogers does not employ such techniques because he believes that doing so suggests that he knows better than Mr. J what direction to proceed in next. Rather, the direction of psychotherapy is based first and foremost on Mr. J's organismic experiencing, which enhances Mr. J's trust in himself. Psychotherapy directed by Rogers, on the other hand, might undermine this trust. Rogers's commitment to unconditional positive regard, and relatedly, to Mr. J's organismic experiencing, is perhaps most evident in his omnipresent unwillingness to offer interpretations or employ techniques of any kind. Though Rogers adamantly opposes the use of techniques and interpretations, I believe, he implicitly provides recommendations as to when and how a counselor might use them in a manner reasonably consistent with his person-centered approach. Such a discussion, however, is beyond the scope of this article.

Most, if not all, body-oriented psychotherapists employ techniques. The techniques vary widely, from those involving rather intense hands-on interventions (e.g., Bodynamics, Bioenergetics, Reichian therapy, Radix, Rolfing) to those employing less intense and more gentle, hands-on interventions (e.g., Biosynthesis, Feldenkrais, Hakomi) to those based on verbally guided or modeled physical exercises (e.g., Alexander Technique, Emotional Reintegration, Tai Chi, Yoga). Rogers's assertion about techniques raises thorny questions for practitioners of these approaches. Does use of a technique really facilitate the client's development? Or, since the technique typically is selected by the psychotherapist, not the client, does its use inadvertently undermine the client's spontaneous inner directions and movements, his or her immediate existential intentions?

One noted body-oriented psychotherapist, Rolf Gronseth, stands in very close agreement with Rogers. Trained as a vegetotherapist by Ola Raknes, Reich's closest student and friend, Gronseth for many years employed strong and intense hands-on techniques. But now, in the twilight years of his career, he refrains from using such techniques. And, going a step further, Gronseth states: "I see it as malpractice… when the body-therapist instructs his clients into doing something else than they are already doing" (Gronseth, 1995, p.8). Such therapists, he suggests, fail to recognize and respect their clients "present intentional activities" (Gronseth, 1998, p.53).

Body-Centering

In less than two hours with Rogers the characterologically armored and defensive Mr. J moved into a state of greater openness and sub-stantial organismic experiencing. Mr. J's breathing deepened. He gave up control, loosening his tight grip on himself. His body armor softened, at least for a brief time. Feelings long buried began to emerge into awareness. He became more intimately connected to both Rogers and his own inner being. These observations prompt the question: How did Rogers facilitate such openness to organismic experiencing?

The simple but incomplete answer makes reference to the three qualities mentioned above--empathy, genuineness, and unconditional positive regard. The answer is incomplete because it does not recog-nize that the person-centered approach first and foremost is an attitude, a way of being in relationship. For Rogers, empathy, genuiness, and unconditional positive regard are not techniques. Rather, they are human qualities (Rogers, 1951, 1957). The emphasis is not on what the psychotherapist does; it is on who he or she is in the moment.

As psychotherapist, Rogers does not respond in a planful or ana-lytic way. Rather, he reacts unreflectively, his non-conscious verbal responses being based on his organismic sensitivity to the client. "I let myself go into the immediacy of the relationship where it is my total organism which takes over and is sensitive to the relationship, not simply my consciousness" (Rogers 1961, p. 202). Colloquially expressed, Rogers both stays in and responds from his body.

Rogers's focus is not exclusively on the body, his own or Mr. J's. As the word "organismic" implies, Rogers's approach is wholistic, including mind, body, and their interactions. Indeed, Rogers's description of the stages of psychological process and growth detail the development and interaction of physiological and mental processes (Rogers, 1961). As Mr. J. speaks his mind, Rogers listens carefully and intently to each of Mr. J's words. Yet Rogers clearly states that he wants especially to hear the feelings just below Mr. J's words. (Rogers, 1977 b).

The primary medium of communication for Mr. J and Rogers clearly is words. However, as the preceding quotation indicates, Rogers's words emerge not just from his consciousness (i.e. his mind), but from his total

organism, his body. And, the intent of Rogers's words is to facilitate Mr. J's being more aware of his bodily states, particularly affective states. Rogers is a body-oriented psychotherapist.

Reich and Rogers

In making the case for Carl Rogers being a body-oriented psychotherapist, it is appropriate to compare his ideas about human nature with those of Wilhelm Reich, the grandfather of body-oriented psychotherapy. Though Rogers was born only nine years later than Reich, they apparently did not read one another's work, for neither references the other. Nonetheless, their writings about human nature, science, and the nature of the universe are remarkably similar (Davis, 1997). So too are their views of society and their prescriptions for moving beyond individual and group neurosis toward a full life (Reich, 1948; Rogers, 1977a).

Among Reich's many important contributions, perhaps the most significant is his objection to Freud's death instinct (Reich, 1942). Reich believed that the core of human nature is inherently life-enhancing and positive. He writes, "Beneath these neurotic mechanisms, behind all these dangerous, grotesque, irrational phantasies and impulses, I found a bit of simple, matter-of-fact, decent nature" (p. 148).

Rogers also objected to the notion of death instinct, and though strictly reared in the Christian tradition, he rejected the idea of original sin (Rogers, 1961). He notes that in psychotherapy hostile and anti-social feelings are continually being uncovered, which suggests these feelings constitute basic human nature. But such feelings, Rogers suggests, are neither the deepest nor strongest. The inner core of human personality, he suggests, "is the organism itself, which is essentially both self-preserving and social" (p.92).

Reich distinguished between the neurotic character, whose behavior is contra nature and moralistically driven, and the genital or healthy character, whose behavior is self-regulated and aligned with natural functions (Reich, 1942). Reich believed that healthy self-regulated behavior was rare. Neurotic moralistic behavior was far more common, and often it took on a collective or social form, which Reich called the "emotional plague" (Reich, 1945). The term "plague" refers to the contagious nature of moralistic acting out, blatantly evident in social or group pathology such as fascism in Nazi Germany and the Catholic Inquisition of the Middle Ages and less apparent but nonetheless omnipresent in the many repressive groups and institutions throughout society. Reich was aware of the widespread social nature of neurosis. He believed most human beings were prisoners of both society's and their own moralistic attitudes and traditions (Reich, 1948, 1953). His fervent hope was to free men and women from moral fascism.

Reich was acutely aware of the life-constraining political, educational, and childrearing practices of his times. He believed in the self-regulating capacities of the human organism, and he did what he could to eliminate repressive policies and practices that interfered with self-regulation. One such effort involved his work in sexual hygiene clinics where he affirmed both the need of adolescents to masturbate and their right to learn about and obtain contraceptives (Sharaf, 1983). Reich was very interested in educating young people in a life-affirming manner, one that supported their inherent capacity for self-regulation. He had a life-long friendship with A. S. Neill, founder and director of the Summerhill School, well known for its progressive pedagogy. In Neill's school Reich saw the application of work-democratic and self-regulatory principles which he valued (Sharaf, 1983).

Self-regulation is the red thread, to use Reich's phrase, that runs throughout Rogers's work. In fact, the term person-centered means self-regulated. Like Reich, Rogers recognized the widespread social and institutional traditions that aided and abetted neurosis. He applied concepts and principles he had discovered in his conduct of therapy to larger social issues. The student-centered approach presented in his Freedom to Learn (Rogers, 1969), a classic in schools of education, parallels precisely the pedagogy presented in Neill's Summerhill (Neill, 1960). In his next-to-last book, On Personal Power: Inner Strength and Its Revolutionary Impact (Rogers, 1977a), Rogers examines the politics of interpersonal relations, including the politics of the helping professions, marriage and partnerships, the family, administration, and international and intercultural differences. Throughout all of his work, Rogers's message is persistent and clear: The innermost core of human beings, the organism, is trustworthy, positive, life-affirming, social, rational, and self-regulating.

Reich and Rogers were men ahead of their times. Both were revolutionaries – Rogers, a gentle revolutionary who in his next-to-last book wrote, "I walk quietly through life,"(Rogers, 1977, p. xii) and Reich, a not-so-quiet revolutionary, a "fury on earth," according to biographer Myron Sharaf (1983). Suppose Reich had not been ahead of his times. Suppose he had believed that human instincts were evil, that sexual and aggressive impulses were inherently unmanageable and dangerous. His psychotherapeutic efforts then might never have focused on dissolving body armor, releasing biological energy, and encouraging full emotional expression. But such was not the case. Reich believed in an inborn human predisposition toward life-affirming movement, and with this perspective he began body-oriented psychotherapy. Given Rogers's similar views of human nature, it is not surprising that his person-centered approach, initially referred to as non-directive and subsequently as a client-centered, is essentially body-oriented. Wilhelm Reich is the grandfather of our discipline. Perhaps Carl Rogers also should be granted a significant place in our genealogy. I suggest favorite uncle.

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Moving Clinical Work into Research: Study Preparation, Design, and Implementation

Cynthia Price, M.A.

Abstract

There is growing interest among bodywork therapists and body-psychotherapists, as well as among other health care providers, in bodywork and body-psychotherapy research. Therapists who choose to become researchers will draw from their clinical expertise while entering the world of conceptual framework and linear models. It is important that clinician-researchers have access to conversation and resources about the preparation and implementation process of intervention research in this field. At this time, there is very little literature of this kind available. This article provides a brief account of a doctoral student's learning process as she develops and oversees a body psychotherapy intervention.

Keywords

Body work – Intervention – Moving clinical work into research

Introduction

The following article describes the preparation for, and implementation of, my doctoral research study in body-psychotherapy. I came into the doctoral program having completed a very small pilot study of body-oriented therapy among women in recovery from childhood sexual abuse (Price, 2002a; Price, 2002b). In this initial pilot, there were remarkable reductions in dissociation, PTSD, and somatic symptoms among the experimental group compared to a wait-list control (Price, 2002c). My Faculty Advisor and I were interested in exploring what aspects of the intervention facilitated these changes. To examine the questions related to the underlying mechanisms of the intervention, my doctoral study needed to be designed differently than the initial pilot study. Much that I've learned about research preparation and implementation has been a result of the identified changes made in measurement, protocol development, instrumentation, study design, and the training and supervision of research clinicians. These five areas, and the learning involved, are explained below. The data collection in my doctoral study is close to completion; study results are not yet available.

Study Overview

My doctoral study is a pilot study of 24 women randomly assigned to receive either body-oriented therapy or a standardized massage. Body-oriented therapy is defined as a combination of bodywork and verbal therapy focused on somatic and emotional awareness. Study participants receive eight one-hour sessions of massage or body-oriented therapy for eight consecutive weeks. Utilizing a repeated measures design, a set of six questionnaires is administered prior to the massage and body-oriented therapy interventions - twice during the intervention, one-week post intervention, and at one and three month follow-up. These questionnaires gather data related to psychological well-being, body connection, and somatic symptoms. An initial questionnaire is also administered to gather demographic, health and abuse history. A final written questionnaire is administered to gather qualitative information on the experience and impact of receiving the sessions (both massage and body-oriented therapy). The massage group receives a standardized massage (i.e. it is the same each session). The body-oriented therapy group receives a verbally interactive intervention focused on increasing body awareness through three distinct components: massage, body-awareness exercises, and delving. Delving, developed during my years in clinical practice, is derived from Focusing and involves attending to the felt sense in specific areas of the body. The therapist facilitates the delving process through physical touch, meditation-like attention to the inner experience of the body, and questions about sensory awareness. To maximize the comfort and sense of safety in this population, both interventions are done over clothes and the protocols for both interventions can be individualized to meet the safety and comfort needs of the participant.

The following questions are being explored in this study.

How does the efficacy of a body-psychotherapy process involving massage compare to a standardized massage for women in therapeutic recovery from childhood sexual abuse?

Does increased body awareness play a role in positive outcomes? What is the relationship between body awareness and dissociation?

Does level of engagement in body-psychotherapy process correlate with positive outcomes?

Study development and process

Protocol: The protocol for my doctoral study needed to be more specific than what I had used in the initial pilot and it needed to facilitate examination of the essential elements of the intervention. I went through three steps in protocol development. Each of these steps involved reflection and writing, and each was a challenge because my approach had been developed over many years of clinical practice and much about it had never been articulated. The first step involved identifying the essential elements of my clinical work and the ways in which they tend to fit together. In doing so, I identified three specific approaches - massage, body-awareness exercises, and delving – and these became the three stages of the protocol, the backbone of the intervention.

The second step involved thinking about the details of my inner process as a clinician. For example, how do I frame an individual session and a series of sessions over time; what are my decision-making processes and assessment procedures? This step was particularly difficult for the hands-on aspects of my work. For example, how do I assess with my hands? How do I combine physical and verbal assessment? How do I physically respond if someone is dissociating or has a traumatic memory? To answer these questions, I reflected on my clinical experience and focused on identifying consistent and effective patterns of assessment and therapeutic response. These were then incorporated into the protocol.

The third step involved translating this information into a training manual that provided step-by-step instructions for the clinicians who would work on the project. The instructions had to be clear, the language had to accessible, the format had to be linear. The protocol had to be specific enough that the intervention was consistent and expansive enough that the research clinicians could work with the unforeseen possibilities of a session and individual needs of a participant, and stay within the protocol. The assessment procedures became the focal point around which this was achieved. For example, the clinicians needed to assess whether study participants understood and could successfully engage in the body awareness exercises. The training manual gave specific instructions for the tactile and verbal assessment involved. Progression through the protocol depended on the outcome of the assessment. For example, if the exercise came easily to the participant then the clinician would move on to the next level of the protocol. If, however, the exercise was a challenge for the participant then the protocol focused on specific steps to facilitate and support the therapeutic work of the body awareness exercise.

Repeated measures design:

Unlike the initial pilot study, my doctoral study utilized a repeated measures design. This means that the questionnaires used in the study were administered at numerous time points to examine the intervention process. The body-oriented therapy protocol had three distinct stages and measures were administered prior to each stage and after the final stage, to examine change associated with different aspects of the intervention. The same time line for administration of questionnaires was used for both the massage and body-oriented therapy groups.

Instrument Development:

This study examines the role of body awareness and dissociation from the body in the therapeutic process. I needed a measure that would allow me to examine these concepts, and to my knowledge no such measure existed. I needed to design such a measure. I took a course on instrument development and designed a questionnaire with two scales – one scale on body awareness and one scale on dissociation from the body. The items for these scales were developed through a reflection process that drew on the clinical expertise of many colleagues and myself. After completing the scale, I collected 300 responses to this questionnaire for the purposes of confirming that the instrument was reliable and valid.

Two treatment groups:

The design of my initial pilot-test had a wait-list as the control condition. This means that participants were randomly assigned to either a group that received the intervention immediately or to a group that waited two months prior to receiving the intervention. The wait group served as the control - the pre and post measures were administered at the beginning and end of the wait period. In the initial pilot-test, the comparison was between an intervention and no intervention. In contrast, in my doctoral study the comparison group received touch (in this case, massage), allowing a rigorous test of the efficacy of delving as compared to a standardized massage and examination of the hypothesized mechanisms in the body-oriented therapy process.

Training and Supervision:

In the initial pilot-test comparison, I wore two hats: I administered the project and provided the clinical intervention. For my doctoral study I needed to take myself out of the role of clinician to better evaluate the

efficacy of the intervention (i.e., can it be taught and successfully administered by clinicians other than myself?). Consequently, I sought four bodyworkers to work as research clinicians on the project: two to provide the standardized massage and two to provide the body-oriented therapy intervention. For the massage group, I hired clinicians without a psychology background who were comfortable providing a fairly standard and technical massage. For the body-oriented therapy group, I hired clinicians with a psychology background who had experience combining touch therapy and verbal therapy. All four clinicians needed to have a minimum of five years in practice, and experience working with women with an abuse history. I contacted many bodyworkers whose names were referred to me by colleagues and I recruited through the local massage schools and a large massage practice that caters to walk-in clients. I was struck by the interest and support for research within the bodywork community – almost every clinician I spoke with was interested in working on the study.

I trained the clinicians using protocols for their particular intervention (massage or body-oriented therapy). Teaching the standardized massage was relatively straightforward since the protocol was the same every session and there was little verbal interaction. Teaching the body-oriented therapy process, however, was much more complicated – the work was subtle, and involved the interplay of tactile and verbal work – and, the protocol changed three times over eight weeks. The body-oriented therapy training involved considerable time – many hours of the training were focused on practicing the protocol and role-playing hypothetical situations that required utilizing the 'what-if' aspects of the protocol. In other words, it was a lot to learn and a lot to teach.

I realized, starting out, that the process of teaching the body-oriented therapy would involve some collaborative refining of the protocol between the clinicians and myself as we went along. The clinicians thought of things I'd not yet considered (for example, how to do closure on the final session); their personal styles influenced certain aspects of the protocol (the choice of words or phrases used in the protocol); and when practicing the intervention we inevitably encountered therapeutic situations that weren't yet addressed in the training manual (for example, how to respond to a participant who isn't interested in doing any of the 'homework'). In each of these situations, their input was invaluable and their perspectives helped to guide my decisions as I refined the protocol.

One of the goals of taking myself out of the role of clinician was to learn to teach my work – and to teach it within a research framework. It was difficult at times to balance the role of clinician with that of researcher – particularly when I needed to come up with specific guidelines for situations that could be responded to in a variety of ways. I could empathize with the clinicians who were similarly struggling as they practiced following a protocol rather than following their own therapeutic approach. Not infrequently one of the clinicians would ask me what to do in a situation that I hadn't previously considered. The hypothetical situations that I hadn't considered and were not clinically straightforward were challenging to answer with an immediate, concrete response. For example the time someone asked, "If the participant requests a hug at the end of the final session, is it okay to give one?" I had to resist the temptation to throw up my hands and exclaim, "Whatever you feel is the most appropriate response in the moment!"

The data collection process also provided important opportunities for refining the training manual and protocols. Each session was audio-recorded to monitor compliance with the protocols and as a tool for clinical supervision. Clinical supervision occurred through individual feedback to each clinician after I had reviewed the week's audiotaped sessions, and through scheduled group supervision meetings with either the massage or body-oriented therapists. When listening to the audio taped sessions, I would occasionally hear segments of the protocol delivered somewhat differently than expected. I would immediately realize that I hadn't adequately clarified or demonstrated a particular point during the training. From this process - of listening to the tapes and providing supervision - I learned how to better teach the protocol and gained important information to further clarify the protocol within the training manual.

The process of listening to the audio-taped sessions, in the role of witness/observer/supervisor of the therapeutic process, provided me with an important perspective on both the training and delivery of a therapeutic intervention. I learned that it is possible to teach things I'd assumed were too subtle or hard to explain, for example the ability to distinguish when a client has partial versus complete presence focused in an area of her body. Likewise, I gained a greater appreciation of the skills of an effective clinical researcher – for example, the importance of creative intelligence. There were a few times when quick thinking was required to apply the essence of the protocol in an unexpected therapeutic situation not previously encountered. The clinicians were very skilled and experienced, therefore able to successfully negotiate these moments without compromising the protocol. The clinicians working on this project were extremely conscientious and committed to the study – and enhanced my learning immeasurably.

Conclusion

Translating my clinical work for research purposes, developing a questionnaire, and supervising an intervention study have been very rewarding experiences. Through the process of writing and teaching a research protocol I learned how to frame and communicate conceptual and practical aspects of the intervention process. I also learned that protocol development is an evolving process that is greatly enhanced by careful attention to the delivery of the intervention and involvement of research clinicians. Through the process of

developing a questionnaire I learned the steps involved in creating a reliable and valid measure; this experience was also instrumental in helping me to identify the assumptions underlying my work. Through the process of listening to the work of the clinicians on audiotape, and providing supervision, I learned how essential the clinicians are to the success of an intervention study; they must be responsible, have adequate experience, and the appropriate educational background. I did not anticipate the level of intrigue that accompanied each stage of the research preparation and delivery process. There is a sense of discovery that unfolded with each step that feeds my curiosity and deepens my appreciation for this work.

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Biography:

Cynthia Price, M.A. was given an honorable mention at the last USABP Conference for the excellence of her research proposal. She was subsequently awarded a pre-doctoral fellowship from the National Center for Complementary and Alternative Medicine at NIH to pursue her doctoral research described below. Cynthia, a body-oriented therapist for 17 years in the Boston area, is a doctoral student at the University of Washington School of Nursing in Seattle, WA.

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CRITERIA FOR ACCEPTANCE
How does material in this manuscript inform the field and add to the body of knowledge? If it is a description of what we already know, is there some unique nugget or gem the reader can store away or hold onto? If it is a case study, is there a balance among the elements, i.e, back ground information, description of prescribed interventions and how they work, outcomes that add to our body of knowledge? If this is a reflective piece, does it tie together elements in the field to create a new perspective? Given that the field does not easily lend itself to controlled studies and statistics, if the manuscript submitted presents such, is the analysis forced or is it something other than it purports to be?

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