

Making Somatic Psychotherapy More Effective

Anne Isaacs and Joel Isaacs

Received: 1.11.2018; Revised: 6.09.2019; Accepted: 23.09.2019

ABSTRACT

In our ongoing effort to make somatic psychotherapy more effective, we have identified and eliminated a number of obstacles and constraints to the therapy process as commonly practiced. Using our Bodydynamic approach, this has led to consistently enhanced therapy outcomes in our work with developmental disruptions.

Keywords: somatic psychotherapy, Bodydynamics, developmental disruptions, developmental trauma, (more) effective psychotherapy, (removing) obstacles to psychotherapy, enhanced therapy outcomes

International Body Psychotherapy Journal *The Art and Science of Somatic Praxis*

Volume 18, Number 2, Fall/Winter 2019/20 pp. 65-74

ISSN 2169-4745 Printing, ISSN 2168-1279 Online

© Author and USABP/EABP. Reprints and permissions secretariat@cabp.org

Over the years, as we continued our studies, as we worked with clients and trained other therapists, we often found ourselves struggling with how we could do more for them. Our questioning led us to ask what psychotherapy is trying to resolve. The answers we're finding and the changes we've introduced into our somatic psychotherapy modality have led to enhanced therapy outcomes. We will explore these here in the hope that parallel changes can usefully be made in the reader's own practice.

Historically, one large constraint on the general practice of psychotherapy has likely been the complex and fragmented way it evolved for over a century, beginning with psychoanalytic theory and practice. This often led to long-term discussions of childhood experiences, or attempts to evoke memories or emotions, or strong emphasis on particular aspects of experience. Generally, in the ongoing effort to make psychotherapy more effective, attention has mostly been placed on aspects that should be included. Among these are transference, counter-transference, safety, reliability, relationship, attachment, mindfulness, caring, and attunement. While all of these are important, and we do attend to them, what we will explore here is a complementary perspective. The goal of increasing the effectiveness of a process is often most directly and fruitfully accomplished by identifying and eliminating obstacles (McKeown, 2014). Our perspective going forward here will be to examine some of the constraints and obstacles to the therapy process as it is commonly practiced.

Aside from the effects of trauma per se, our perspective is that many of the issues people bring to psychotherapy are the result of developmental disruptions. These disruptions do not happen in a sudden and dramatic way like trauma, but result from the daily drip, drip of misattuned connection with our caretakers. Developmental

disruptions generally affect the motor, mental, and psychological abilities coming online for the child at that time. The resources or abilities that would have allowed a child to resolve an issue or move through a related developmental stage in a healthy enough way were not available or not accepted. As opposed to experiences of trauma, which are primarily imprinted in the autonomic (involuntary) nervous system, the developmental disruptions we work with are primarily imprinted in the voluntary nervous system, in the elasticity of the psychologically related muscles, and in the corresponding implicit understanding in the mind.

As opposed to experiences of trauma, which are primarily imprinted in the autonomic (involuntary) nervous system, the developmental disruptions we work with are primarily imprinted in the voluntary nervous system, in the elasticity of the psychologically related muscles, and in the corresponding implicit understanding in the mind.

The ensuing protective behavior of the child, their attempt to preserve some measure of connection with themselves and with caretakers, is organized by unconsciously modifying these same abilities. To these ends, the abilities may never be learned, are given up (resignation), or are held back. Common results of disruptions include fear of abandonment, not trusting others, giving up sensing our needs, not expressing our impulses, primarily taking care of others and not ourselves, etc. These are aspects of the processes of self-regulation and co-regulation in the vagaries of childhood development. The resulting protective behaviors, once adaptive, are later in life the source of many contemporary issues.

Let us examine the origin of a common example of possible disruption: that of an infant being fed in a highchair. When the child senses they do not want more food right then, one of the ways they signal is by pushing the spoon away. If this action—the use of the triceps muscle in the back of the upper arm, is repeatedly respected by the caretaker, the child will learn that they can express needs and set limits. If the action is repeatedly overridden, the child may not learn to set limits, or might learn to set them rigidly. These outcomes will be imprinted in the voluntary nervous system, in the elasticity of the muscles involved, and in the mind.

Then, later in life, the person often might not be aware of their limits, or they may act rigidly about their limits and needs. This will likely show up as a problem in their relationships, especially intimate ones. When that disruption, an unconscious yet chronic way of behaving, is addressed in therapy, using the triceps muscle in an expressive way can develop a new ability to set practical limits in present-day situations. The same action also provides access to the emotional history of the issue being worked with. While this is only one example, a similar process is also true for each of the multitude of motor and psychological abilities arising as children develop. To continue our exploration, we can ask how the concept of developmental disruptions

can be used to explore the process of psychotherapy. How will it help us to recognize where constraints and obstacles to the process may arise? We can begin by formulating a *minimal statement* of the effects of these non-traumatic disruptions on childhood development. Complexity can always be added to this formulation, if and when it is felt to be needed. This minimal statement might be something like: “Developmental disruptions result in internalized constraints. These constraints affect the child’s, and later the adult’s, access to certain mental, psychological, and motor abilities, and also affect their relationships with other people.”

**Developmental disruptions result in internalized constraints.
These constraints affect the child’s, and later the adult’s,
access to certain mental, psychological, and motor abilities,
and also affect their relationships with other people.**

This statement on the results of developmental disruptions suggests that since the limited availability of a related resource or capacity is the origin of many issues presented by our clients, it is also one of the main contemporary obstacles to resolution of those issues. Thus, identifying the needed resource, and gaining access to it in the present, are necessary steps in eliminating this constraint. And further, that the most direct healing procedure may likely involve learning or accessing these abilities, while working on that issue in the context of a positive relationship. This change in our view of psychotherapy also correlates with an earlier insight that psychological problems are generally not solved; they are more often resolved. Something in a person has changed. The task then is to explore how we can most positively and directly access the changed state.

Not by coincidence, the modality we practice, Bodydynamics somatic developmental psychology (Macnaughton, 2004), is based on a wealth of empirical research related to this task. The work of the founders empirically correlated psychological abilities coming online at specific ages with specific muscles as they come under voluntary control (Marcher, 2010). The Bodydynamic model of “seven developmental stages” is a detailed account of the interaction of childhood motor and psychological development (Bentzen, Bernhardt, Isaacs; 1995-1997). It describes what healthy (resourced) development looks like, as well as the effects of disruptions that occur earlier or later in each stage. In practice, we can use this empirical knowledge to reasonably relate most psychological issues to their developmental stage of origin. By focusing on the developmental origins of the *issue*, we avoid any (historical) tendency to “characterize” the client. (Most clients have issues from a number of stages.) Once we know the developmental stage, the Bodydynamic system helps us to determine, in the moment, which related abilities are not available to this client. The expressive use of the muscle corresponding to a missing ability now provides access to learning or releasing that missing but needed ability. We can then follow the client’s process, without having an endpoint in mind.

A Case Study

To make our exploration more concrete, we will first present an actual therapeutic experience. Here is a vignette of the first session of a client who came to get help with how her very busy life seemed to be in charge of her. She is a high-functioning corporate lawyer, and has a lot of energy and creative impulses. However, as she keeps talking about her problem, her shoulders start to sink a bit, and her chest collapses a little. I note that this could be an indication of a collapse from a developmental time when the child is between two to four years old. She talks about a particular work project that takes a tremendous amount of energy, but is not gratifying, even though it had been so in the past. We make an agreement to explore her response to this unsatisfying project. It turns out that once she takes something on, she really does not know how to stop doing it, especially if others depend on her to continue. This response is quite common in someone who has a disruption in the time between 2-4 years. She has already told me about other frustrations with people expecting her to be the dependable one. She is now using her body in an unconscious way. At this time, I am aware that if she could consciously use these same muscles to support the change she desires, an obstacle could be removed.

She then mentions that in her early childhood, when she was 2 years old, she had also stepped into the role of helper, after her mother had a late-term miscarriage and became sad and withdrawn. As she talks about this early experience, the support muscles in her back let go more, and her body further collapses around her shoulders and chest. I ask if she recognizes what has happened in her body with this collapse, but of course it was an unconscious process. I speculate that this early time might be when she first learned to take on big tasks and care for others. I teach her a bit about how the body is developing at that age, and how the child is learning to assert herself and develop her own authority. I recognize that this collapse is a disruption in the Will Structure, ages two to four. We also talk about the altruistic response that can manifest at that time — when her mother became so withdrawn. She began to be a caretaker in a loving way, and has not been able to step out of that role.

I also share how moved I am by how hard it must have been to be so little and have her mother be so sad. She says she never thought about that or felt it, because her mother and father were so in need of help. With this relational support, she begins to feel her own pain, and deep sobs emerge. She then begins to have compassion for this early unconscious role she took on. The obstacles of not knowing how this behavior began, of having taken on a role without being able to stop it, and of being alone in this experience are being addressed. We often find that this didactic explanation of how ruptures specifically impact a young person, when told with compassion for the child, helps people to have compassion for themselves. This is also helpful in removing obstacles of frustration, blame, or shame related to the unconscious behavior the person wants to change.

I show her how muscles in her shoulders and back are active today in taking things on unconsciously. At ages 2-4, children are also getting stronger and often play by carrying or pushing heavy objects from one place to another. To do so, they use the same muscles in their shoulders and middle back that are involved in her present-day collapse. People

who get stuck in this role need help to shake off the burden of unconsciously carrying things for others. When she makes the movements that would help her with that, she feels more energy.

I explain that children in this developmental stage can for the first time make choices and plans, and follow their intentions. For the first time, they can also change directions and decide to do something different. (The preceding developmental stage is driven by impulses, without planning.) Another indication that someone has a rupture from age two to four is that it is difficult for them to change direction once they get going. I show her how certain muscles around her center and some in her lower leg and foot activate movements that can support that behavior. We take our time exploring these specific movements. Later, we go back to her present-day situation. I have her work with a movement of her shoulders to throw off the unsatisfying project at work. By not automatically carrying a burden, she has more energy to explore what would make her happy. We then work with changing direction to find what would be more satisfying for her now. Towards the end of the session, she looks and seems more alive, with energy available for herself in a different way. She says, "I feel free to let go of this project and do the ones that make me feel more alive!" I encourage her to practice using these muscles at home and at work to support herself when she changes direction, and to tell others what her new choices will be.

What we are seeing here is that when the appropriate ability is stimulated or released, in the context of a supportive and caring therapeutic relationship, the client often quickly attains a new psycho-social competency related to the issue being worked with. And our experience is that this competency is often stable and lasting. It was so in her case.

**...when the appropriate ability is stimulated or released,
in the context of a supportive and caring therapeutic relationship,
the client often quickly attains a new psycho-social competency**

Establishing A Different Framework

Now let us examine in more detail the obstacles and constraints we have recognized over time in our work, and the actions taken to remove or reduce them. One possible constraint on the therapeutic process can arise from the habitual way a session is begun. Does the client passively wait for the therapist to speak? Do they go into a protective, "reporting" mode? Do they say what they consciously or otherwise believe we might want to hear?

One way we have found to set a different framework is generally to start by discussing what the client would like to work on in this session. Clients often know what they'd like to change in their daily life, and we know ways to directly access new abilities and to initiate changes. We then ask for examples of how the issue they bring up is affecting them in their present life, and use these examples to help discern the change they desire.

Together, we form an agreement to work on that in this session. This agreement helps to focus the work and minimize diversions. (In this process we can also affirm that any issues or aspects not chosen now are possible choices for a later session.) By forming this agreement we have both decreased their dependence on us and moved towards collaboration. Additionally, by primarily focusing in the present we minimize bringing in provocative history that can more readily stimulate protective behavior. The past can be brought in if and as needed.

Forming an agreement with a client is one step in focusing our work. As we continue now to explore other possible constraints and obstacles to the process of therapy, we also attend to the back and forth of working with process versus working with the structure entailed in our Bodydynamic modality. How much are we initiating, and how much comes from the client? We can then attempt to balance the two. The agreement of what to work on is a process that originates in the client's perception of their life. How much are we then influencing/limiting the client's experience by locating the issue developmentally? The muscle we might ask them to use is a response to our observation of their process, of what is missing as we explore the issue. By broadly containing their process, we are simultaneously facilitating their ability to resolve the chosen issue.

As therapists, we are aware that another primary protective mechanism is a client's wandering, diverting, or simply avoiding an issue. To deal with this type of obstacle, we endeavor to circumscribe the area in which we work with the issue agreed upon, to contain it. Over time, this has led us to a sense of the elements most frequently employed in successful sessions. We were then able to form a model for what we now call a "developmental container." The first element of this container is the agreement (discussed above) made about what we will work on. Another part comes from the detailed knowledge of physical and psychological development available in the Bodydynamic system. As mentioned, this enables us to recognize verbal, physical, and psychological patterns characteristic of the specific developmental stage in which this disruption of an ability most likely first occurred. We gather this information with respect to the issue chosen, and from our observation of the client's physiological, verbal, and emotional presentation. It is then generally possible to keep our work on a particular issue focused in one developmental stage. In this way, compensating abilities from other stages are less likely to be accessed. This containment promotes a healing of disruptions in the developmental context in which they were formed. We have found that this leads to a fuller and more rapid integration of new behavior into daily life.

As we build the developmental container, all the elements (to be described further) act together to limit the client's unconscious attempts to use protective behavior from other stages, ones that could divert or defocus the work. The most direct element in forming the container is the expressive use of muscles from the related developmental stage. Once we have a good sense of this stage, we can then focus on identifying the muscles involved.

With our knowledge of the abilities that are embodied during a healthy (good-enough) experience in a given stage, we can sense and perceive when abilities are missing in a client's verbal and physiological presentation. These missing abilities often correlate with visible physiological collapse or rigidity of the related muscles, and with the psychological counterparts of these. Familiar examples of some of these psychological

functions are grounding, centering, support, self-regulation, self-assertion, energy management, as well as interpersonal skills. Each of the functions are correlated with specific muscles in different developmental stages, and each can be expressed with more precision as the child grows through the successive stages.

As the session unfolds, the client often begins to use some of the muscles from the developmental stage where the problem originated. We may then see more clearly whether the response is collapsed, held back, or resourced. Then, at an appropriate time in the context of our verbal exchange, we can have them expressively activate the relevant muscle in a way that stimulates the needed ability (if it has not been learned or was resigned), or releases it (if it has been held back). (Generally, this work can be done with or without touching the client.) Using the right muscle at the right time brings forth the very abilities whose absence led to the developmental disruption. This relieves the therapeutic constraint of the needed ability being missing, and helps a person to be released from the effects of the past. Clients are often very surprised that using a specific muscle can have such a profound impact.

**Using the right muscle at the right time
brings forth the very abilities whose absence
led to the developmental disruption**

One type of intervention we do emphasize is the tracking of small, sometimes momentary physiological, energetic, and contact changes. These are not just signs of trauma (Rothschild, 2017; Porges, 2018), but also of developmental disruptions. These include changes in a client's eyes, skin color, breathing, tone of voice, and the tone of particular muscles. These small changes are often below the person's conscious awareness, and can easily disappear. They are indications of some deeper sense of self-emerging, or a response to connecting that can be unconscious. As such, they offer a tremendous opportunity for change, as they are moments when the unconscious visibly appears, either as protection or as a new resource. At these times, we work with our client to sense and support a new resource, or to see if they are willing to explore a possibility that is different than their usual protective response. Not taking full advantage of these moments needlessly limits the process of psychotherapy.

Another concern in psychotherapy is safety, attunement, and our relationship with the client. Historically, the degree of safety and attunement that was available to them as a child is a factor that can lead to attachment disruptions or developmental disruptions in a given area. To the extent that a client has historical expectations of difficulties in relationship, there can be a corresponding constraint on their trust in the relationship with us, and to their surrender to the therapy process itself. While there are many ways to build a positive and empathic relationship, using the body offers some special opportunities. Our use of a specific muscle while working on an issue will also regularly bring up themes, feelings, and memories from the related stage. By affirmatively relating to the client around these, we demonstrate that we are familiar with the issue and their

experience of it, and that they will not be addressing it alone. We also simultaneously strengthen containment to the developmental stage in which we are working. In this new context of support and a caring relationship with us, a client's experience of these newly available abilities helps them to move past the historical constraints of "I don't know how", "I'm not able to", "I'll be in trouble if I do", "Something bad might happen", etc.

In addition to giving emotional support verbally, we may choose to give physical support. When appropriate, this is done by touching a muscle on the shoulder or the back, one that is related to support from the developmental stage being worked on. This new sense of support reduces a client's vulnerability to overwhelm, helplessness, or resignation, wandering, or other forms of protective distraction. As a client becomes able to take in this support, they can learn to generate this experience by voluntarily engaging that muscle. Further, our support and encouragement can facilitate the spontaneous expression of emotion. This can reduce their holding back of energy. A client's experience of self-support and support from us, together with this newly available energy, gives them access to more choices, more behavioral options. It also enhances their emerging experience of competency, of "I can do this." The once-sensed need for a protective response is diminished, and new and flexible behavior is felt as possible and appropriate. The constraint of not knowing how, or of not feeling able to, has been removed.

This new sense of competency enables clients to respond more flexibly and expressively, with more choice in the present. One session that illustrates this well comes to mind. I was working with a client on how she wanted to stop letting herself be talked-over by men during group meetings at her office. After giving support and working with muscles having to do with assertion and setting limits, I felt it might be empowering to have her express her feelings more forcefully. I gave her a thick cushion to place on her lap and asked her to hit into it and to speak forcefully, as she imagined being at such a meeting. She looked at the cushion, looked at me, threw the cushion on the floor, and calmly said: "I will not ever let them speak over me again!"

Meta-processing

The presence and reality of these new competencies, of these changed states, can be further anchored by client and therapist talking about the experience, i.e., meta-processing (Fosha, D. 2011). This dialog directly addresses the obstacle of change seeming like a lonely and possibly ephemeral process. For example, we might ask how they feel different now from when we started the session; or we might discuss how it was to share the experience with us; or how the new competency might be used in different areas of their life. This exchange activates other aspects of the brain, ones related to sharing and to acknowledging relationship and change. This top-down integration compliments the bottom-up experiential changes that have occurred. Meta-processing can also reduce self-questioning about the reality or the lasting ability of the change. And it can bring to awareness nascent competencies in related areas. All this helps a client to bring the changes into their daily life and anchor them there. Finally, the experience of change in a short time relieves a possible concern that change is too difficult, or not really possible.

In Summary

In summary, we have reduced or eliminated many of the obstacles to somatic psychotherapy by:

- Collaborating with the client to find the issue to be worked on, so as to avoid unconscious habits.
- Working with present-day examples of the issue to minimize evoking the past.
- Recognizing the developmental stage in which the issue likely arose, and keeping the work focused in that stage so as to minimize the use of protective responses from other stages.
- Using specific muscles from that stage to bring forth the needed but missing abilities.
- Using support muscles from that stage to reduce overwhelm and wandering.
- Supporting our relationship by using the themes from the stage in which we are working, to avoid weakening the developmental container.
- Using meta-processing to diminish any tendency to suppress or forget the new competency.

Our newer understanding and elimination of obstacles to the therapy process has allowed us to accept, and even expect, seeing significant and lasting changes in people, changes that often happen rapidly. And we look forward to eliminating further constraints to the practice of somatic psychotherapy, asking ourselves questions like: “How can we help clients to not ...?”, or “Instead, why don’t we try ...?”.



Anne Isaacs, LCSW, has taught body psychotherapy for thirty years, and practiced body psychotherapy for over forty years. Anne specializes in the integration of attachment theory, developmental disruptions, and somatic development. She helps people develop new resources that change old somatic, relational, and emotional experiences. She is a Bodydynamic Analyst who has trained with Diana Fosha, Mary Main and Erik Hesse. She is a founding board member of the United States Association for Body Psychotherapy, and has been on the adjunct faculty of Santa Barbara Graduate Institute, and lectured at CIIS. She has a private practice in Los Angeles, CA, USA.

E-mail: aisaacs@bodydynamicusa.com



JOEL ISAACS, PhD, has practiced body psychotherapy for forty years and trained other therapists for over thirty years. He has written and coauthored eight articles published in somatic journals, and was on the adjunct faculty of Santa Barbara Graduate Institute. Joel trained in Bodydynamic Analysis to the Analyst level and then became a trainer. For the last ten years he has worked with his wife Anne to develop *Healing Developmental Disruptions*, a modality that trains practicing therapists to rapidly begin using some of the depth and power of the Bodydynamic system. His scientific background and passion for improving trainings has also spurred development of ways to make somatic psychotherapy more effective. He is in private practice in Los Angeles, CA, USA.

E-mail: jisaacs@bodydynamicusa.com

REFERENCES

- Fosha, D. (2000). *The transforming power of affect*. New York, NY: Best Books.
- MacNaughton, I. (2004). *Body, breath, and consciousness*. Berkeley, CA: North Atlantic Books.
- Marcher, L., and Fich, S. (2010). *Body encyclopedia*. Berkeley, CA: North Atlantic Books.
- Bentzen, M., Bernhardt, P., Isaacs, J. (1995 -1997). Waking the body-ego – Parts 1-4. *Journal of Energy and Character*; Vols. 26-28.
- McKoewn, G. (2014). *Essentialism*. UK. Random House.
- Rothschild, B. (2017). *The body remembers: Volume 2*. New York, NY: North Atlantic Books.
- Porges, S. (2018) *Polyvagal theory in therapy*. New York, NY: W. W. Norton & Co.