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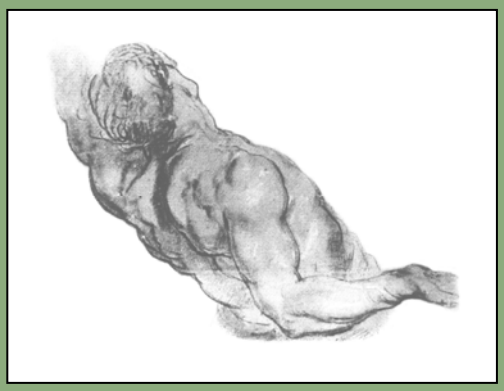

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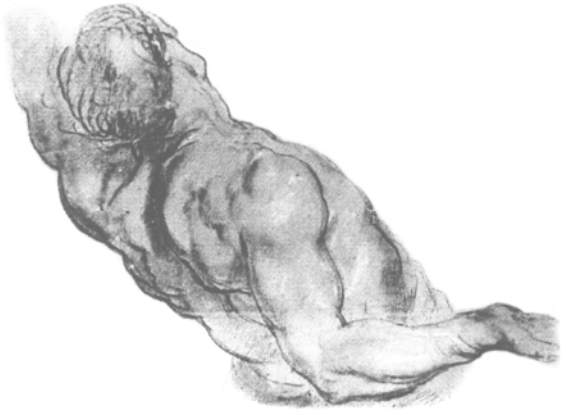

USABP Mission Statement
The USABP believes that integration of the body and the mind is essential to effective psychotherapy, and to that end its mission is to develop and advance the art, science, and practice of body psychotherapy in a professional, ethical, and caring manner in order to promote the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

Relational Living Body Psychotherapy: From Physical Resonances to Embodied Interventions and Experiments

Julianne Appel-Opper

Abstract

Many of the concepts of body-oriented psychotherapy concentrate on therapist awareness of a client's bodily sensations. The focus of this article is the important role of the *therapist's* physical resonances. In their ongoing nonverbal communication, therapist and client co-create an embodied field in which both relate with and refer to one another. Examples from my clinical work demonstrate the way in which such resonances can be developed into embodied interventions. This "Living-Body-to-Living-Body Communication" can reach and access implicit relational knowledge, empowering both healing and change.

Keywords

Physical Resonances – Embodied Interventions – Living-Body-to-Living-Body Communication

Clients bring their pre-verbal implicit relational knowledge with them into our consulting rooms. The way a client enters the room, looks at us, sits, moves, and gestures tells us about their relational rhythms and melodies. Their bodies broadcast the stories of how they were looked at, held, and touched; whether they were comforted and supported or abused and mistreated. The living body communicates in a certain language: a still shoulder, a look away, a gasp for air, or a slight movement says something. We as therapists physically react to these embodied stories. They reach us skin-to-skin, heart to heart and muscle-to-muscle without much cognitive or reflective process involved, and unintentionally we react. We react with tiny movements: we lean back, we hold our breath, we become tense and look away, or suddenly feel cold. I firmly believe the subtle physical resonances of the therapist also broadcast something to the client. This motivated my exploration of the ongoing embodied communication between therapist and client, the main focus of which was how to bring this rich and often unnoticed communication into awareness in the therapeutic space.

What follows is a body-oriented approach to psychotherapy which I have termed "Relational Living Body Psychotherapy" (RLBP).[1] I have published several articles on this approach in Britain (Appel-Opper, 2008a, 2008b, 2009) and am pleased to have this opportunity to present it to colleagues in the U.S. Many concepts of body-oriented psychotherapy focus on awareness of bodily resonances and sensations in the client. The therapist's physical resonances, or reactions, such as subtle changes in postures, gestures, and movements are mainly used for further information on the client (Joyce & Sills, 2001), or are viewed as physical counter-transference (Soth, 2006). I believe it is not enough to bring the therapist's and/or client's physical resonances into awareness. It seems more effective to develop embodied interventions, which then act as a healing Living-Body-to-Living-Body communication. I view this non-verbal communication between therapist and client as a co-creation, in which both relate and refer to each other. The embodied stories of the client co-create bodily resonances with the therapist, which in turn co-create further resonances with the client. In RLBP, the therapist brings her/his own physical resonances into the therapeutic space, thus affirming body-to-body the stories of the client's body broadcasts. This is an important part of RLBP because it encourages the body of the client to continue to speak. The stories are confirmed in a safe and mindful step-by-step process. Embodied interventions and experiments/exercises are then co-created within this bodily field between therapist and client. By remaining receptive and present in body, the therapist can monitor how her/his interventions bodily impact the client.

The Bodily Sensations/resonances…

As a Gestalt psychotherapist, I root myself in the phenomenological method of inquiry and field theory. I make a conscious effort to slow down so that I can sense how I am in my body in the moment, trying to be aware of my own rhythm and melody so that I can clearly hear and receive my client's own rhythm and melody. It is as if I am slowly descending a staircase that leads me deeper into my body and the relational embodied communication of my client and myself. In that space I am able to listen to the stories the body of another wants and needs to tell and share. I hear the echoes and sense the shadows of related somatic patterns from contacts of the past.

Merleau-Ponty wrote that only as lived bodies are we in the world ("e*tre-en-monde"*,1945/1974). I agree with Kennedy (2003) that "the phenomenal field as the lived body is part of phenomenology and carries all the richness and promise of what we call field theory" (p.76). Schmitz (1989) focuses on milieus and atmospheres in the body and draws attention to the fact that "felt perception is not a reception of signals but a lived body communication and incorporation" (p. 13, my translation). His alphabet of the living body inspired me to explore sensations further. In one exercise, I ask participants at my workshops to look out for a "narrow" space in the body. I then ask for a "wide" space in the body. I suggest staying on a phenomenological level and not analyzing, having them simply describe in respectful and non-shaming terms. From my experience this kind of vocabulary helps the participants to widen and deepen their sensations and allows them to be impacted

and "impressed" by the stories of another body. In another exercise I ask two participants to let themselves be impressed by the "grace" of the other body as they sit together in quietness (Appel-Opper, 2008). This exercise is useful to sharpen the sensitivity of the subtle non-verbal communication between two bodies. In this connection I teach the metaphor of the anchor. I agree with the sentiment of Gilbert and Evans that therapists need to be anchored in their thinking so that they can hold onto a meta-perspective as they let themselves be deeply physically impacted and impressed by another body (2000). Examples of a bodily resonance could be cold hands, a headache, tension in the forehead or spine, holding one's breath, getting dizzy, or feeling chaos in the body.

Within the Gestalt tradition, there have been several contributions to bringing the body into the heart of psychotherapy **(**Clemmens & Bursztyn, 2003, Clemmens, 2010, Frank, R. 2004, 2005). James Kepner, one of the pioneers of physical process work in Gestalt, has introduced metaphors based on rich clinical experience (Kepner, 1987, 1995, 2003). He writes of the therapist's role in creating and holding an embodied field instead of merely talking about body experience. He has influenced authors such as Tervo (1997, 2007) who further refined and developed his work. In vignettes of her work with children and adolescents, Tervo describes how she experiences herself as an improvisational dancer, learning to listen to the "natural beat" of the child (p.78). The reader gets a sense of her bodily presence: her observation, imitating, mirroring, and staying in the embodied field, creating games which give the child the opportunity to breathe and move. This allows the child's body to structure, enliven, and defreeze.

… Are Co-created and Refer/relate to Each Other

During the years I lived and worked in Great Britain, I became fascinated with Dialogical Gestalt Psychotherapy and Relational Psychoanalysis in theory and in practice. My experiences coupled with the study of related texts opened my horizons.

Dialogical Gestalt Psychotherapists discuss what they refer to as the "between" of a healing dialogue, wherein therapist and client share meanings and phenomenology (Hycner, 1991; Yontef, 1988). Parlett (1991) points out: "through creating a mutual field each of us is helping to create other's realities" (p. 76). Personally, I wish to apply these concepts to *non-verbal* physical communication between therapist and client, as they also co-create one another's *physical reality*. For example, clients broadcast and transmit their embodied stories in the way they hold their breath and lean forward. We might not consciously notice this but our own bodies will physically respond to it. We may react by leaning forward as well, or by leaning back. At the same time our breathing rhythms can be impacted. These tiny reactions also broadcast and transmit something to the client's body: we convey to the other that we are getting a glimpse of the world the client has experienced. In this way we share *physical meaning*.

The following metaphors from psychoanalytical thinking can also apply to the living body. Bollas' (1991) metaphor of the shadow of the other also illustrates how all experienced relationships continue to live and leave shadows in our bodies. Bollas writes of an "unthought known" which I would describe as an *unsensed known*, that lives in the body waiting to be heard by "some-body". From a Living Body perspective, Tolpin's (2002) concept of the growing edge transference can also be seen as a hopeful, healthy striving of the body that one day another body will be able to listen and see the invisible.

Relational Psychoanalysts are currently developing their concepts from a stance of inter-subjectivity to a focus on two bodies in relationship. I have been inspired by authors like Aron (1998), Harris (1998) and the Boston Change Process Study Group (2008), focus on relational perspectives on the body and and bodily based communication. Also impressive are how Gestalt concepts such as Field, Gestalt, and working in the Here and Now play a role in this literature. Beebe and Lachmann (1998) conclude it is the task of the analyst to "read the non-verbal communications" (p. 501) which they view as organized self and interactive affect regulation, mutually co-constructed by therapist and client. Aron (1998), focuses on bodily communications in which "the analyst must be attuned to the nonverbal, the spirit (breath) of the session… and his or her own bodily responses" (p. 26). He adds that analysts "need to convey their visceral understanding of the patient" (p. 29). Beebe and Lachmann (1998) point out, that "subtle nonverbal communications are particularly powerful because they occur in the here and now of the interactive matrix" (p.501). For additional discussion of the significance of attending the implicit embodied communication between therapist and client, see for example Anderson, F.S. (1998, 2008), Balamuth, R. (1998), Knoblauch, S.H. (2005, 2008), Nebbiosi, G. & Federici-Nebbiosi, S. (2008), Petrucelli, J. (2008), Stern, D.N. (2004).

LaBarre (2008) provides us with a case study which includes such a nonverbal encounter between therapist and client described in minute detail in a" kinetic text". I agree with Jacobs (2008) that such articles bring gestalt therapy and contemporary psychoanalysis to points of convergence. In this connection I would like to mention Denham-Vaughan, (2005) who focuses in a recent article on the shift in gestalt to a relational aesthetically orientated approach that increasingly works with structures of ground. Such a style of developing gestalt therapy further is close to my heart.

Now that I am back in Germany I have started to read the recent German literature on body-oriented psychotherapy. I am happy to have found texts by colleagues describing how they integrate body processes into their work. I cannot quote all of these rich texts, but wish to mention the following authors with whose work I feel a certain connection: Bauer,H. (2006), Downing, G. (2008), Geißler, P. (2008), Geißler, P. & Heisterkamp, G. (2007), Korbel, L. (2008), Poettgen-Havekost, C. (2004). Thielen, M. (2009), Volz-Boers, U. (2007, 2008), Worm, G. (2008)

… And Can Be Refined Into Embodied Interventions

This next section includes some examples from my clinical work which demonstrate how I bring my physical resonances into the therapeutic space and develop embodied interventions. The spot light is not on the client alone, but on the bodily relation and referral between the client and myself. Together, therapist and client co-create a "Relational-Living-Body-to-Living-Body Communication" in which healing and change can take place.

Ants All Over the Body

I remember a female client, Mrs. S., whom I saw at a psychosomatic clinic in Germany. She started talking as soon as she walked into my room. She talked and talked; after a few minutes I felt as if I were sitting in a rhythm of chaos and anxiety. My head felt dizzy, my hands cold, and I felt as if I could not breathe. To say something I had to interrupt her, so I started to lift my right hand as a sign that I wanted to have a word. This enabled me to gradually express my sensations. I told her about my cold hands and how my body did not have enough space to breathe. I can still see her immediate glance at her hands. It seemed as if she noticed them for the first time.

In the sessions that followed, we focused on her hands and her experience that she "did not feel them". We discovered that it was hard for Mrs. S. to "focus on anything", so I asked her to touch her own hands and try to concentrate on just that. We decided that I would simultaneously touch my own hands. In one of these sessions she came up with the image of ants running all over her body, the floor, and "everywhere". As she explained the image, I noticed her shoulders had moved up slightly and her arms seemed to be hanging there lifeless. At the same time, I sensed an impulse to move my own arms. From these ongoing relational bodily communications, we gradually created an exercise utilizing this ant image, with her moving her arms and hands as if she were gathering the ants. Mrs. S. expressed her enjoyment of this exercise. It looked as if the movements unfroze her shoulders and arms while structuring them. Mrs. S. also started accompanying the movements with phrases like: "it is alright now, calm down". In the following sessions we noticed how her breathing rhythm had changed, and that she was able to gather her thoughts more. We both recognized the connection between her mother, whom she described as "pure chaos" and "all over the place", and the remaining chaos in her body.

As I reflect on the session, I note the strong reaction of raising my arm to say something, which I had never done before and have never done since. This embodied intervention had conveyed something to the client. I believe my arm had received the stories transmitted by Mrs. S's arms and had acknowledged this from her body to my body. This encouraged her body to continue to express what was unspoken.

The Pain Finds Words

Recently in Germany I worked with a client Mrs. V, 50, about my age. She came to see me because of "chronic pain and anxieties around her body". After some time we focused on her anxiety of developing breast cancer. She had just gotten her regular scan and received the good news that she did not have cancer. As I sat with her, I had a sense of tension in my chest. From the corner of my eye I could see she was hardly breathing. I asked her what her breasts had experienced in her life so far. Immediately she replied that she had not been able to breastfeed her son, and that the recent experience at the clinic had been awful, adding how the nurses in the "old GDR hospital" had been ignorant. As I listened to her experience, I sensed a tension and heaviness in my breasts. I then noticed that I wanted to hold my breasts as if they were in pain. I expressed my sensations and my need to hold my own breasts, explicitly asking her whether this would be OK to do "amongst women". Her "yes" came promptly and clearly, so I crossed my arms and cradled my breasts in my hands. I made these movements slowly so that I could monitor how my client's body would take my intervention. Seeing me like this made her cry, and I encouraged her to express herself fully. Later I told her I had felt as if her breasts had been left at this hospital. She nodded, and I asked whether it was time to take them back. The subsequent sessions revealed that she had treated her breasts as if they were still in the clinic and not really part of her body.

I agree with Soth (2006) and Landale (2002) that working with clients who have had to objectify their bodies is challenging. Landale (2002) states: "most people have complicated relationships with their own bodies" and "that embarrassment, shame and fear of the body are common" (p.120). In my workshops I teach how we can find interventions that honor the body for what it has done in terms of creative adjustment. Interventions can be self-touch and communicating to the body as in the example of my clinical work with Mrs. V.. At the same time, the bodily impact of the intervention can be monitored, and if necessary, negotiated between therapist and client. How the body is spoken to and the words we use are of great importance. From my personal experience I have gathered there is a huge difference between addressing the client's shoulder as "tense" versus "still". In workshops I use the metaphor of "a window opening". The words we use may directly reach the child who had to come up with creative adjustments, but they may also burden the client by adding to the weight that is already there. By this I mean the weight of guilt, embarrassment, self-hate, shame etc. Following is an example of how this can develop in the clinical situation.

Embodied Messages to the Forehead

I remember the following scene from one of my workshops. B., a colleague, told the group how she did “not have any relationship with her own body”, and that her mother had “controlled everything”. As she spoke I noticed a tension in my forehead, as if the area was under some pressure. At the same time, I saw that the skin of B.’s forehead was paler than the rest of her face. Her eyes also seemed a bit watery. She was nearly crying, but I noticed she screwed up her eyes and tried to continue to talk. I kept looking at her, feeling the pressure and tension in my own forehead. I felt like I was on thin ice. With this embodied co-created message in the field I decided on a tactic of intervention. I said something along the lines of: “as I sit with you and listen to what you are saying, I feel an impulse to touch my own forehead.” As I said that I looked out for physical signs of how B. would take in what I had just said. I focused on her breathing, the tension in her body, her eye contact and the paleness of her skin. I gathered from the signs that the intervention had reached her body; the rhythm of her breathing slowed slightly and she looked at me openly. She immediately said yes, that this would be fine with her. I slowly and mindfully stroked my forehead very softly as if my hand caressed my forehead. I let my breathing flow in a regular rhythm and watched her body, especially her forehead and her eyes to see how this intervention impacted her. Immediately I saw tears form, her lips move, her mouth open a bit and a distinct presence of sadness. I watched carefully to check that she was supporting herself by breathing regularly.

B. later told me that she wanted to touch her own forehead. As she did so in a soft, gentle way she talked about how she had learned not to show feelings, as this had been “dangerous” when her mother was around. I added that it was good her forehead had been able to learn to hold these feelings inside. I noticed that she let out some big sighs, which I encouraged and joined her in doing. While we both were sighing, I started to feel more at ease as if the thin ice had turned into much more solid and trustworthy ground. She looked different than she had at the start of our work. Her skin looked less pale and her eyes were under less pressure.

We later talked a bit about what had happened. Another participant said she had felt relieved that B. had been able to let go a bit. B. shared how her regular headaches now made sense at a different level. It became clearer how B. had felt shamed by her mother. Previous experience has taught me that old patterns are often associated with feelings of shame. Sometimes there is an expectation of being shamed, which keeps the window of the body closed.

The Body under the Stone

The participants of my workshop had done an exercise in pairs. Before moving on I looked around to see how people were doing. I noticed that one of the participants, A. was looking down at the floor and that her body seemed heavy with a downwards movement. I had known her for some time, as she had already been to my workshops, and I had seen this before, but not at this intensity. A. then moved her head up and looked at me with a mixture of hope and fear. I felt drawn towards her and was full of curiosity. I inquired whether it was all right if we focused on her a bit longer. She agreed, and I sensed I was very touched by how she appeared at that moment. Somehow my head wanted to analyze and understand what had happened to her during the exercise. When I questioned how she was feeling now she answered she felt "shattered, like under a stone.” I noticed her eyes looked sad and she was supporting herself by rounding her back again. I empathized with her, feeling crushed and somehow down there too. I started to sense an atmosphere of heaviness, darkness and resignation. This felt like deadening oneself. Then I thought: “this is old bullshit”, and decided to risk expressing this. I felt the strong urge that somebody had to say that this was “old bullshit”, and how it had been for her in the past. I remember saying this in a clear voice, trying to reach out to somebody inside her who wanted to face this creative adjustment from the past, or a young A. who had to learn to deaden herself. I kept on looking at her as if my eyes could tell her: “come on try, let us try”. Moving my head slightly up I asked her whether this old bullshit had to stay or whether she wanted to create something new together with me. A. answered yes. A. was somehow imprisoned in this old creative adjustment she had developed in order to survive. Her spine was held down, her breathing shallow, her chest closed and her perception narrowed.

I asked her to lift herself a tiny bit, which she did. As she did this I noticed that my eyes wanted to look away from her. I told A. about this sensation and checked with her how it would be if I were to look at her. She told me she had trouble being looked at. My response to this was quick and clear: I told her I would close my eyes so that I could not look at her. After I had kept my eyes closed for a few minutes A. told me that she wanted to stand up. I remember that I asked her whether she was standing since I could not see her. She answered “yes” and I recognized that her voice came from a standing position. I then also lifted my head more and let my spine move up a bit. and waited. Nothing seemed to be happening, so I asked her again: “Do you want me to look at you?” and heard a quick yes in response that sounded like an automatic answer. I invited her to check with all of her A.'s available: little A, the counselor A. etc. and what the reply would then be.

There came another “yes”, but this time her voice sounded much softer and younger, as though it came from a little girl. In trying to address little A. I asked her: What needs to happen so that this little A. can be looked at? She answered that she was afraid of having to leave the room, of being thrown out. With eyes still closed I asked somebody to stand in front of the closed door to make sure that nobody would be able to throw her out. I noticed how serious my voice sounded and that I gave very clear instructions. I remember that I checked that there was really somebody standing in front of the door. Then I asked her again: What needs to happen so that little A. can be looked at? Immediately she replied she was afraid that somebody

could shout at her. I took a deep breath and decided to ask another participant to stand behind her and cover A.'s ears without touching them so that these ears could not be shouted at. With my eyes still closed and not seeing what was going on I felt the need to check with A. again. She expressed she wanted somebody to hold her hand, which another participant did. At this moment A. told me I could open my eyes. When I did, I realized I had a few tears in my eyes. She noticed this and I saw her take it in. I reminded her to continue breathing and support herself through it. At the end I thanked the participants who had taken part in our work and doing what I had asked. Someone remarked I had only passed on what little A. needed from them.

In this powerful piece of work I decided to move under the stone and from there I encouraged her to move away. As I had my eyes closed I experienced how it must have felt to be under that stone; dark, lost, and alone, I could not see a thing and just heard voices, which was scary at times. I realize now that I got a felt sense of what happened to A. I felt very sad throughout my whole body as I sat there not being able to see anything.

This makes me wonder now whether A.'s mother had also felt shattered under a similar sort of "stone". My fantasy was that her mother had battled with the fact that she had left her daughter under one. I believe that A. needed to physically see with her own eyes that there was somebody standing in front of the door and that just speaking about it was not enough.

Some Thoughts at the End

I hope that these examples highlight the way I work from a Living Body perspective. In earlier articles (Appel-Opper, 2008a, 2008b, 2009) I describe other embodied interventions. In one, I wrote about how I worked with a male client whose "trauma was written into his hands". From my physical resonances of cold hands and his feeling that his hands were not his own, we developed embodied interventions. We worked out a plan that he would look at my hands for a few seconds and I would keep an eye on how his body reacted by doing so. The next intervention of moving my fingers impacted him under his skin. This opened up space to focus on his shame around his trauma, since he had not been able to do anything when he was abused. I believe these interventions allowed the physical information held in his hands to be passed on to the rest of his body: the breathing, his skin, his spine and his eye contact. Through this his whole body was involved in carrying the burden of the information held in his hands. This helped to bring back the felt sense of his hands. These clinical examples confirm for me the importance of the language of the body. Especially when working interculturally, the language of "the body can be the primary means of expression." (Möhring, 1995, p. 102, own translation)

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Note

I prefer the term "living body" to "lived body" (for example, Des Kennedy, 2003). In my mind the former captures the image of the stories and the past relationships living in the body.

Biography

Julianne Appel-Opper is a Psychological Psychotherapist (German State Registered Psychotherapist), Clinical Psychologist (German Association of Professional Psychologists), Registered Integrative Psychotherapist, Body and Gestalt Psychotherapist with the United Kingdom Council for Psychotherapy, supervisor, and trainer with twenty years' clinical experience. She is a viva examiner and visiting tutor at Metanoia Institute in London. She worked in psychosomatic clinics with a wide range of patients, both individually and in groups. For twelve years she lived and worked in various countries (France, Israel, California and the UK). Julianne is now in private practice in Berlin and also works internationally. She has developed her approach of the 'Relational Living Body Psychotherapy' which she has taught internationally. She is also particularly interested in the interface between body and culture and in intercultural communication. She has published articles on these themes. Julian*ne can be reached at julianne.ao@web.de

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