

# INTERNATIONAL BODY PSYCHOTHERAPY JOURNAL

THE ART AND SCIENCE OF SOMATIC PRAXIS

INCORPORATING US ASSOCIATION FOR BODY PSYCHOTHERAPY JOURNAL

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USABP  
United States Association for  
Body Psychotherapy

The Hub of Somatic Psychology

**International Body Psychotherapy Journal***The Art and Science of Somatic Praxis**(formerly US Association for Body Psychotherapy Journal)**volume fourteen · number two · fall 2015*

The International Body Psychotherapy Journal (IBPJ) is a peer-reviewed, online journal, published twice a year in spring and fall. It is a collaborative publication of the United States Association for Body Psychotherapy (USABP) and the European Association for Body Psychotherapy (EABP). It is a continuation of the USABP Journal, the first ten volumes of which can be ordered through the website <http://www.ibpj.org/subscribe.php>.

The Journal's mission is to support, promote and stimulate the exchange of ideas, scholarship and research within the field of body psychotherapy as well as to encourage an interdisciplinary exchange with related fields of clinical theory and practice through ongoing discussion.

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The cover image is *Earth* by Hilde Hendriks

## Honoring Jacqueline A. Carleton, PhD

The current issue of the IBPJ marks the end of the Editorship of Jacqueline A. Carleton, PhD.

Dr Carleton founded the United States Association of Body Psychotherapy (USABP) Journal in 2001, which continued until 2011. In 2010 she opened negotiations with the European Association for Body Psychotherapy and brought about the collaboration of the two sister body psychotherapy organisations USABP and EABP in the International Body Psychotherapy Journal: The Art and Science of Somatic Praxis (IBPJ).

Dr Carleton continued as the Editor in Chief for the next eight issues. This is the end of her fourteenth year. Thankfully she will remain as the Founding Editor and has brought in a new young team to ensure the continuity of the Journal.

We acknowledge here her enormous achievement! Through her untiring work she has delivered 28 issues on time over the space of 14 years, each containing from 4-8 articles. She has encouraged, cajoled and mentored psychotherapists working across the US and Europe to write about their work: she has given them a space to exchange ideas and research and to communicate with other disciplines. She has inspired a more rigorous approach to writing and her own thoughtful and insightful editorials have in themselves made a great contribution.

In the years of the USABP Journal Dr Carleton had the support of Robyn Burns and since the IBPJ was founded I have had the great honor, and even greater pleasure, of working alongside Jacquie and supporting her in the work.

Thank you Jacquie for you enormous inspiration!!

Jill van der Aa  
Managing Editor

## In appreciation of Jacqueline Carleton

At a Board meeting of USABP in 2001, we decided, with Jacquie's prodding, that we needed a Journal. Jacquie volunteered to become the Founding Editor of the USA Body Psychotherapy Journal. What a brave soul I thought she was to undertake such a time consuming, difficult, and vitally important job. At the time I was not aware of the many editorial jobs she had already done. I was aware of her as a supremely gracious hostess of the many USABP Board meetings held at her home in NYC. I did not know that she speaks French, Spanish and Turkish, or that she had taught and lectured all over the USA and Europe. I did know she was a Senior Faculty member and Supervisor at the Institute of Core Energetics in NYC but not that she held those same posts in Germany, Switzerland, Mexico and Brazil. I had not yet read her wonderful articles connecting Reich's concept of infant/mother attachment to the recent findings of neurophysiology. And the USA Journal had yet to merge with our European colleagues in the more recent International Body Psychotherapy Journal: The Art and Science of Somatic Praxis.

Jacquie's resignation is our loss but possibly her gain. She may have a bit more time to breathe freely, something all us Body Psychotherapy practitioners think hugely important. We can't begin to thank you enough Jacquie for the huge contribution you have made to

Body Psychotherapy through your editing of the two Journals, your lecturing, teaching and supervision.

THANK YOU FROM ALL OF US AT THE UNITED STATES ASSOCIATION FOR BODY PSYCHOTHERAPY.

Alice Ladas

USABP Member & Former Research Chair

## Thank you Jacqueline A. Carleton

In saying, ‘Thank you, Jacquie’, I can speak not only for the members of the EABP, but also for all members of our professional community. By founding the USABP Journal in 2001 you created a platform for the development of our profession.

This platform was broadened to Europe when you contacted the EABP in 2010 to see whether there would be ground for collaboration between the USABP and EABP, which resulted in the International Body Psychotherapy Journal: The Art and Science of Somatic Praxis.

Being a good psychotherapist does not necessarily make people good writers. You requested strong content and writing skills and by being firm and friendly you steered the Body Psychotherapy community in the direction of developing and clarifying our ideas and theories. Your hard work has made an enormous contribution to the development of Body Psychotherapy.

Now you have handed over the Editor in Chief’s post to the next generation, but we know you will stay involved as the Founding Editor. In our minds we all rise and applaud:

‘Dear Jacquie, thank you very, very much!!’

Lidy Evertsen

President EABP



## Editorial

### volume 14 • number 2 • fall 2015

Jacqueline A. Carleton, PhD

I am ambivalent about saying good-bye. After almost fifteen years editing this journal, I realized a couple of years ago that I was getting tired and ready to relinquish it and that a younger editorial staff could bring not only new energy but different skills and outlooks to its publication. It has taken some time, but the new team is ready to take over in 2016. In my mind I have been calling them the triumvirate, so I may as well introduce them that way. Asaf Rolef Ben-Shahar will take the title Editor in Chief and be joined by co-editors Debbie Cotton and Nancy Eichhorn. All three have a great deal of experience in the fields of somatic psychotherapy, writing and editing. In addition, each brings a unique set of skills and interests, the co-mingling of which will benefit the Journal and its readers. They work on different continents in different milieus. Their profiles follow.

Asaf Rolef Ben-Shahar, PhD, is a relational psychotherapist, practicing in Tivon, in Northern Israel. He has written two books, *Touching the Relational Edge* and *Speaking of Bodies*, both published by Karnac. He has founded body psychotherapy training programs in both the UK (Touching the Relational Edge at Entelia Institute) and Israel (Psychosoma) and teaches worldwide in clinical and academic settings. He is on the editorial boards of several journals including *Body, Movement and Dance in Psychotherapy* and *Self*. He has written extensively on body psychotherapy, relationality, politics and psychotherapy, and hypnosis. He is involved with shamanism and is particularly connected to animals. He is a novice DJ, a vegan, and has two amazing daughters, Zohar and Shuy Grace.

Nancy Eichhorn, PhD is an accredited educator with a doctorate in clinical psychology, specializing in somatic psychology. Her current projects include publishing *Somatic Psychotherapy Today*, work as a writing mentor, workshop facilitator, freelance writer, and editor. She has been on the Editorial Board for the *International Body Psychotherapy Journal*, is an Editorial Assistant for *Body, Movement and Dance in Psychotherapy*, and is a member of the EABP publications committee. Her writing resume includes over 5,000 newspaper and magazine articles, chapters in professional anthologies, including *About Relational Body Psychotherapy*, *The Body in Relationship: Self-Other-Society* and the soon to be released 2016 collection entitled in *When Hurt Remains—Relational Perspectives on Therapeutic Failure*.

Debbie Cotton MA, BHSc, ND works both as a relational body psychotherapist and as a naturopath in London, UK. In her capacity as a relational body psychotherapist, Debbie employs her knowledge of physiology, touch, movement and the mind-body connection, taking a holistic and relational stance with all of her clients. As a naturopath Debbie has both a scientific and eclectic interest in nutrition and herbs, and how they impact our mental and physical health. She frequently lectures, writes training material, clinically supervises students both in nutritional and herbal medicine and organizes CPD in relational body psychotherapy. If she isn't working, you will probably find her foraging with her little boy, or cooking up some strange concoctions in the kitchen to try on an unsuspecting victim.

In the course of the transition, I have had a chance to experience in depth the capacities of each. Debbie has been working with me on peer review for more than a year. Asaf and I have been ironing out questions both editorial and administrative for even longer than that. And, we are all familiar with Nancy Eichhorn from her role as editor of *Somatic Psychotherapy Today*.

She has been a pleasure to coordinate many projects with. They bring new perspectives and an energy I have long lacked, much as I loved the Journal. And, witnessing the emails flying back and forth as they coordinate from three different continents is enormously gratifying. They have been kind enough to copy my on their correspondence so that I can allow it to warm my heart and assure me that I am leaving my “baby” in wondrously competent hands.

I truly do feel like a parent watching a child emerge into the world and applauding each step. It reminds me of when my daughter left for university, and long before that really, when her emerging interests were different from mine and therefore fascinating. It was all I could do not to ask her to share her college syllabi and reading lists! The rows of her books on the top shelves of the library are familiar to me, but mostly things I have not read. She used to pick out a couple from each semester and assign them: “Mom, you have to read this, you would love it!” I often did. Now that she is living in Los Angeles, engaged full time in her medical residency, I can browse as I like and I have enjoyed broadening my own horizons.

I am similarly delighted by and in awe of the new editorial team. They are immediately picking up on tasks that I wanted to do for years, like tightening the submissions and peer review processes, mentoring authors more carefully, and promoting the Journal through social media that are totally beyond my ability to encompass. Asaf’s energy is prodigious and his work is deep, as you will see if you glance at his CV. The same is true of Nancy. They both span several worlds. Debbie brings the organizational and scientific perspective: a naturopath. And, she has accomplished more in the time we have been working together while simultaneously taking care of an infant than anyone I have ever known. As an editorial team, they have all the bases covered.

My constant companion and co-founder of the *IBPJ*, managing editor Jill van der Aa, will be providing needed continuity as I step out. I think what I will miss most is the constant companionship of that working relationship. Jill’s competence and flexibility and reliability have been invaluable to me, as has her unique presence and outlook. I have enjoyed the virtually daily contact, again across continents, that has characterized our working relationship and friendship.

We lead, as has been our custom, from the “right brain” with two poems, whose authors are both psychotherapists and whose work has been published in past issue of the Journal. Marcel Duclos reflects upon the non-evidence based practice of the inwardly directed psychotherapist. And Salita Bryant highlights the place where psyche and soma meet... and don’t.

The image on the cover of this issue is a photo of a part of a felt sculpture by its creator, Hilde Hendriks. As Hilde describes it, the image resulted when she placed the earth section of a felt-work piece representing the elements of earth, air, fire and water under a shower to rinse the soap away. You see the soapy water at the top. Her embodied creative process is described in an interview with our managing editor, Jill van der Aa: a consciously embodied, visceral procedure by a person working in the plastic media of felt: wool, soap and water. Encouraged by Jill in an interview, the artist articulates and illuminates her process involving dance, movement, and her bodily involvement with her materials.

In “Embodied Clinical Truths”, Terry Marks-Tarlow a seasoned relational psychotherapist and artist, reflects on assumptions she made as a fledgling psychotherapist and the embodied truths that have become apparent over her many years of practice. She begins with an incisive discussion of the neurobiology of learning and memory as the foundation for a discussion of clinical intuition. “For practitioners, after countless hours, months and years of open immersion in clinical practice, if we are lucky, then our body-based capacities will reach full

maturation to flower into wisdom.” She then goes on to reflect on how each of her original assumptions made as a fledgling clinician, now seen as disembodied presumptions, has been contradicted by the ensuing embodied truths: clinical wisdom.

In “The Return to the Self: A Self Oriented Theory of Development and Psychotherapy” Will Davis extends and elaborates conceptualization developed in an earlier article in this journal (Vol. 13 No. 1, Spring 2014, pp. 31-51) entitled “The Endo Self: A Self Model for Body-Oriented Psychotherapy?” Addressing what he feels has been an overemphasis on the role of the other in both developmental theory and in psychotherapy, he introduced readers to the “endo self”, which he defined as “a unified body/mind state with a coherent subjectivity existing a priori to contact with others... self-starting, self-organizing, and self-regulating.” In the present article, Davis elaborates his original conceptualization, discussing eight principles of his self relations theory.

Continuing the research theme from our last issue devoted entirely to somatic research, Christine Caldwell and Rae Johnson introduce the rich possibilities for cross-fertilization between clinical practice and research in somatic psychotherapy by looking at parallels in both skills and conceptualization. Clinicians are encouraged to generate more of a research mind, which is not so very different from a clinical mind, and are given concrete recommendations for going about doing so.

In her courageous article, “Let’s Face the Music and Dance: Working with eroticism in relational body psychotherapy: the male client and female therapist dyad”, Danielle Tanner takes on a subject often danced around, or shoved under the nearest piece of carpeting. It is, of course, especially relevant to body psychotherapists, whether they employ touch or not. It is to her credit that she faces directly the challenges of touch, not skirting them at all. This impassioned and personal, but at the same time well-researched and referenced and deeply thought out article is an incredible gift, not just to body psychotherapists, but to the relational psychotherapy community. Danielle is taking a refinement of the conceptualization of not only the erotic transference and countertransference but also of the whole meaning of the Oedipal complex as it has come down to us in its various permutations and is taken up in the most recent issue of *Psychoanalytic Dialogues* (Vol. 25, No. 3, 2015).

In an extended and thoughtful review of four recent relational body psychotherapy publications, (most notably, our new Editor in Chief’s *Touching the Relational Edge*) Aline LaPierre discusses the concepts and methods that underlie this important approach to body psychotherapy as it has developed over the past two decades. She points out that the relational approach in body psychotherapy has created opportunities to introduce embodied clinical applications to the broader field of psychotherapy and psychoanalysis. It has certainly been my experience over the last three decades, that beginning with the explosion of neuroscience research in the 90’s, other approaches to psychotherapy, particularly psychoanalysis, have realized that they can no longer ignore the body and are curious as to how to include it in their conceptualization and practice. In a recent interview with Serge Prengel, which will be released in September 2015 (*Somatic Perspectives on Psychotherapy*, [www.somaticperspectives.com](http://www.somaticperspectives.com)), she refers to “the intelligence of the tissues...relational intelligence and visceral knowing about intelligence” as the allies of both patient and therapist in the healing journey. In her writing, her background in painting, Continuum and Jungian psychology are exquisitely evident.

In “Held Experience: Using Mindfulness in Psychotherapy to Facilitate Deeper Psychological Repair” Shai Lavie adroitly interweaves the case of “Carla” with an exposition of the importance of helping those who come to us tolerate distressing internal experience. With a background in Hakomi, Lavie illustrates how “deep psychological repair can be facilitated



by the simultaneous engagement of relational attunement and guided mindfulness.”

Our final offering is a case history, of a Chinese woman resident in Germany. It is authored by Ulrich Sollmann and commented upon by Wentian Li. The additional commentary by a cultural native who is also a body psychotherapist adds depth to the presentation. It is an intriguingly thoughtful and detailed walk through an initial body psychotherapy interview. The author highlights the practical relevance of body experience in a transcultural perspective which is psychodynamically rooted. Sollmann’s openness is marked and would be of value in any initial interview, but is especially important in the increasingly multicultural world in which we all live, and which I certainly experience every day in New York City.

As you will see evidenced as you peruse the offerings in this issue, the Journal has come a long way from the first issue of the USABP Journal in 1991, which Robyn Burns and I put together on a prayer and a shoestring. But now, in the hands of the new team, it is poised to grow exponentially, and I look forward to watching it soar.

September, 2015  
New York City

## A World Apart

Marcel A. Duclos

I leave it to the learned and trained  
to design the tools for the gathering  
of measures and quantities.

As for me, I swim in the inner  
and outer worlds, thanks to the chemistry  
of it all, in and out of

the sacred physicality of that  
body-inclusive psychotherapy;  
daring one on one,

in the poetry of the moment,  
a sphere away from proud academics,  
experimental research,

conference-touted newest best-practices,  
alive in the trenches, exploring  
tomorrow's emerging best.

### **BIOGRAPHY**

Marcel A. Duclos enjoyed an academic career as a professor of psychology and philosophy, as well as college administrator for 28 years, and practiced as a clinical mental health counselor for 35 years. Clinical supervision and training both at home and abroad complemented his community involvements as a consultant and agency Executive, and Clinical Director. He is an AMHCA Diplomate as a specialist in Trauma, Addiction and Co-Occurring Disorders. He writes and experiments as an amateur oil painter. Without any doubt, he is still walking the labyrinth to the still point as an unfinished man.

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## Manuel de l'enfant trouvé—mémoire The Foundling's Handbook—Memory [n & v]

Salita S. Bryant

Most never imagine the true cause of their illness. It never occurs to those, so afflicted, that this pain, this deadly fit of longing, this deep-vein loss, this sickness, is anything of significance or in need of succor; for it does not speak itself on the body proper, like a clubfoot, or a knife wound—not so anyone can see, at any rate.

And most do not value what they cannot see.

They therefore do not perceive the burning belly, stoked by the unsettling draft they sense at the blind edges of their own bodies—in the shallow depression at the back of the knee, or in the empty palm of the hand, or at the hollow of the back— issues from yawning caverns that fall darkly away into beinglessness.

They do not want to believe these phantom injuries.

Can't accept something beyond the edge might gnaw so at them— like a mislaid limb they forgot they had; or say a tongue that has never spoken; or something burned away, the untouched flesh curling back like candled parchment. The ache, the breach, can make one feel something has been poached, stolen.

Or worse, it has absconded on its own. Died.

But in fact, the opposite is true. Everything is still there; it is simply secreted. And, if one looks closely enough, through certain small gashes in the sternum, between the ladder of ribs, what one will see are love and desire tearing around the cloistered heart like a band of orphans, their hands full

of knives, shredding the cavernous walls of their cells.

### BIOGRAPHY

Salita S. Bryant holds a Ph.D. in literature, an M.Ed. in Clinical Counseling, and an MFA in poetry. She is Associate Professor of English with the City University of New York and is author of *Addie Bundren is Dead*. She has won Boulevard's Emerging Poet's Award, Spoon River Poetry Review Editors' Prize, and the 2013 Gradiva Award for poetry from the National Association for the Advancement of Psychoanalysis, among others, and has been nominated for three Pushcarts. She has published in *The South Carolina Review*, *Psychoanalytic Perspectives*, *Agenda*, *Nimrod*, and *The North American Review*, among others. She lives in NYC and is a psychoanalytic candidate with Harlem Family Institute. Email: salita.bryant@nyu.edu.

## Embodied Clinical Truths Terry Marks-Tarlow

Received 25 January 2015; accepted 12 May 2015

### Abstract

Among clients and psychotherapists, the body is not only the repository of trauma, but it is also a vast storehouse of expert knowledge. As therapists, we gather relational patterns slowly and implicitly through experience via full immersion within a variety of clinical contexts. This essay begins with the neurobiology of embodied truths, including the importance of implicit learning in service of executive memory and prescriptive knowledge as guided by right-brain intuition. Next, I set forth seven assumptions about professional development I held at the beginning of my career as a clinical psychologist. One by one, each assumption is presented and then systematically rebutted in light of embodied clinical truths I have garnered over the past three decades.

*Keywords:* embodied knowledge, clinical intuition, wisdom

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Within the somatically-oriented healing community, it is well-known that the body “bears the burden” (Scaer, 2001) as well as “keeps the score” (van der Kolk, 2014), especially with respect to trauma. Unprocessed emotions and other residues of traumatic events accumulate deep within the brain/body’s electrical, chemical, and mechanical workings. In what seems like an increasingly stressful and stressed-out society, we clinicians regularly encounter people with dysregulated emotions and undigested trauma. Some are victims of tragedies; others have witnessed atrocities; still others were subject to subtler forms of relational trauma. Relational trauma (Schoore, 2001) emerges from the very earliest misattunements, whether consisting of emotional “misses”, or outright abuse or neglect. Beginning in infancy and lodged deep in the body in pre-symbolic form, the relative presence or absence of relational trauma shapes insecure or secure attachment style. What the mind cannot recall or translate into words, “the body remembers” (Rothschild, 2001). If statistics give us any clue, it appears that the incidence of insecure attachment has gone up considerably over the past 20 years, especially within the avoidant/dismissive category (Konrath, Chopik, Hsing, & O’Brien, 2014).



*Figure 1. Earned Attachment, Caption: Although many of our clients begin psychotherapy with insecure attachments, if all goes well, they will finish with the status of an earned secure attachment.*

Happily, trauma is not all that the body holds onto, because the body also remembers positive experiences as well as tracks the entirety of our professional accomplishments. As psychotherapists, the integrated body/mind/brain system collects relational patterns revealed over the course of each clinical encounter. Every practitioner enjoys a slow accumulation of embodied expertise that is gathered in context, without effort. The 10 year, 10,000 hour rule, as formulated by Obler and Fein (1988) and recently popularized by Malcolm Gladwell (2008), states that it takes approximately 10,000 hours or 10 years, whichever comes first, to gain full competency in any skilled enterprise. This rule applies to widely diverse areas – psychology, architecture, mathematical discovery, musical composition, cooking, dance, surfing, and virtually every area of the humanities, arts, and sciences.

When the integrated mind/body/brain system is repeatedly immersed in full context, then “executive memories” (Fuster, 2003) form. In contrast to the “what” or “why” of life, executive memories involve the pragmatics of “how”. In contrast to semantic knowledge, this is the stuff of “prescriptive knowledge” surrounding questions like “How do I respond to this dilemma?” “What should I do next?” (see Goldberg, 2005). As body workers and psychotherapists, through repeated practice in dealing with a host of problems, interventions, and outcomes, our bodies develop prescriptive knowledge. As this happens, we implicitly, unconsciously grasp levels of nuance and degrees of complexity in bodily-based processes impossible to achieve consciously through explicit learning. Whereas explicit memory takes effort, deliberation, and conscious attention, implicit learning is automatic, effortless, and nonconscious (Claxton, 1997). Explicit knowledge gets stored in various lobes of the neocortex related to initial contexts of learning, while implicit memories get stored in the frontal lobes (Goldberg, 2005), the seat of executive decision making.



### **Brain Lateralization and Embodiment of Work**

When collecting knowledge of all kinds, the mind and body work hand-in-hand. The conscious brain/mind gathers explicit knowledge in tandem with the nonconscious brain/body gathering implicit knowledge. Cooperation between these two aspects of self parallels cooperation between the left and right sides of the brain. The left brain is in charge of the right side of the body, including the right visual field, while the right brain takes charge of the left side of the body. Simultaneously, the right brain is also in charge of integrating information from both sides of the body (McGilchrist, 2009). This additional integrative aspect means that the right brain functions in an open, holistic way, as opposed to the more narrow pursuits of the left side.

During evolution, brain lateralization, i.e., division of labor between right and left sides, extends as far back as millions of years to the onset of vertebrates. This means that brain lateralization preceded later mammalian capacities for social emotions and higher cognitive functioning. The most basic division of the two halves of the brain surrounds a primitive distinction – novelty versus habit. Among reptiles, mammals, and even birds, the right half of the brain takes charge of new situations, whereas the left half of the brain governs habitual activities (MacNeilage, Rogers & Vallortigara, 2009). Within human beings, we observe a progression of switches in brain dominance over development. No matter what one's culture or historical era, universally, the first two years of human life are devoted to right brain development (Schore, 2012). During this preverbal period, emotional, relational, and even cultural knowledge is gathered as a foundation for layering on later-developing cognitive skills. At approximately the start of the third year, dominance switches to the left brain in order to acquire language and conscious thought. Because Western culture so often privileges thinking over feeling, we can lose track of implications of this developmental picture – thought doesn't control emotion; it works the other way around. Emotion comes first, and sound emotion is necessary for sound thought.

From the standpoint of the body, the left brain is primarily in charge of voluntary movement. Through free will and activation of the striated muscles, we make and implement executive decisions. This means that when we consciously consider and decide to take an action or activity followed by moving our bodies accordingly, we operate in the domain of the left brain. By contrast, when we operate more out of internal silence and/or act more automatically or intuitively, we have shifted over into the domain of the right brain. Since effective psychotherapy is all about novelty and change, our interventions will be most effective if we approach our clients with open attention, again in the domain of the right brain. This stance allows us best to attend to the full context and complexity of the moment so that we may tap most deeply into our holistic font of embodied knowledge (Marks-Tarlow, 2012a; 2014a, b, c).

As an aspect of processing novelty, the right brain also perceives and responds to danger via the amygdala's warning system in combination with arousal of the sympathetic and parasympathetic branches of the autonomic nervous system (ANS). When we get excited, the sympathetic branch becomes activated. As we calm down, the parasympathetic branch kicks in. When chronically stressed, we may suffer from sympathetic hyperarousal or parasympathetic shutdown in the form of dissociation. Meanwhile, the enteric branch of the autonomic nervous system, which is evolutionarily the oldest of the three ANS branches, gets involved with digestion. We therapists become privy to "gut" feelings as part of embodied knowing precisely because of the right brain's oversight and stronger connection with the

smooth muscles of the organ systems. In conjunction with sensing our own arousal levels, various limbic structures like the insula and anterior cingulate help us sense what is happening in our own bodies (interoception) to assist us in gauging what is happening in the minds and bodies of others. When we feel pain in response to our clients' pain, we activate the very same internal circuitry as they do. What is more, the experience of social pain like exclusion or rejection activates the same neural circuitry as physical pain (Lieberman, 2013).

Whenever verbal and somatic psychotherapists attend to dysregulated emotions in our clients, it is the arousal dimension rather than the valence of emotion that is most problematic. To have negative emotions like anger or fear is normal and appropriate in context. Problems occur when the intensity of these emotions becomes too much to bear, leading people to live under chronic stress states of hyper- or hypoarousal. When we psychotherapists use our own mind/body/brains to regulate the nervous systems of those we serve, we intuitively attend to the arousal dimension of emotion, either by down-regulating, i.e., soothing, overly intense feelings or by up-regulating, stimulating, numb, suppressed or dissociated emotion. Because the right brain regulates emotion and arousal by drawing upon bodily functions automatically and subcortically (without conscious awareness), Allan Schore (2011; 2012) asserts the right brain is the receptacle of the unconscious mind, while the left brain is guardian of the conscious mind. This relational, body-based account of unconscious and conscious functions differs considerably from Freud's more disembodied, nonrelational formulation of the psyche.

The issue of brain lateralization is a controversial one whose study has received lots of attention following the era when Sperry first conducted split brain research in search of a cure for epilepsy. When split-brain research became popularized in the 1980s, people made simplistic attributions of different activities to each hemisphere. For example, verbal activities like language were assigned to the left, while nonverbal activities like music were assigned to the right. In light of more nuanced research (see McGilchrist, 2009), virtually any activity can be processed by the right or the left brain. Most of us hear music with our right hemispheres, yet professional musicians differ by processing music with the left hemisphere. Similarly, while most language is processed by the left side, there are important exceptions to this rule of thumb, including processing our own names, curse words, other expletives, poetry, metaphor, and humor.

McGilchrist (2009) suggests it is most useful to conceptualize each side of the brain as carrying its own unique perspective on the world. The corpus collosum that connects the two halves, while designed to integrate opposite sides of the body, carries a different design when it comes to the conscious mind. Our subjectivities can only entertain one perspective or the other at a single point in time, not both at once. Whereas the left brain focuses on the detail and well-known patterns; the right brain focuses on the big picture and novel pursuits. During clinical work, I have emphasized the importance of shuttling back and forth between the two modes. This often amounts to right-left-right shifts in processing (Marks-Tarlow, 2014b), as when we begin with open focus (right), zoom in on a detail (left), only to open up again through free association (right). Meanwhile, over the course of time, as our various activities lose novelty, patterns get transferred from right-side to left-side processing. As we age and gain more experience, what started out new eventually becomes old. In the process, more and more implicit patterns get transferred from the right side of the brain over to the left side (Goldberg, 2005). As a result, many elderly people retain expertise in their fields of study and active hobbies, even though their aging brains may suffer from memory loss

or other cognitive decline. Happily, because the shift from right to left may never occur for complex social interactions, we clinicians, immersed in the uniqueness of each clinical encounter, enjoy the privilege of remaining perpetually grounded in the right brain's creative potential.

### **Clinical Intuition as the Source and Product of Embodied Truths**

I present this brief account of the neurobiology of learning and memory to offer up the body as a storehouse of embodied truths. Embodied truths differ from the Aristotelian kind of truth that offers only two choices – true or false – with clean divisions between. Instead, the embodied variety are pragmatic truths that light our path in life, including heuristics for conducting our clinical practices with cunning and creativity. Pragmatic truths don't fall into neat categories. Instead, these are fuzzy truths with jagged edges that emerge from foggy circumstances. This kind of truth is not very useful for a game show competition, but does come in handy in scary or hairy, complex social circumstances. Embodied truths provide inner guidance; they are the stuff of wisdom. They assist us in groping through the chaos of life, despite feeling drenched in waters of uncertainty, mired in the mud of ambiguity, or torn into two by contradictory urges.

In short, embodied truths are the foundation for clinical intuition – a topic I feel quite passionate about (Marks-Tarlow, 2012a, 2014a, 2014b). Even for clinicians who concentrate in verbal psychotherapy like myself, through tapping into intuitive channels, we are all grounded in the body's learning. For this reason, I firmly believe that the interpersonal neurobiology of clinical intuition should occupy center field in every clinical training program, whether somatically oriented or not. In the thick of the moment, clinical intuition is what comes into play during the actual clinical encounter to fill the gap between theory and practice. I also maintain that access to these kinds of embodied, intuitive truths is a necessary, though not sufficient, condition to bring about deep change. What is more, the same kind of body-based knowledge is not only important in ourselves as clinicians, but is just as necessary in the people with whom we work. Embodied truths light up a 2-way street in psychotherapy as together, therapist and client search for the novelty and creativity inherent in deep, cellular change.

For practitioners, after countless hours, months, and years of open immersion in clinical practice, if we are lucky, then our body-based capacities will reach full maturation to flower into wisdom. Although wisdom is not much discussed in our professional circles, it should be. A lit review by Meeks and Juste (2009) within a PubMed database using “wisdom” as the keyword revealed a seven-fold increase in articles on this topic between 1970 and 2008. Yet the total number of papers was shockingly low. Only 20 papers existed at the beginning of the time frame compared with 150 papers toward the end. Within professional circles, the topic of wisdom is neither a standard aspect of clinical training nor a regular part of professional dialogues. All too often the subject gets restricted to religious or spiritual discourse, with different religions viewing wisdom differently depending on their view of the mind/body interface. Some traditions elevate the mind while denigrating the body, which gets reduced to the “soulless” existence of “lowly” animals. From this perspective, in order to achieve wisdom and spiritual elevation, one must transcend the material level and rise “above” animal instincts. I admit, this is not the perspective I personally endorse.

Other spiritual traditions, especially the mystical ones without clear separation between god and humankind, erase clear distinctions between material and spiritual levels. They

posit an interconnectedness between everything that also extends to animals. From this perspective, the body often enjoys exalted status as temple of the soul. As a practitioner of yoga for the past 30 years, I am more comfortable with this stance. This is partly how I have come to respect my body as a vast repository of life truths extending beyond traumatic imprinting into embodied realms of intuition, play, and creativity. My two most recent books, *Clinical Intuition in Psychotherapy* and *Awakening Clinical Intuition*, emphasize this link between intuitive and bodily processes by focusing on limbic circuitry that humans share with other mammals. To analyze the underlying neural circuitry of clinical intuition, I place special focus on the SEEKING, CARE, and PLAY circuits shared by all social mammals (see Panksepp, 1998; 2012).



*Figure 2. Spider Monkey Trust, Caption. Because the CARE circuit operates in all social mammals, mothers are motivated to care for their young.*

Along with clinical and personal tales, my books contain animal tales. My aim is to honor the body's wisdom as shared by other animals. Not only do they sport the same basic emotions as we humans, such as anger, fear, and joy, but evidence also exists for complex social emotions, such as justice and morality, among four-legged canines who live in packs (Bekoff, 2004; Bekoff & Pierce, 2009).

### **The Wisdom Inherent in This Clinician's Experience**

With this lengthy introduction in mind, the remainder of this essay reviews 30 years of practice as a clinical psychologist through the lens of embodied truths in order to highlight differences between disembodied presumptions and embodied truths. As a fledgling clinician

in the 1980s, I started out with a host of assumptions about what I should do and who I should be. Looking back with the benefit of 20-20 hindsight, the evidence of my life has contradicted each and every one.

**Assumption 1: Certainty is better than doubt, and certain knowledge is best of all**

Certainty definitely feels good, especially for beginning therapists. Most clinicians, whether oriented toward somatic or verbal psychotherapy, enter the field taking our job very seriously. This can lead to incessant worries surrounding desperate and traumatized people we encounter. We so urgently want to be of help. Particularly in life and death circumstances, the responsibilities we face feel overwhelming. We seek respite from the anxieties surrounding uncertainty and the self-doubts it so easily breeds. Certainty is one solution to our struggles. Beginning therapists often seek certainty in books, prescriptive formulas, or the elevated stance of supervisors, much like little children crave omnipotent, omniscient parents to quell feelings of danger and return to a sense of security.

Here is my first embodied truth: when it comes to clinical practice, certainty is not the answer. In fact, quite the opposite – the quest for certainty all too often constitutes part of the problem. Through my formal studies, I have learned that the universe is fundamentally nonlinear. This means that it is holistically interconnected, such that it is nearly impossible to pull apart all of its pieces cleanly. Clear concepts of truth and falsity may resonate with bodily experiences, yet emerge from language and concepts different cultures foster. Some people would hand over clear vision of what is true and what is false to God. I am not one of those.

From my perspective, a clean and clear division between what is true versus what is false is reserved mostly for technical calculations, like making tables or solving mathematical equations. From this viewpoint, the complex social universe in which our bodies and relationships reside is way too fraught with ambiguity, contradictions and paradoxes for certainty to be of dependable use. As clinicians, there is great danger in too much certainty. We can grow cocky, inflated or closed minded. The more certain we become as a regular stance, the more we narrow our scope of vision and close down our openness to other points of view or changing circumstances. Real life is damn messy, with dynamics that shift and turn fluidly like waves of water. If we become too certain, we also become rigid and impenetrable. Buddhism, which is more of a philosophy than a religion, is also a psychology which offers antidotes to various afflictions of the mind. What is the Buddhist antidote to doubt, one of the mind's worst afflictions? The prescription is not certainty. Instead, the prescription is to lower ourselves down so that we may connect with the earth. By placing our hands in the dirt, we become grounded, quite literally. This stance helps us to hold the uncertainty that is not only intrinsic to our very being but also to our clinical work with clients/patients who continually face crises and chaotic life transitions.

**Assumption 2: Creativity is frivolous, while psychopathology occupies the center of any serious clinical practice**

While I was in graduate school in clinical psychology, I chose a dissertation on depression. There was a huge prospective study already underway, and I wanted to be practical about finishing on time. While I kept to my timetable, there was a major problem with this course of action: I had very little interest in depression. After graduating and earning my California psychologist license, I suffered an early career crisis. Where was my passion? One day, I did a self-guided, deep meditation. Upon finishing, I knew that creativity was how I wanted to



focus my energies. Yet, no sooner did I discover what truly unified my heart, body, mind, and soul, then I became filled with self-doubt and shame. No one else I knew was focusing on creativity. Under the harsh lens of intense self-scrutiny, the subject seemed trivial. I felt self-indulgent. Or, perhaps I was merely a *Puella Aeterna* (eternal child). Why didn't I have more interest in areas like trauma or the severely disabled like the rest of my cohort?

Fortunately, I suffered through these self-doubts without letting them stop me. Something drove me on relentlessly. I studied theories of creativity and couldn't read enough about creative people. The more I have followed my passion, the more I have very slowly embodied the significance of what I was doing. I developed the courage intellectually to attend to nonlinear science and use my creativity to marry its concepts with clinical practice. I next turned to clinical intuition as nonlinear science in action, only to realize how much clinical intuition represents the art of psychotherapy, whereby each person, dyad, and clinical moment inspires a unique and creative response. Finally, I have discovered that everyday creativity isn't just the territory of talented therapists. Quite the opposite. As I mentioned earlier, to help patients ground themselves in their own intuitive foundations is to open up their full expression and bring alive their creativity, however ordinary the context may be. Along with fulfilling relationships, what more could anyone want?

**Assumption 3: If I don't specialize and declare a narrow niche of expertise, I won't be taken seriously as a clinician**

My graduate school at UCLA was completely research-oriented. When I entered the program, it was assumed that every incoming student would choose academia for a future career. For some unknown reason, everyone in my year rebelliously rejected this agenda. Not one of the ten or twelve of us wound up as a researcher solely in academia. Yet, no one was properly trained in the mechanics of private or community service. As I watched others hang out their shingles, most everyone else declared a specialty. Some people worked with anxiety conditions, others with eating disorders, and still others with sexual dysfunction or anger management.

As everyone else found their niches, I was busy doing the opposite. My net was getting broader and wider; some force in me resisted narrowing my focus. I continually read and trained outside my field. Meanwhile, my patient population was getting more, rather than less, diverse. Over the years, I have been blessed by such an interesting variety of folks who have crossed my threshold: FBI agents; artists, call girls, lawyers, doctors, composers, teachers, police detectives. I adore working with people from different ethnicities and cultural backgrounds, with patients who are African American, Japanese, Chinese, Indian, Iranian, Orthodox Jewish, and Cambodian. I have treated people who are gay, bisexual, and polyamorous. Over the last 30 years, I have also worked with just about every category of psychopathology there is, while treating people from every social class. I've even had several years of a healing correspondence with a man in prison for life under the charge of murder.

As I look back over my incredibly broad base of clientele, I realize that it is the breadth and diversity of my practice that has led to my current day expertise, not a course of specialization as I had presumed. An old trope translates PhD for Piled High and Deep out of generalizing (if not stereotyping) academics as concentrating more and more on less and less. But a complexity model of mental and physical health emphasizes the importance of moving in the opposite direction – toward variability, adaptability, and flexibility.

**Assumption 4: Unless I affiliate with a single orientation and school of clinical thought, I am a dilettante, or even worse, a charlatan**

The question of orientation has been a difficult one for me from the start. At UCLA, I was trained in cognitive, behavioral therapy. Never terribly comfortable with the idea that thought is more central than emotion, I went outside the gilded walls of the university to receive additional clinical training. I first gravitated toward Gestalt therapy, following the advice of a charismatic supervisor whose experiential approach felt so fresh and alive. While I loved Gestalt therapy in practice, I wasn't wholly satisfied in theory. During the 1980s the Gestalt community lacked a depth theory of the psyche. So I added psychodynamic to the stew by studying self-psychology and felt internal pressure to join an analytic institute. But I wasn't comfortable with the social politics of the various local institutes, which seemed petty, arbitrary and authoritarian. I desperately wanted to belong to a community of like-minded folks, yet something inside me prevented me from joining any group. Whatever this was kept pushing me on. Professionally, I found myself in a very lonely place for quite a number of years. The more I did my own thing, the more I felt like an outsider in my own field.

But once again, the embodied truths I have slowly gathered not only have challenged my preconceptions but eventually also settled my uneasiness about my own course and professional choices. Over time, my strength has come from my willingness to follow my heart, even at the expense of my internal, often naïve name calling. Looking back, each training I received was what I needed just when I needed it. My current grounding in interpersonal neurobiology has finally given me a community large enough to emphasize universal truths about psychotherapy that transcend any particular orientation or school of thought. Meanwhile, recent research affirms my embodied sensibilities by highlighting the quality of the therapeutic bond, regardless of orientation. Within the field of psychotherapy, trends come and go, much like fashion. They are neither right nor wrong; what is popular today is often passé tomorrow. As part of these trends, orientations and schools of psychotherapy seem to proliferate like rabbits. Each new school brings an important, often new, nugget to the therapeutic community. But no single one has a corner on the whole truth.

**Assumption 5: The best way to gain expertise as a clinician is to study and emulate the practices of great clinicians**

In clinical trainings, I vividly recall watching films of the various greats. I remember the Gloria tapes showing Carl Rogers, Fritz Perls, and Albert Ellis all doing psychotherapy with the same patient. On film, I have seen the work of Milton Erickson and Virginia Satir. I have read transcripts of countless other master therapists. Most recently, I have watched the videos of Pat Ogden doing sensorimotor therapy. I have marveled at the work of each of these individuals, each of whom is clearly a genius. At the very same time, especially at the beginning of my clinical career, the main impact of watching other clinicians in action was that I got terribly uncomfortable and confused. How did this person know to say that in that particular moment? That would never occur to me. What is wrong with me? So many of the responses I witnessed seem so connected to the various personalities, each so different from mine. Which comes first, personality or technique? How valuable is technique apart from personality? The more I watched others work, the more anxious and self-denigrating I became.

After all of my formal trainings, I went through a period of professional isolation. Looking back, I think I was trying to deal with my confusion by drawing a circle around

myself and my own practice. I needed to find myself from the inside out. Eventually, this brought me in an embodied way to my own style of doing clinical work, as well as to the importance of clinical intuition, whereby each clinician is encouraged to tap into his or her unique set of strengths and weaknesses as based on idiosyncratic genetics and social histories. To find my own style of psychotherapy from within my own practice was to capitalize on the constellation of strengths and weaknesses unique to me. Only by practicing in isolation could I seek and eventually find my authentic voice. Only in isolation did I find the safety to express myself authentically and transparently, with a non-defensive attitude. Looking back, the impulse to push away all other practitioners for a while allowed me to develop and learn to operate from an embodied foundation. Only from this solid perch, many years later in my career, have I grown better able to watch the work of others in a constructive fashion.

### **Assumption 6: Play is the opposite of hard work**

I come from a high achieving family. My sister went to Harvard and is currently a tenured professor of developmental psychology who runs a culture lab that is named after her. My brother founded the world's largest nongovernmental peace-keeping organization, Search for Common Ground. My siblings are 15 and 12 years older than I am, respectively, and I felt the need to compete with them both from the start. Needless to say, especially in my early years, I was destined to lose the competition. This filled me with self-doubt and left me very insecure and neurotic in high school, but at the same time got me into prestigious places—Stanford undergraduate, followed by UCLA for advanced degrees. When I entered graduate school, I felt lots of pressure to work hard, but at the same time I no longer wanted to be neurotic. So, instead of joining my fellow students in study groups and running the risk of “catching” their anxieties, I often hauled my books down to the beach in order to study alone. I also practiced yoga and started to rock climb. Additionally, I countered my heady existence and intellectual confusions by learning how to dance. Upon finishing graduate school, when I entered private practice, from the very start I decided to limit my clinical practice to three long days – Tuesdays, Wednesdays, and Thursdays. I desperately wanted to retain balance in life and used the other days for other activities, including making art, indulging my body in yoga and exercise, and writing papers and books.

I started out feeling sheepish and rather guilty about my playful way of approaching clinical work. But looking back, again with the benefit of 20-20 hindsight, I now feel extremely grateful for the path my embodied wisdom has guided me toward. My balance of head, heart, and body activities has helped me stay fresh and passionate about my work, without a trace of burnout 30 years later. My preconception placed work and play on opposite sides of a continuum, yet my embodied experience has merged the two. I do my greatest clinical work out of a playful spirit. When playing, my clinical work doesn't feel hard at all, even though there are plenty of really difficult moments. Meanwhile, the more I study about play, both developmentally and evolutionarily, the more I realize that play is often where the greatest action and movement is in psychotherapy (Marks-Tarlow, 2012b, 2014c, 2014d, 2015). Trauma resolution tends to bring us back to safety, while play is the source of greatest growth. Certainly, this is true developmentally. All children stretch cognitively, emotionally, and behaviorally the most by exercising their imaginations.



*Figure 3. Glee, Caption: Through imaginative play, children develop intrinsic motivation to follow their passions.*

Through my intellectual work on a play model of long term psychotherapy I have come full circle on this issue. I now believe that formal games, like hide-and-seek, exist at implicit levels of psychotherapy as bids for engagement and disengagement, safety and trust. The more we participate in playful ways with clients, the stronger therapeutic bonds tend to grow.

**Assumption 7: Psychotherapy is its own world that should remain cordoned off and separated from various other practices and pursuits**

As mentioned, throughout my adult life I have been deeply absorbed in a wide variety of very different activities. Some involve the body; others involve the mind. Some involve solitary pursuits; others involve social interaction. I have practiced yoga for more than 30 years. I regularly draw and have illustrated most of my own books. I was a serious rock climber for years before having children. I take ballet and jazz classes several days a week. I started out doing many of these things in order to retain my own sanity. Maybe this is why I believed early on that each of these activities should remain quite discrete from my professional life as a psychotherapist.

As time has gone on, my embodied experience has once again flown in the face of this preconception. The more integrated everything is in my life, the more I realize that there are no separate chambers. Especially as I focus on authenticity and transparency within my relational style of psychotherapy, I can't help but to bring all of myself everywhere. I see this as the foundation for integrity. Meanwhile, my whole self is informed by the whole of what I do. Consider yoga. Whereas 20 years ago, I remained mum about this pursuit, now I talk about it whenever I can to

patients. I like to send people to yoga who are open to it. When patients have an active practice, it tends to speed up the change process. Meanwhile, I can move freely between emotional issues in the room and physical manifestations embodied on the mat.

A similar thing holds true for art. I used to follow this interest privately and apart from my professional life, but now I feel free to share art with fellow practitioners. I believe that each of the arts cross fertilizes psychotherapy in a different way. I have co-conceived with Pamela McCrory, PhD, curated, and co-edited “Mirrors of the Mind: The Psychotherapist as Artist” (Marks-Tarlow, 2013; Marks-Tarlow & McCrory, 2014). This juried visual art exhibition in Los Angeles, which includes poetry and other performance aspects, has touched a national nerve. Psychotherapists all over the country are interested in the arts, partly because of the embodied truths the arts offer to psychotherapists.

### Final Thoughts

In the paragraphs above, I have set forth 7 assumptions of professional self-creation only to revisit each in light of the embodied truths of my actual clinical experience. Like the uroboros, the snake that swallows its own tale/tail (see Marks-Tarlow, 2008; Marks-Tarlow, Robertson & Combs, 2002), I have returned to the beginning of my career with the end in sight.



Figure 4. Uroboros

I love the symbol of the uroboros, especially as a student of nonlinear dynamics, with particular focus on chaos theory, complexity theory, and fractal geometry (see Marks-Tarlow, 2008; 2011). Throughout recorded history, the serpent has remained a symbol of chaos (see Hayles, 1990). The serpent that swallows its own tail is a symbol of chaos contained. Every known culture spins a creation myth that spells out the relationship between chaos and order (see Von Franz, 1972).





*Figure 5. Chinese Dragon, Caption: In Chinese culture, chaos and order work hand and hand and the dragon is guardian of the pearl of wisdom.*



*Figure 6. Dragon and Hero, Caption: In Western culture, chaos must be vanquished in order for order and civilization to proceed.*

In Western culture, perhaps our most popular creation myth is science in general, with physics of particular relevance to the relationship between chaos and order (Marks-Tarlow, 2003). Whether implicitly held or explicitly formulated, each person also spins out and carries our very own self-creation myth.

Perhaps an inborn, genetically programmed fear of snakes relates to a fear of chaos in our lives as well. The snake has always been a bipolar symbol of opposites, e.g., chaos and order, because the snake's venom provides both toxin and cure. This dual aspect accounts for the two intertwined snakes forming the healer's staff, or Caduceus, ancient symbol for Western medicine.

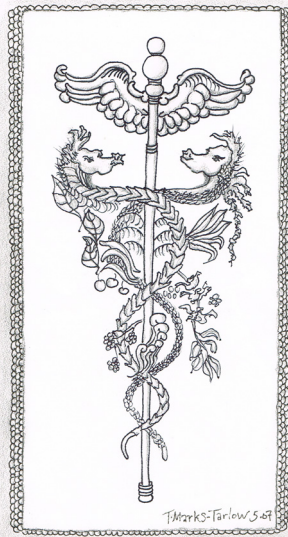


Figure 7. Caduceus

Jungian psychologist Eric Neumann (1954/1993) depicts the uroboros as the symbol of self-creation. In this essay, I assert that embodied truths as garnered from endless feedback loops of life experience form an important aspect of self-creation. We must all sort through the chaos of life to find inner order and the wisdom that is ours alone. By swallowing our own tails/tales, we take in and spit out life by first experiencing and then reviewing in light of further experience.

When it comes to clinical practice, truths are embodied in the lives of practitioners. I end with this advice: Follow your heart. Seek connection with your own inner vision and guidance. At the same time, be sure to stay open to input and feedback from others. This combination allows an internally grounded foundation alongside an externally open and flexible orientation. If you remain dedicated to truths as they present themselves in embodied form, I truly believe you stand the best chance of allowing your clinical intuition eventually to flower into wisdom. It takes courage to sink into your own experience and find your own embodied truths. The process can lead to great chaos and uncertainty at times. It is helpful to keep in mind the words of William Cowper, “Knowledge is proud that it knows so much; wisdom is humble that it knows no more.”

## BIOGRAPHY

Terry Marks-Tarlow, PhD. teaches developmental neurobiology at the Reiss Davis Child Study Center. She is a Research Associate at the Institute for Fractal Research in Kassel Germany and on the faculty of the Insight Center in Los Angeles. Her most recent books, *Clinical Intuition in Psychotherapy* (2012, Norton) and *Awakening Clinical Intuition* (2014, Norton) concern the importance of play, imagination, and creativity in psychotherapy. Dr. Marks-Tarlow embodies the balance of life between play, imagination and creativity through dance, art, and yoga. In 2010 she also wrote the libretto for the opera, “Cracked Orlando,” with music composed by Jonathan Dawe.

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## The Return to the Self: A Self Oriented Theory of Development and Psychotherapy Will Davis

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### Abstract

In order to address an overemphasis on the role of the object, I discuss eight principles of a self relations theory: (1) There is an innate, self organizing endo self, (2) The self is the aim of the drive not the object, (3) The self, not the other, is the organizing agent of experience, (4) The self to self relationship is the earliest relationship, (5) The self creates the object, (6) The self creates the object to satisfy its desires, not its needs, (7) The object does not gratify, (8) Detachment is as important as attachment.

*Keywords:* Self relations theory, self, Reich, instroke, self referential, default mode network, brainstem consciousness

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### Introduction

To overcome an over emphasis on the formative role of the other in development and psychotherapy I argue for an early state of subjectivity that is a coherent, sense of self-existence, prior to relation with others (Davis, 2014). Arising autopoietically, this self is brought to initial relationships, leading in turn to its own further development. The importance of the other is not denied, but redefined. There is increasing evidence of the self-initiating and self-regulating resources of the infant: the self as the organizing agent of its own experience (Beebe, in Mitchell, 2000; Kouider, 2013; deCasper and Fifer, in Mitchell, 2000; Heppner, 2002; Laeng et al., 2012; Stern, 1998; Laeng et al., 2013). I have called this self-agency the endo self in order to accentuate the inner origins of this interoceptive state (Davis, 2014). Based on the endo self is the self-relations theory – the return to the self.

Psychotherapy and object relations in particular, stress the environment as if the object is the creative force in development. Mahler described the baby moving towards the object and away from the object (Mahler, 1972). Is the role of the infant in this formulation non-existent, only receptive, or simply passive? The theme of the overemphasis on the other runs through the history of psychology. In the 1930s the behaviorist John Watson (1998) took the extreme position that you could “create” a person:

Give me a dozen healthy infants, well-formed, and my own specified world to bring them up in and I’ll guarantee to take any one at random and train him to become any type of specialist I might select – doctor, lawyer, artist, merchant-chief and yes, even beggar man and thief regardless of his talents, penchants, tendencies, abilities, vocations and race of his ancestors (p. 82).



In 1955 Gordon Allport, the president of the American Psychological Association, had to defend the existence of a self and its relevance to psychology (Strauss & Goethals, 1991, p.5). Despite the later works of self-oriented theorists like Maslow, (1968) Rogers and Kohut (2001) the self's role in its own development was minimized. This overemphasis on the other encouraged an exaggerated importance of the role of the therapist. Fairbairn went so far as to say the object is the ultimate aim of libidinal strivings (Fairbairn, 1941).

A self-relations theory is the obverse of an object-oriented theory. It is not a matter of exclusion, but of emphasis; one does not invalidate the other. Subject and object are both necessary in a creative, pulsatory dynamic towards development and healing. The object is critical to development but not causative. Even chimpanzees raised in isolation do not develop a sense of self. Self development is not an individualistic affair but is dependent on specific qualities in a relationship. "There is a tendency to look at the self as an individual, separate from others. But the true self can only emerge in relatedness: intersubjectivity" (Ryan, 1991, p.221).

The self's participation in its own developmental/healing processes is critical. Neither development nor therapy is about what the other *does*; it is about what *happens* to the self. An additional reason to develop a self relation's theory is to move away from the pathologically oriented medical model and continue to develop what Maslow called a positive psychology (Maslow, 1968).

## **Eight Principles of a Self-Relation Theory**

### **1. The Endo Self**

The endo self describes an early, self organizing, embodied, coherent sense of self whose unique quality is that it exists *a priori* to relationship; an autonomous self, grounded in relationship (Davis, 2014). There are suggestions for an endo self-concept from a variety of disciplines. Maslow's (1968) "being states", Guntrip's "inner core of selfhood", Winnicott's (In Buckley, 1986) "incommunicado core", Loewald's (In Mitchell, 2001) "primary experience is best described as being" all suggest a deeper sense of consciousness/being/self. Jantsch (1979) comes directly to the point: "...with existence comes consciousness" (p.10) and Maturana and Varela (1972) define cognition as a biological phenomenon; "if you are living, you have consciousness" (1972, p.5).

Indeed, the Cambridge Conference on Consciousness (2012) emphasized that affect systems are concentrated in subcortical regions. There is subjectivity in the fetus before the development of cortical activity; before cognition and language. Mark Solms and Jaak Panksepp have elaborated the importance of "subcortical energies". They call for a reorganization of consciousness and unconsciousness. They argue there is an affective core consciousness in the brain stem that is universal in all mammals and that higher cortical brain functions - cognition, language and representation – are built on this lower, "basement" affect consciousness. For a counter argument, see Gallese, 2013.

Freud "...assumed that the ego enlightened the id. It now appears more likely that the opposite happens" (Solms & Panksepp, 2012, p. 168). The "seat of consciousness" - the declarative, abstracted, corticocentric, represented self - is in fact "unconscious in itself". This reverses Freud's image of the tip of the iceberg as consciousness and the underwater section as the unconscious. I suggest that the underwater part of the iceberg is consciousness and the tip of the iceberg is motor/sensory based perception and awareness that is dependent on the brainstem's "core" consciousness. "The neocortex, the supposed repository of consciousness,

is intrinsically unconscious” (Solms and Panksepp, p. 166).

Of particular interest is Solms and Panksepp’s differentiation of *two* internal bodies. The classical model is in the insula cortex represented by the Homunculus which was considered the internal, subjective body; the “self”. They argue that this is an *external* body representation, an “object” located in the same brain functions as all objects. The true *internal* subjective body is represented in the affect consciousness of the brainstem, not as an object, but as the “subject” of perception. On this level of functioning, “...perception happens to a unitary, embodied subject” (Solms & Panksepp, p. 156) that I refer to as the endo self.

The interoceptive brainstem...generates internal “states” rather than external ‘objects’ of perception. It gives rise to a background state of ‘being’; this aspect of the body is the *subject* of perception (Solms & Panksepp, 2012, p. 156).

As body oriented psychotherapists, we ask which “body” do we work with: the external oriented “body” engaged in external relationships, or the interoceptive, internal “unitary, embodied subject” in relation to itself? Or both?

Consciousness is “endogenous, subjective, and fundamentally interoceptive” (Solms & Panksepp; 2012, p. 164). There is a “vast variety of selves” on the cognitive level, but on the functional level there is but one endo self. This is the root of my argument for an endo self and a self-relations theory.

## 2. The Self, not the Object, is the Aim of the Drive

Fairbairn quotes a patient who demanded: “What I want is a father!” (Fairbairn, 1941). He emphasized the word “father” to support his theory about the importance of the object in determining development and by extension, the therapist. He concluded that the object and not gratification is most important. The diagram below represents the unidirectional, object-oriented movement as the goal of the drive.

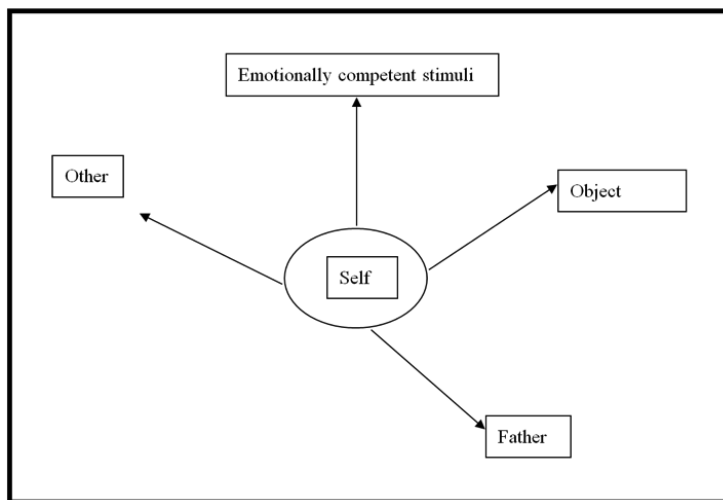


Figure 1. Diagram of the unidirectional view of developmental theory.

Self-relations theory emphasizes: “I” and “want”. Therefore, the aim of the drive is the self. Only when the self experiences itself in object contact can the drive be fulfilled. When a need state persists, the goal of the drive becomes the object, and thus the self is never satisfied.<sup>1</sup> The contact with the object must be incorporated into the self’s experience of itself or else no development/satisfaction has occurred. To use Damasio’s terminology, there must be “an experiencer of the experience” (In Kandel, 2013, p. 464). The creative developmental force is when the self experiences *itself* through the contact with the other. A self to other model is an endo psychic experience of an interpersonal event. A self to self model is an endo psychic experience of an intrapsychic event! This is in line with Solms and Panksepp’s (2012) interoceptive, phenomenological experiences arising endogenously in the brain stem.

The overemphasis on the other leads to well known problems of being other oriented, low self esteem, pathologically dependent, narcissism and orality. It also raises the important developmental themes of autonomy and heteronomy as well as attachment and detachment. In *The Nature of the Self in Autonomy and Relatedness* the cognitive psychologist Ryan (1991) points out that when the other is overemphasized one can be in different relationships with the object: i.e. to satisfy one’s own needs - other as object, being-for-others - self as object; or in contingency, conditional love. With an overemphasis on the other there is a risk of introjection; an external regulation and set of values that one mistakenly takes for one’s own which is “...re-enforced by guilt, anxiety or other self esteem dynamics”; heteronomy rather than autonomy (Ryan, 1991, p. 217).

The subject’s participation in her own healing process is essential. As a result, Ryan (1998) argues for a “[n]ascent core of self” (Ryan, 1998, p.214). “Agency is not just a post-behavioral construct but an aspect of experience from infancy onwards” (Ryan, 1998, p. 215). Agency is the psychic manifestation of the organizational properties of all living entities” (Ryan, 1998, p. 214). This leaves the infant with three possibilities: give up relatedness to preserve the self, enmesh to not lose the other, or maintain a bond because autonomy is respected and self is accepted (Ryan, 1991, p. 224-225).

A touching example of the self as “aim” is from a patient whose autonomy was not respected by her father, but she still managed to keep her sense of self *while maintaining a bond with him*. She was 48 years old, on disability with depression, passive aggressive, had a narcissistic wound that left her with little self-esteem, undifferentiated abdominal pain and migraine headaches. She had organized an art exhibition at a local center and she was proud of herself when it was extended. After this, she was dreading going home for Christmas expecting to have migraines the entire week. Later, she was surprised at how few migraines she had and when she told her father about her success he responded indifferently: “Oh that’s normal.” She then said: “I feel sorry for him that he could not enjoy his daughter’s success.” This is an example of satisfying the self not the object. She could stay in contact with him on an adult level and with herself at the same time. An attachment to the self, not the other, leads to further development.

### 3. The Self, Not the Other, is the Organizing Agent of Experience

A main characteristic of the endo self is its sense of agency: “...an entity that possesses both the power to bring about an event and the power to refrain from bringing it about. A person as agent is considered to be partly, or wholly the originator of his own actions” (APA

<sup>1</sup> For elaboration, see the section 6 entitled: The self creates the object not to satisfy its needs, but its desires.

Dictionary of Psychology, 2007). Stern's (1998) work is a good example of the shifting paradigm from the role of the other as organizing experiences for the infant to an increased understanding of the infant's "sense of self as the primary organizing agent." (p. 26). This is self as subject, as knower as opposed to self as object or known (Davis, 2014). The self is not understood by its observed behavior but by a process lived. "Most problematic for neuroscientists is that any theory of consciousness must ultimately refer to introspective experience, a sense of self and of feeling, a phenomenon not readily accessible to objective scientific study" (Kandel, 2013, p. 463). A self as agent is teleorganic, able to serve the necessary life needs of the organism.

In studies measuring pupillary responses, Laeng, Sirois and Gredabäck (2012) suggest that pupil dilations and constrictions represent an access to the preconscious. Their results with infants led them:

...to start asking serious questions about consciousness early in ontology, and it may open an entire new frontier of research within developmental cognitive science and comparative psychology (Laeng et al., 2012, p. 25).

These findings should also renew the discussion of the self's participation in its development and healing. A patient brought up this theme. When he started therapy he was on medication for anxiety. At 26 he had just moved out of his mother's house, had no work or social life and he sat at home with ear phones plugged into an amplifier and played guitar to himself. He described social fears, always watching others to control everything and strong contractions in the extremities. He told me that when we started therapy he thought that the bodywork was like "magic" and I was some sort of shaman. But now "I participate in the therapy more and that is good". When asked how that was good, he reported there was a sense of satisfaction and security that he was involved with himself. Touching his abdomen, he spoke of a "rooting in myself."

A self-organizing process was formulated by Syngg (1941) and reflects the Gestaltist's figure/ground concept from the end of the 19th century. "Behavior is completely determined by and pertinent to the phenomenological field of the behaving organism (Syngg, 1941, p. 412). This phenomenological view is reformulated in biological terms by Maturana and Varela (1998): (I have, in turn, reformulated this quote into psychotherapeutic terms.)

If a cell [the self] interacts with a molecule [its environment i.e. object] and incorporates it [introjections, identifications, internalizations] in its processes, what takes place as a result of this interaction is determined not by the properties of the molecule [object] but by the way in which that molecule [object] is "seen" or taken in by the cell [self] as it incorporates the molecule [object] in its autopoietic dynamics. The changes that occur as a result of this interaction will be those changes caused by the cell's [self's] own structure and unity (1998, p. 51-52).

The phenomena of communication depend not on what is communicated, "...but what happens to the person who receives it" (Maturana & Varela, 1998, p. 52). The cell or the self is determining what is experienced. All systems are self referential in the first line (Jantsch, 1979).

This self referential "individuality" of experience is highlighted by problems in studies whereby it is getting harder for scientists to reproduce one another's experiments (Kiermer, 2014).

Biological processes do not work in linear ways independent of one another but in tightly

interconnected networks. [M]ice bred with identical DNA behave differently. Two cells growing side by side in a petri dish cannot be considered identical (p. 7).

This is true for cloned subjects as well.

Research in perception supports the individual nature of experience. The neurobiologist Eric Kandel (2013) describes the self-referential nature of perception; how we create our own “reality”. Throughout his discussion of visual perception, he is pointing out that “the eye is not a camera” (Kandel, 2013, p. 234) and “...every image is subjective” (Kandel, 2013, p. 200). This is also true for all perception as well as emotions. “We do not have direct access to the physical world ...this is an illusion created by our brain” (Kandel, 2013, p. 203). Gombrich and Kris took up the Gestaltists use of this phenomenon and declared that there is no “innocent eye” (Kandel, 2013, p. 203). All visual perception is based on classifying concepts and interpreting visual information. “Biological findings confirm that vision is not a window onto the world, but truly a creation of the brain” (Kandel, 2013, p. 216). Even color is constructed by the brain and this may be the reason why different people respond differently to a painting and even the same viewer differently at different times. This can also be said about one’s varying response to the same object/other. In addition, since we are creating all these objects, it also explains why we can continually misinterpret and see the same object “incorrectly” again and again; for example in projection and transference.

The fact that one cannot “see” what one cannot classify has meaning in development and psychotherapy. Therapists know this in the form of how a patient will deflect compliments, positive affirmations, progress in the therapy or in the form of the “bottomless bucket” of oral neediness. No matter how much they “get”, they don’t “get” it. You cannot tell someone something that they do not already know! How the object is “seen”, not the properties of the object is what contributes to development. The subject is deciding what happens to it, not the actions of the object. To illustrate, Kandel (2013) uses the well-known figure/ground illusion drawing of a rabbit or a duck depending on how one looks at it. There are two points he makes. One, the visual data on the page don’t change. What changes is the interpretation of the data. We “decide” what it is and there is no ambiguity. These decisions are based on “hypothesis testing” grounded in our innate neural pattern recognition abilities and past experiences. The principle of no ambiguity underlies all of our external perceptions. The conscious act of seeing is fundamentally interpretative. Rather than seeing the image and consciously interpreting it as a duck or a rabbit, we unconsciously interpret the image as we view it; “thus interpretation is inherent in visual perception itself” (Kandel, 2013, p.208).

The second point is that we are seeing something that isn’t there, (Kandel, 2013, p.210) There is only a single two dimensional image on the page. This is the principle I argued previously; all selves are self-referential (Davis, 2014). Meaning, value, belief, thought and decisions are based on the self-referential quality of testing out the experience, hypothesizing through our innate sense of self and our past and present experiences. Not only is the eye not a camera analogous to a TV or a computer recording pixel by pixel to create an image, the eye chooses and discards information, something neither a TV nor a camera can do. The eye is selective. It is a self referential agent self-organizing its perception. “Our perception of the world is a fantasy that coincides with reality” (Kandel, 2013, p.261). As therapists, we know “coinciding” can be tenuous. Involuntary perceptions “...have a fixed repetitive structure and thus ensure the continuity of self experience but thereby determine a limited perception of present reality” (Gottwald, 2014, p.68).

Kandel (2013) also reports that every conscious perception arrives half a second after visual processing is finished. Because sensory information must first undergo preliminary processing, (which I am calling self referential and self organization) all events that emerge in our consciousness must first have begun in our unconscious (Kandel, 2013, p. 466). There is a delay between the appearance of “premotor activation” and the decision to move. Usually interpreted as we have no free will, Solms and Panksepp (2012) say it shows only that the cortex based, abstracted represented self’s movement occurs later than the brainstem’s “core consciousness” initiating the movement. In fact, “...unconscious thought is superior for decisions that require comparing many alternatives” (Kandel, 2013, p. 468). Unconscious processing underlies every aspect of our conscious lives including all sensory perception. All experience is self-organized and filtered through our unconscious experience before it is decided what will be our *conscious* experience.

Unconscious processing is supported by and elaborated in recent studies on the vegetative level in pupil dilation and constriction. “Researchers have firmly established that the pupil changes in size not only in response to changes in the ambient light but also to significant nonvisual stimuli as well as thoughts and emotions” (Laeng et al., 2012, p. 18).

The idea that infants understand and organize experiences unconsciously is revealed in studies in which they are exposed to strange visual stimuli and their responses are documented by pupil constriction and dilation. When 8-month-old babies viewed a film of a train both entering and coming out of the same tunnel at the same time they were startled. As well, 6-8 month olds viewing a “socially unacceptable feeding situation” (Laeng et al., 2012, p. 24-25) recognized it as such. This is why these authors suggest that it might be time to re-evaluate the cognitive capabilities of infants.

#### 4. The Relationship to the Self is the Earliest Relationship

In light of current infant research (Beebe, in Mitchell, 2000; Kandel, 2014; Kouider, 2013; deCasper and Fifer, in Mitchell, 2000; Heppner, 2002; Laeng et al., 2012; Stern, 1998) it is clear that the first nine months in utero are a time of formative experiences including cognitive activity. After birth, the “logical” left-brain does not come “on line” until 18 months later, and it does not dominate until 5 years old. Therefore, the infant is learning self regulation for 27 months with non-linear, associative learning based only on right brain functioning with an “implicit” self that is body-based, non-verbal and emotional (Schore, 1999). Pagis, (2009) has argued for a “somatic self consciousness” before and below language that is not “dependent on direct social interaction” (p. 277). One becomes the object of one’s own subjectivity. For Solms and Panksepp, the interoceptive brainstem generates internal “states” rather than “objects”. The internal body is not an object of perception. Instead there is a background state of “being”. “It is the *subject* of perception” (Solms & Panksepp, 2012, p. 10).

In classical theory of the narcissistic phase the infant is undifferentiated from its environment so all experiences must be hers. In other words, the infant has already developed subjectivity. If the narcissistic self is “threatened” by external reality, as Kohut (2001) suggests, it must have enough coherence, enough sense of itself and its existence to *feel* threatened and take action against the perceived threat. Just as there is no “innocent eye”, there is no tabula rasa, or fragmented self. There is merely an undeveloped self with great potential. This primary relationship with that self is the template for all other relationships. I think that it is an example of Totton’s “engram”, a neurological term meaning “something inscribed within” (Totton, 2014, p. 5).



## 5. The Self Creates the Object

I take the position that there is an early, coherent, self regulating sense of subjectivity responding to the initial interpersonal relationships and as we have seen from the perceptual point of view, the self not only chooses the object, but creates the object.

Psychoanalysis has suggested that it is the infant's fantasies of the object not the object's actions that are crucial in object choices. The object need not do anything, the subject will spontaneously move towards it. Damasio (2000) describes this as "emotionally competent stimuli". Jacobson spoke of "affect matching" whereby there is no "good" mother but a mother that "feels good" to the child (Jacobson, 1996). In fact, the fertilized egg does not merely attach to the uterus. It spends time moving along the uterine wall and selects an appropriate place to attach itself.

A theme in object creation is "investment"; giving significance to the object: a specific quality, a charge of energy, desire or need. Most theorists argue that it is not the object qua object that is important but the investment made in the object by the subjective self. Mitchell (2000) comments that in the language of infant research, the mother and baby co-create each other and refers to the earlier writings of Loewald. Taking the obverse position of Winnicott, Loewald suggests that objects: "...do not exist independently of the subject. Objects are created by being invested with significance ...out of the primal density or primary process" (Mitchell, 2000, p.38). Kohut (2001) takes a similar view: "Narcissism is defined not by the target of the investment, but of the quality of the investment" (Kohut, 2001, p.26). And, according to Ryan (1991), "Research shows that it is the quality that determines functional significance rather than the particular event or object" (Ryan, 1991, p. 220). The same is true in a phenomenological approach. As we have seen from the perceptual view, of all the incoming information, it is the subject that chooses what to focus on. The result is: "...the focus of the behavior's field is most directly potent in determining behavior" (Syngg, 1941, p. 414).

Investment moves endopsychically outward creating an object and then a relationship. That is why it is difficult to agree with Fairbairn (1941) that the aim of the drive is the object. Why would the self go to all that trouble to get nothing back? According to Solms and Panksepp (2012) the internal body functions automatically, but it also arouses the external body to serve its vital needs. Indeed, Ryan (2003) argues that an over emphasis on the other causes a "psychological vulnerability", a dysfunctional state rather than natural self-organization.

There is no objective object. *Campbell's Psychiatric Dictionary* (2004) describes introjection as: "The incorporation into the ego system of the picture of an object as *he conceives the object*" [emphasis added] (p. 348). Idealization is an example of the self-created object. I had a patient who had schizoid tendencies. Middle-aged, professionally successful, she could not form long-term love relationships and came to me in a relational crisis. Even though she had friends, basically her life was her work and that was not enough to sustain her. Any time she talked about her family it was always in glowing terms yet she reported: "It is strange that every time I visit my family I have to leave after three days." During the course of therapy it became clear that there were deep-rooted problems in that family: a distant and dominating father, drug additions, alcoholism etc. As she became more secure, she could risk recognizing she had "created" a reality to fit her needs. She had to "create" a wonderful family who loved and supported her because she had no alternative. To use Jantsch's (1979) terminology, she is engaging in "temporal, optimal structuralization."

The psychoanalyst Andre Green (1999) criticizes object relations theorists as being too focused on the object to see “the objectalizing function of the life drive.” They overemphasize the role of the object and do not appreciate the endopsychic strivings, the investments of the self in creating objects and then relationships to satisfy *itself*. For Green, (1999) the object does not create the drive, it only reveals the drive toward the object; an emotionally competent stimulus. The object is a necessary precondition for the drive to be activated, but the drive is already there (Green, 1999, p. 85).

Green’s (1999) comment on investment is of interest in object creation. The role of the drive is not merely:

...to form a relation with the object but it is capable of transforming structures into an object even when the object is no longer directly involved. To put it another way, the objectalizing function is not limited to transformations of the object but can promote to the rank of object that which has none of the qualities, characteristics and attributes of the object, provided that just one characteristic is maintained in the psychic work achieved, i.e., meaningful investment (p.85).

He even suggests that the self creates objects in their absence. An example of this is poignantly described in a memoir by J. R. Moehringer (2005). His parents were separated and he rarely saw his father. But because his father had a radio program, in the warm summer evenings he sat on the front steps of his grandparent’s house and listened to his father’s voice. He created a whole persona of the father that was later to be shattered once the father finally showed up. He was “seeing” something that wasn’t there.

To make matters more difficult, it has been suggested that it has never been proven that humans even make mental representations (Anderson, 2003). Kandel (2013) raises this issue when referring to the cognitive psychologist Richard Gregory:

Is the visual brain a picture book? When we see a tree is there a tree-like picture in the brain? ...the answer is a clear: no! Rather than having a picture, the brain has a hypothesis about a tree ...that reflects as a conscious experience of seeing (p. 232) ...we do not yet understand the detailed neural mechanisms of this symbolic representation” (Kandel, 2013, p.233).

For Green, (1999) hypothesis testing is the subject investing in the hypothetical, self created object promoting “...to the rank of object that which has none of the qualities, characteristics and attributes of the object” (Green, 1999, p. 85). For example, my patient had a hypothesis about her family until it was possible to “recreate” a more reality-oriented family. The external data remains the same. Her family didn’t change; she reorganized her data and her experience of the family changed.

In addition to Kandel’s work, this is supported by research in pupillometry. “During changes in perception, nothing changes in the world of environmental input, so any change in perception must be attributed to internal change of the state of the brain that results in interpreting the same world state as a different event” (Laeng, Sirois & Gredebäck, 2012, p. 22).

Mitchell (2000) asks why are early object relations so persistent and resistant to change considering how much we suffer from them. Loewald (Mitchell, 2000, p. 44) responds. On the conscious, adult level, there are boundaries between the self and other. But on a primary process level, I *am* my objects. They cannot be expelled but can be transformed; they can be re-hypothesized. The objects don’t change, the self’s experience of them does. The self creates objects and therefore it is able to also recreate them if circumstances change; temporal, optimal structuralization.

For example, I had never discussed with a patient his relationship with his father. Yet, after a series of sessions he was reading one evening and he spontaneously thought of his father and began to cry deeply. He explained that he cried because he realized that his father loved him. He realized that his father was a troubled man and the negative things the father “did” to him were not actually done against him. He understood that his father did stupid things and he, as a boy, suffered from that. But it was clear that the father loved him and then all his anger towards his father simply disappeared. He could then love his father. The aim of the drive was not his father but his *loving* of his father. In addition, he redefined his sense of self and he became a “lovable” boy. How could such a transformation take place? Simply by re-hypothesizing the same object differently his experience changed. First it was a duck, and then it was a rabbit. First he was unlovable, then he was lovable. The external data does not change. As one patient said, “Now that my sadness is clear, I don’t have to cry about it anymore.”

At the same time, the role of the other is critical to development. A rephrasing of Green’s (1999) “the other reveals the drive” is Ryan’s (1998) position that the true self can only emerge in relationship. Individualization happens *with* others not *from* others. With this model, the role of the object is being redefined, not dismissed.

## 6. The Self Creates the Object not to Satisfy its Needs, but its Desires.

It is common to talk in terms of “needs”. Maslow’s (1968) hierarchy of needs is a model for development and human nature. It is generally understood that the psychic and physical needs of the infant are what initiate the interaction between mother and child, and they must be satisfied well enough in order for healthy development to continue.

To differentiate between desire and need changes the theoretical landscape. Need arises when the desire is not met. Need is a state of difficulty, a sense of deprivation with a goal implied – usually at a distance. Desire suggests mutuality, a give and take dialogue by placing a “request” to respond upon the other to whom the desire is expressed. It has an impervious quality, a request that must be responded to (Crabb, 1917). *Need is frustrated desire*. A desire to be in contact is a different state than a need to be in contact; It has a different origin, intention and outcome.

When a child feels alone, she “desires” contact; a “positive” drive. When she is lonely, she needs contact. From a humanistic view, we must be in contact to be fully human. In a desire state, there is no tension that has to be discharged to use drive theory or Reichian energetics. The “tension” that does exist within a desire is an excitement that acts as a mobilizing force towards the object and is well within the tolerance levels of the organism. It is pleasurable. If the desire is not met, then it transforms and turns into need – a lack state. The “pushy”, “gluey” shrill quality of the need state is a symptom of the unmet desire. A need state is symptomatic of a lack. When desire is met satisfactorily, development continues as desire evolves and transforms into the next stages of development. An unmet desire turns into need that in turn is also usually unmet resulting in an arresting of development with all its frustration, anger and loneliness: the pathological orientation.

Additionally, it should be noted that satisfying needs only creates the *possibility* that the desires will be met, which brings up the theme of immutability. I have argued for the humanistic model of an inexorable “push” towards development, differentiation, growth and satisfaction (Davis, 2014). As Reich’s (1950) energy concepts formulate, you can interfere with development, but you can never stop it from trying to move forward towards completion and satisfaction. For example, sublimation, transference and projective identification have

the same root. Kohut (2001) called it the “narcissistic stream” which remains unaltered throughout life and is the basis of creativity, love, and all future relationships. Even when met, this innate, immutable push towards development and satisfaction will spontaneously continue to transform into the next phase of development. It is embedded in health and dysfunction. The patient cited earlier is an example. Despite his history, he continued to desire a loved and loving father, and once this was achieved, he could move past his resentment and enter into an adult relationship with his father and not a bad father/resentful child relationship.

Immutability is shown in the fascinating film from the 1970’s, *Three Approaches to Psychotherapy*. The same woman, Gloria, is the patient in three separate therapy sessions with Fritz Perls, Carl Rogers and Albert Ellis. In the middle of the session with Rogers, in what seems to be a classical transference, she says: “I wish I had a father like you.” Rogers demurs, commenting that surely she would make a fine daughter, but pointed out that the theme was about her relationship with her real father (Shlein, 1984). Besides Rogers gently deflecting the focus back on the patient, what is interesting is she did not say, “I wish *you* were my father.” Fairbairn’s (1941) patient also did not say she wanted him to be her father or in fact wanted her *own* father probably because that didn’t work out so well. Gloria was simply calling out to be “fathered”. With Rogers’ interaction Gloria’s *need* to have a father was recognized and accepted by his caring presence. She felt seen and respected. She could then focus on her desire for a father and not have to continue to distract herself by acting out a lack. When the father figure changes from a love object (need state) to a loved subject, (desire state) she will be satisfied.

In discussing transference, Shlein (1984) refers to what I call the immutable desire for contact.

One of the errors in transference theory is the illogical assumption that any response duplicating a prior similar response is necessarily replicating it. Similar responses are not always repetitions. They appear to us to be repetitions because, in our effort to comprehend quickly, we look for patterns, try to generalize. There is breathing as a general respiratory pattern, but my most recent breath is not taken because of the previous one: rather, for the same reason the previous breath was taken, and the first breath was taken. It is not habit. It is normal function, repeated but not repetition (p. 21).

Schore, (1999) like Kohut, (1999) emphasizes this continuing search. “Embedded within the patient’s often vociferous communication of the deregulated state (need in terms of this discussion) is also a definite, seemingly inaudible, urgent appeal for interactive regulation (desire in terms of this discussion). This is a lifelong phenomenon” (Schore, 1999 p. 14). Guntrip (1975) referred to the dual nature of all relationships; the seeking of the “good object” within the transference. Disguised behind the denial and projection, the sadness and disappointment of the lack state, the “normal function” of the original immutable desire is still there.

Reich (1976) emphasized that the analysis could not proceed without reaching a level of “genuine transference” with the patient; “...the glimmerings of rudimentary genuine love” (p. 143). The original desire for the object is still intact but obfuscated by false positive transference. Genuine transference is desire, rooted in the endo self. False positive transference is need and lack rooted in dysfunction and sought in the object.

Shlein’s (1984) argues that original love for a parent is not transferred because there is no earlier instance. This love emerges because the “conditions” are right; an emotional competent stimulus is present. Repeat these conditions and the same response will be produced and not *reproduced*. Each instance is new; repeating but not repetition.

...consider that every second instance might as well been the first. Warmth feels good to the body, not only because it felt good when one was an infant, but because it always feels good.

It is “wired in” as an innate physiological requirement. When one tastes a lemon at age 30, does it taste sour because it tasted that way at age three? It always tastes sour the first time at any age. This logic is functional (Shlein, 1984, p. 14).

My position is that desire is wired into the endo self.

Similar to Kohut (2001) and Schore (1999), Green (1999) points out that there can be more than one object (Green, 1999, p. 9). Continual searching for an object is usually indicative of the need state. It is not to satisfy the need or to satisfy the object for that matter, but to fill in the spaces, *what did not happen*. Because of immutability, a need state will automatically seek to detach from an object, re-organize and search for a more satisfying object.

## 7. The Object Does Not Gratify

The object does not satisfy the desire. The object can only satisfy needs. Needs are object oriented and are dependent on the object itself. The psychoanalyst Hanna Segal (Buckley, 1986) mirrors Maturana and Varela’s (1998) communication model. She emphasizes that the object can only be correctly evaluated in relation to what it means in terms of the infant’s own instincts and fantasies. It is what is “invested” by the self that determines the outcome.

The infant is not seeking the object per se. It is seeking the experience of itself within the object relationship; the experience of the experiencer. In energetic terms, gratification is the completion of the instroke of the pulsation, the return to the self. This results in the incorporation of relational content; what has been received, not what has been transmitted determines the infant’s experience. “A man does not live on what he eats, but on what he digests” (Pollan). The diagram below represents the movement outward to the other, then the return to the self for metabolizing of the relational content. It is at this point that experience occurs.

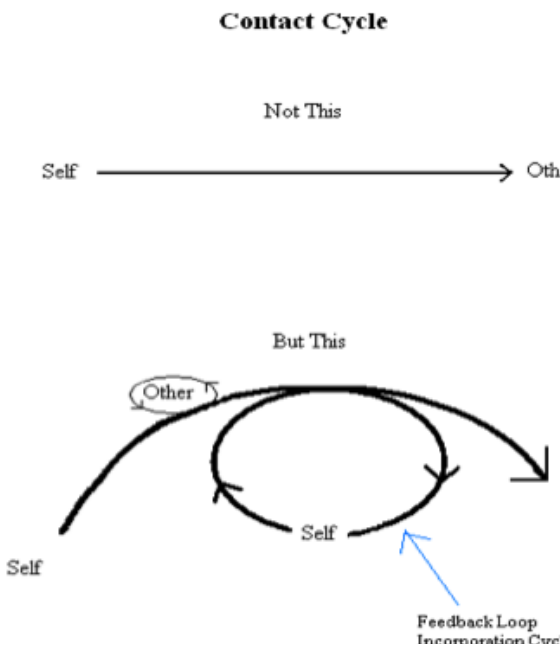


Figure 2. Diagram of the contact cycle.



The patient with the “stupid” father re-created a primary object with exactly the same data: his life history. His immutable desire to be “fathered” had been met. His experience of the father was what was important in both the first and the second instance *not what the father had done*. Perception is based on the “eye of the beholder” and not on some absolute external reality. This is why we cannot only re-experience the object as a need based repetition, but can recreate the object to be self-satisfied. There is no objective object, no “innocent eye”.

Piaget’s position is that intrinsic motivation is merely for itself. “The pleasure in mastery, in effectance, in experiencing action merely for its own sake is, as Piaget once called it, a basic fact of psychic life” (Ryan, 1991, p. 209). There is self-oriented satisfaction in “mastering” the task. Vilayanur Ramachandran (Kandel, 2013) writes that the wiring in our brain ensures that the very act of searching for the solution is pleasurable. This is why Green (1999) referred to the “objectalizing process” itself as that which satisfies. If it is the object that satisfies, why is it that even when the object wants to satisfy it cannot? Any parent knows this feeling. Any left lover knows this experience.

### **8. In Both Development and Therapy, Detachment is as Important as Attachment**

Attachment theory was an important step forward but more attention needs to be paid to defining *detachment’s* role in development: what it is, how it works and why it is necessary as the pulsatory obverse of the all important attachment process.

Developmental theories describe a series of phases the child passes through i.e.: from a fused mother/child dyad, to separation and on to autonomy. But how does a child develop into the next phase if he is attached to the present one? How can he redefine the role of the mother if he is still experiencing the “same mother?” He must let go to get a hold of something new or else there is fixation. Everything stays the same; she is still my “mommy”. In healthy development, we see the data, the mother, being recreated into another representation. But in order for that to happen, we have to let go of the previous representation and trust what comes next. What is this letting go process in order to evolve? How does it happen and how does it not happen?

Ryan (1991) addresses the paradox of separation while being in a relationship. Autonomy is dependent on strong familial bonds: an autonomous self, grounded within relationship. “...a facilitating interpersonal environment. Clinical evidence suggests that extreme detachment leads to self pathology” (Ryan, 1991, p. 223) leading to less individuality, self-cohesiveness, and diminished feelings of safety, trust and self esteem.

A sense of security, an anchoring, must be in place in the primary relationships in order to face the risk of letting go so that the next developmental phase can emerge. “Autonomy does not entail severing emotional ties. Continued emotional attachment during adolescence facilitates individualization” (Ryan, 1991, p. 222). A major source of this anchoring is in the familial bonds, but I would also argue that the felt sense of security needed is in the well developed being state of the endo self. Security is present because previous desires have been met by familial bonding. A patient reported: “Now I know my mother loves me and I understand that has given me security in my life.” I asked “Did the mother ‘give’ security to you or were you allowed to develop it yourself?” She responded, “I developed it in myself.”

Changes in development or therapy are not done in “stages” or even phases. They are done in the sense that Freud first used the word “*schübe*”; rhythmic, pulsatory movements

back and forth. A child does not suddenly become autonomous and leave the house or see its mother as an adult woman with a separate life. It goes through pulsatory movements away from the mother and then back again in an ever widening and deepening pulsatory loop; back and forth with the emphasis of the pulsation towards development with a return to the relationship to recharge as Winnicott (Buckley, 1986) noted or Mahler's (1972) refueling. It's a pendulum movement using its own momentum to "throw" itself into the next development theme. The diagram below shows the rhythmic, pulsatory movement as the child moves away from the mother (detaches) in exploratory/evolutionary movements and then back again (reattachment). If all goes well, each movement back towards the mother to recharge will diminish progressively and simultaneously support the next exploratory movement outward. If all goes well, all experiences of the mother in the return movements will be slightly altered from the previous one.

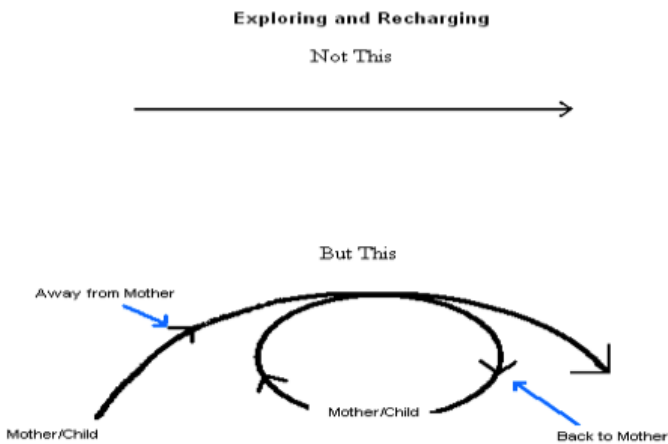


Figure 3. Diagram of Exploring and Recharging.

The exploring/recharging dynamic is also represented in an attachment/detachment/re-attachment schema. "Object-cathexis is not the investment of an object with some charge, but an organizing mental act [t]hat structures available material as an object. Such a cathexis creates – and re-creates and re-organizes – the object qua object. It is an objectifying cathexis" (Mitchell, 2000, p.38). The re-creating process can only happen through detachment so that re-attachment is possible to a newly perceived, "re-created" object. De-objectualizing, detachment, is a function of the instroke process whereby the person returns to a deep sense of self and re-creates his experience of the very same external object. "...all events that emerge in our consciousness must first have begun in our unconscious" (Kandel, 2013, p.466). Unconscious processes underlie all perception and all experiences are "filtered" through our personal history/structure/engrams.

The function of the instroke, unconscious processing, detaching and re-creating reality, is creativity. Kandel (2013) reports that the unconscious can deal with several items simultaneously in an orderly fashion, while our conscious attention can only focus on a limited amount of information to avoid ambiguity (Kandel, 2013, p.467). In tandem, the Default Mode Network of the brain when it is "idle" is seen as an "organizing

center” and this function of the brain is always “online” (Raichle, 2010):

While conscious thought processes integrate information rapidly to form an occasional conflicting summary, unconscious thought processes integrate information more slowly to form a clearer, perhaps *more conflict free feeling* [emphasis added] (Kandel, 2013, p. 469).

Solms and Panksepp (2012) call for starting in the “basement” of the brain; from the brainstem up to the cortex. There is the same bottom/up movement in robotics and computer design (Anderson, 2003).

Kandel (2013) describes subjects in a study that were presented with different mental tasks and then divided into three groups. The first group was to respond to the task immediately, the second group had some time to think about it, and the third group was immediately distracted with another task. The distracted group consistently performed the best (Kandel, 2013, p. 468)!

Kandel (2013) brings instroke/detachment into clearer focus. Creative solutions require association areas of the brain to integrate information unconsciously in a way that it could not do consciously. “Once focused, the brain needs to ‘relax’ in order to seek out other potential paths to a solution” (Kandel, 2013, p.483). This is why the distracted subjects in the experiments were able to come up with creative solutions to the tasks; the brain was given time to unconsciously process more information than could have been processed consciously. The conscious mind has to create a rabbit or a duck. The unconscious can tolerate ambiguity and paradoxes for a longer period of time giving it access to more information.

Raichle (2010) has shown that what was typically called background noise in the brain turned out to be the “default mode” of the brain: “a network of brain regions that are active when the individual is not focused on the outside world and the brain is at wakeful rest,” with the unconscious “organizing itself for future events” (Raichle, 2010, p. 28). This is Kandel’s brain relaxing, what I am calling the instroke process. Raichle’s observation of systematic patterns of ongoing brain activity when the subject is in a resting state has transformed the way the human brain is now being studied in health and disease.

The brain’s default network ...is a specific, anatomical defined brain system. [It is] active when individuals are engaged in internally focused tasks including autobiographical memory, envisioning the future, and *conceiving the perspectives of the other*. [Emphasis added] (Buckner, Andrews-Hanna, & Schacter, 2008, p. 1)

Raichle’s (2010) work is a modeling of the instroke process as the detachment process in therapy; the brain “relaxing” to re-experience and create or recreate an experience/object. At its deepest point, the patient goes into an endo self *state* reminiscent of Maslow’s being states (1968) and of Solms and Panksepp’s (2012) “background being state” of the brainstem’s “core consciousness”. The outside world, including the therapist, is not so important at that moment. Then the patient is able to re-organize pre-existent information within and come up with a new perception/experience of the same historical event. A good example is the patient who changed his experience of his father. Continuing to hate and be angry with his father was a fixation on one *facet* of the father that *defined the entire object* and therefore the relationship. Through the instroke process, detachment was possible, a contactful distance was achieved, and when he moved back towards the father he “saw what he did not see”; other facets that redefined

his history as well as redefining his current relationship with his father *and* himself.

The ability to draw on innate, unconscious abilities is also found in “acquired savant syndrome” showing us that this phenomenon is not limited to personal histories. It may be a universal function of the brain to draw on the unconscious’s heretofore-unacknowledged knowledge and redefine how we see the unconscious. (Some researchers suggest that this type of savant is similar to the well-known savant syndrome.)

In acquired savant syndrome, near genius levels of artistic or intellectual skills show up after dementia, a severe blow to the head or another insult to the brain. Discovery of this unusual phenomenon raises the possibility that dormant potential in some artistic or intellectual realm – an “inner savant” – resides in each of us (Treffert, 2014, p. 44)

Using the findings of Kandel, (2013) Raichle (2010) Treffert (2014) and Solms and Panksepp (2012) who postulate a neuroevolutionary “two tiered” consciousness, Freud’s original “iceberg” image of the conscious and unconscious might now have to be reformulated. Consciousness is not generated in the external, relational oriented cortex as previously thought. Consciousness arises in the brain stem, what was previously referred to as the chaotic, destructive, primitive id/unconscious. “Consciousness is endogenous, subjective and fundamentally interoceptive in an affective kind of way” (Solms & Panksepp, 2012, p.164). Maybe classical consciousness is merely having a limited awareness of a rich, deeper stratum of organized and organizing knowledge which has typically been referred to as the (negatively) formulated unconscious. Can we turn the image upside down? Similar to meditation models, can we rename the unconscious as true consciousness that we are unaware of? Raichle (2010) points out that to go from a idle brain – daydreaming for example – to paying attention to the outside world takes less than 1% percent increase in brain energy usage. “Being phenomenally conscious does not, by itself, require much cognitive sophistication at all” (Solms & Panksepp, 2012, p.1). This is the tip of the iceberg.

In addition, the life negative attributes of Freud’s unconscious are not what is being revealed in Kandel (2013), Raichle (2010), Treffert (2014) and Solms and Panksepp (2012): there is order and organizing, knowledge and safety. Will Maslow’s positive psychology finally be verified?

The creative instroke/detachment process allows the return to the self, a temporary self-attachment to a secure, brainstem located being state, the endo self, and then a reattaching to the newly experienced object. There is identification with the self that allows the detachment to be experienced safely so that then a re-creation can spontaneously arise. It allows the patient to participate in his or her own healing process.

## Summary

I have taken the position that there is an overemphasis on the role of the other in development and psychotherapy models. Using a multidisciplinary approach I have argued for a greater emphasis on the role of the subject/self in its own development and offered eight basic principles to elaborate a self oriented theory of development and psychotherapy. The research of Kandel, Raichle, Treffert, Solms and Panksepp and Laeng all call for a reevaluation of a deeper sense of self and its importance in making creative solutions to life’s situations.

Through recent brain research as well as clinical cases working with the instroke, it seems that it is time to re-formulate Freud’s model of the unconscious and his descriptions

of its characteristics. I also suggest that the centripetal instroke movement of the pulsation back to the endo self is the creative and developmental process itself.

The result of this is a reformulation emphasizing the self's participation in its own creation; a self to self theory of development and healing.

## BIOGRAPHY

Will Davis (1943) is an American with over 40 years of experience in psychotherapy. He conducts body psychotherapy training workshops in Europe. Will developed the body-oriented psychotherapy, Functional Analysis, and is considered one of the major researchers in the fields of the functioning of the instroke and of the plasmatic basis of early disturbances. He is on the International Advisory Boards of the *Journal of Energy and Character* and the *International Body Psychotherapy Journal*. He is a member of the Scientific Committee of the Italian Society of Psychologists and Psychiatrists and the European Association of Body Psychotherapy. He lives with his wife in the south of France. Email: willdaviswilldavis@gmail.com Website: www.functionalanalysis.de

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## Research 101 for Somatic Psychotherapists: Cultivating a Research Mind Christine Caldwell & Rae Johnson

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### Abstract

Many parallels exist between clinical practice and research practice in somatic psychotherapy, creating rich possibilities and cross-fertilizations. In this article, the authors introduce and discuss these parallels, and examine how they can be leveraged to advance emerging research interests in the field of somatic psychology.<sup>1</sup>

*Keywords:* body psychology, body psychotherapy, somatic psychology, research, embodiment, clinical research, psychology research

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Traditionally, somatic psychotherapists have focused on building theory as it informs, and has been informed by, clinical practice: an activity that is common across psychological disciplines that are in their formative stages of development. In this formative stage, the field also has tended to organize around theory-building via guild systems; students study both theory and practice under an identified master who is often a pioneer in the field. Under these conditions, the field often ‘borrows’ research from other disciplines in order to understand and identify itself (Caldwell & Johnson, 2012; Heller, 2012). As the field of somatic psychology matures, it has supported the development of university-based academic programs, institutions that devote themselves to cross-modality constructs and scholarly critiques. The activities of these programs can help pave the way for the field to build on its theoretical bases through empirical study, thereby ‘fleshing out’ more fully its own research interests and validating its unique perspectives, using constructs that all students of the field can access and study. This article attempts to identify ways in which clinical and research processes share common values and methods. By taking advantage of these overlaps, it is possible to increase our collective capacity as clinician-researchers to engage in scientific and critical inquiry, and potentially influence the broader culture to engage in more embodied research methodologies.

Though the particular worldview that science creates is only one way to look at and understand phenomena, it nevertheless holds some important values that can assist with the maturation of a field like somatic psychology. Science values systematic inquiry, a way of approaching problems in a methodical way. It commits to self-questioning as a way to surface and correct for implicit biases. It stresses self-correction by replicating studies and exposing them to the criticism of peers.

<sup>1</sup> This article is edited and adapted from an interview for Somatic Perspectives with Serge Prengel. The original interview can be found as an audio recording podcast and as transcription on the United States Association of Body Psychotherapy (USABP) website. Our thanks to Corinne Bagish for providing the interview transcription upon which this article was based.

Most importantly, it cares about understanding the individual and collective world, rather than asserting the self-interest or unexamined views of any particular individual or group (Jackson, 2008). By studying the field as a whole, research in body psychotherapy can help to create an overarching pedagogy that can support and modernize the theoretical and clinical work of its pioneers, and more fully address some of the urgent social and mental health problems of the 21st century.

The professional associations in the field of somatic psychology are comprised primarily of clinicians, many of whom feel somewhat distanced from the research agenda and activities in somatic psychology (Academic Council meeting, United States Association of Body Psychotherapy (USABP) conference, Philadelphia, 2008; Scientific Symposium, European Association of Body Psychotherapy (EABP) conference, 2012). Many members of these associations haven't been involved in any research since they finished their academic degrees. And for some, those degrees or trainings did not necessarily involve being a principal investigator of original research, or involved in any form of research. Given that research can be complicated to undertake, difficult to interpret, and experienced as inaccessible, many clinicians rightly feel under-prepared to engage with research activities and findings in an informed way. Also, given that research often dictates theory, policy and practice in psychotherapy, clinicians may also challenge psychological research as being insufficiently related to the 'on-the-ground' experience of working with actual people and their problems. Historically, there has been some understandable disconnect between the largely academic culture of research and the primarily clinical culture of body psychotherapy or somatic psychotherapy practice. As trainers, researchers, and clinicians, the authors see the intersections between the clinical perspective and the research perspective and are motivated to articulate the common ground across these areas, and to identify an attitude that can be common to both. As Jackson so aptly puts it, "What makes something a science is not *what* is studied but *how* it is studied" (2008, pp. 4).

For instance, the authors believe that there are ways of approaching both the clinical experience and the research experience that are extremely compatible. In fact, they stem from the same root. As academics, we tend to describe those roots in terms like "critical thinking" and "attitude of inquiry", and yet those same skills can be developed by working hard to become a good clinician: one who holds an attitude of curiosity and humility as a therapist. The attitudes and values of a good clinician actually parallel those of a good researcher.

This can be particularly true in the current research climate, where constructivism can be honored as much as positivism (Charmaz, 2000; Denzin & Lincoln, 2011). Positivism comes from the belief that there is a particular, knowable world out there, and it can be discovered through empirical means. Positivism has fueled much of the research activity of the last few hundred years. Constructivism, on the other hand, asserts that human beings build or construct our world out of our unique experiences, experiences that are influenced by our culture and by other social forces. Positivism tends to want to find 'the truth,' while constructivism is interested in people's 'lived experience' of their world: *their* truth. Both these views can be useful, but – because a somatic psychotherapist usually wants to help empower clients to relate to their bodies as a powerful source of inner knowledge—clinicians can learn a lot through constructivist approaches.

A good 'constructivist' clinician asks questions that are genuinely curious and avoids leading questions. Not, "*Let's direct this client over here because we think we know what is best for this person*", but instead, "*What was that like for you?*" This is particularly important when inquiring about the client's somatic experience, which is so inherently complex, subtle, and nuanced. To be genuinely helpful, a good clinician assumes that, even with very highly tuned perceptiveness and a strong

empathic connection, one is never going to know exactly what it is like to be in someone else's body, and that one does not have the right to dictate what is happening in someone else's body or how those happenings are interpreted.

This same process occurs when interviewing a research participant, particularly in a qualitative study. Qualitative methods want to get at the 'qualities' of a person's experience, rather than 'quantifying' experience by reducing it to numerical values (Denzin & Lincoln, 2011). In qualitative inquiry, for instance, researchers don't want to ask a client leading or loaded questions, nor do they want to impose an hypothesis. Like good clinicians, good qualitative researchers want to lead participants to a place of their choosing that they might not be able to get to by themselves. This facilitative role is nearly identical to therapy, where the task of the therapist is to facilitate the exploration and articulation of an experience that is meaningful to the client, rather than impose a pre-packaged analysis.

This important shared characteristic might be described as open mindedness, a curiosity and non-attachment to outcome. A significant impediment to valid research relates to wanting a particular result instead of wanting to learn something. This is also a source of difficulty in therapy. The standards of practice for both psychotherapy and research are designed to provide a framework that keeps the therapist's counter-transference (or the researcher's bias) from intruding.

Unique to research is that the articulation of an experience is understood not just to be useful to the research participant, but potentially also to others wanting to understand this phenomenon. Where a clinician might ordinarily conclude an intervention with, "*Okay, great, sounds like you just got something that's useful for you*", a researcher might wrap up with, "*Thank you! Now I need to figure out a way to frame what you've just communicated to me in a way that makes it intelligible and relevant to other people.*" In this sense, research may have a more of a parallel to clinical training.

One of the root concepts in research – one taught on the first day of any research class – is the concept of skepticism. All researchers are required to be skeptics – to refuse to accept anything without evidence, and to question everything. Another important concept in research is transparency – studies are expected to be transparent, so that others can question it. Researchers are expected to publish how they conducted the study, and to be explicit about the methodology and the analysis. Researchers want their research to survive the skepticism of their peers.

Although the concept of skepticism is central to good research, the word 'skepticism' doesn't usually translate well to a clinical context and could be counterproductive to the therapeutic relationship. Despite this, it can be very useful for a therapist to take an initial attitude of neither believing (nor disbelieving) the client's statements, but attuning to them and trusting that the mutual inquiry will yield therapeutic results. The concept of transparency is also central to the clinical supervision process; the supervisee is expected to reveal the details of their work and to critically examine ways in which it can be improved. As clinicians, we assume that we never outgrow the need to expose our work to the feedback of other professionals.

Another way that skepticism translates to clinical practice is in the examination of bias and clinical "blind spots" – therapists benefit from questioning their work in an open, curious, and rigorous way. Science offers a number of rigorous ways to examine a project, whether it's a therapeutic session or research study. These strategies always involve critical thinking, which is central to learning an academic discipline, including research methods. Critical thinking pushes back against both egocentric thinking ("This is true because I want to believe it to be true.") and sociocentric thinking ("This is true because my people have believed it for a long time"). Clinicians can benefit from this kind of rigor – training in research may be able to make us better self-reflectors, as clinicians.



Skepticism might also translate to a clinical context via the suspension of judgment. A good clinician is discriminating, but is also capable of suspending judgment, until he or she has enough evidence to be able to say, “*I’m reasonably certain that this is what’s going on,*” or waiting until session three or four before saying, “*You know, based on what you’ve said and what I’ve heard and what we’ve talked about, I feel reasonably certain that this may be one of the things that’s going on here. What do you think?*” In research, investigators often hold a ‘working hypothesis,’ which means holding an idea about what is going on while still gathering more data before feeling confident. Postponing certainty is central for both good researchers and good clinicians. In therapy practices, for instance, it is often noted that the more certain a therapist feels about something in a clinical environment, the more likely it is that they are in a state of countertransference (Martin, 2000). Both in clinical practice and in research, it is important not to impose pre-conceptions on methods or interventions.

There is a parallel practice in research that strengthens a research study’s outcome, when the researcher goes back to participants in a qualitative research study and says, “*Did I capture what you told me? Does this description fit your experience?*” Additionally, co-researchers may each analyze the same data to find congruencies and affirm findings: “*This is how I analyze the data. When I analyze the same data that you gathered; I get very similar results. The themes that I identified when I looked at your data are the same themes that you’ve identified.*” This “inter-rater reliability” establishes some degree of confidence that not just the principal researcher asserts a set of findings, but others do as well. In a parallel process, clinical peer supervision gives us inter-rater reliability in a therapy context.

### **Developing Research Skills**

Clinicians may become intimidated by research when they assume that research requires large, sophisticated studies involving laboratories and complex equipment. In reality, there are many simple studies that make important contributions without the need for machines or complex statistical analyses.

Three central concerns of science are to describe behaviour, predict behaviour, and explain behaviour. By doing this, science can help society to solve problems. Therapists are also interested in these three elements, but they tend to focus on studying behaviour in an individual or group as a way of facilitating the healing of just that individual or group. As noted above, there are three basic types of research methodologies. The one that tends to be the most familiar to the public is the explanatory method. This method uses experiments to determine cause and effect between variables. This method can also be called outcomes research. This method would answer the question, “*Did this treatment method cause a beneficial result in a certain number of clients, and does that benefit persist?*” This research can be complicated and difficult to do well, because it requires the researcher to control everything in the study in order to make sure that some other variable isn’t the one causing the result. To use a clinical example, a therapist can test a client in various ways to see if they improved as a result of being in therapy, but if the client was simultaneously taking yoga class while in therapy, it isn’t possible to say that yoga wasn’t the cause of the improvement. Clinically, it is often impossible to control the variables in a person’s life such that it is possible to assert that the salient ingredient in their improvement was psychotherapy. Research has developed strategies for addressing this problem, such as extremely controlled conditions, large sample sizes, and random assignment to treatment groups, but few clinicians have the time, money, training, or will to engage in such controlled environments. Although this type of randomized controlled trial (RCT) is required to ‘prove’ whether a treatment (like a new drug or a therapy) works or not,

there is active debate as to how appropriate this type of ‘medical’ research is when applied to the field of psychotherapy (May, 2012).

The second type of research method is called relational or predictive. In this method, one searches for a relationship, a correlation between two things, but doesn’t attempt to establish which one causes the other, or whether the two things are caused by a third variable. Correlations can be either positive or negative. In positive correlations when one variable goes up, so does another, such as ice cream consumption going up when temperatures rise. In negative correlations, when one variable goes up the other goes down, as in the correlation between increased education for women and a decrease in infant mortality. In predictive studies you don’t necessarily need a control group, and this can make the study easier and less costly. This can be important for research that involves therapeutic interventions, because withholding treatment (from a control group) is considered unethical in some situations.

The third form of research is descriptive. In this type of study, you are seeking to simply describe phenomena, either in a natural setting, or in a laboratory. You might observe non-verbal communication, for instance, or interview someone about their experiences of therapy. Here is where you might do a clinical case study, because you are seeking to just describe the effect – on a particular person – of a course of treatment. Surveys tend to be descriptive as well, as they report the trends in people’s answers to a certain set of questions or statements. Descriptive research studies can be a lot easier to set up and run. It doesn’t take a lot of money or equipment to do a case study, for instance. But a note of caution – it can be easy to do these methods, but hard to do them well. The important issue is to apply ‘the research mind’ to any project that you undertake. That way, even a modest, simple study can contribute to the field, and be a credit to the field, because it is done with intellectual rigor, systematic thinking, examination for possible error or bias, good methodology, transparency, and ethical actions.

In a sense, clinical work involves all three types of research. Therapists engage in descriptive research when they ask clients to describe their somatic experience, and describe the client’s postures, gestures, or expressive movements to them. They engage in correlational research when they support a client to experiment with the relationship between their breath and their anxiety. Therapists engage in informal explanatory research when, over time and repeated trials, the client finds that moving as they feel an emotion causes them to feel more empowered than when they freeze during an emotion.

One difficulty that arises for many clinician/researchers is the need for permission from an institutional review board (IRB) when doing any kind of human subjects research. In order to ensure that the participants in a study are not harmed as a result of their participation, it is necessary to have a proposed study reviewed by a trained group of researchers who will determine whether or not the study obeys ethical guidelines centered around making sure participants are at choice, protected from harm, and fully informed. While all universities and research institutes have IRB Boards, they are difficult to access by private clinicians. This gives the field of somatic psychology one more reason to support the continuance of the field in academic environments, as the research that helps us investigate what we do will need to involve academic or governmental partnerships.

### **Future Directions**

What does it take to build on our clinical mind and generate more of a research mind? Below are some recommendations:

- All good research begins with looking at the literature relevant to the research question, and

having a good grasp of what others have already done in this area, before you attempt to do something new. One way to develop research skills is to read the research literature in topic areas that are of interest, and becoming familiar with the methods used, and how the data was analyzed. Don't just read books on a topic, read the actual research articles that the books are based on. This also requires certain technical skills: learning how to use online databases, and library searches.

- Pair up with a colleague who has done research before, and do a project together. Or pair up with a researcher who wants to do research on some (of your) clinical patients: though both of you will need to ensure that the research does not interfere with the therapy.
- Don't count on grant monies. Grant monies tend to flow to people who already have an established history of research publication. Unless you can pair up with someone who has respected research credentials, it is best to:
- Start small, with a modest number of participants and modest research questions. Construct a project that you can do with little or no money, and that won't take years to accomplish. This will likely be descriptive or correlational research.
- When you do publish your results, make sure it is in a proper, peer-reviewed, scientific, psychology-based journal, ideally one that is fairly mainstream, with a citation index. It is probably best to ask someone familiar with research publications to 'mentor' you through the technical aspects of presentation, lay-out, format, etc.
- Don't attempt a research method that you don't have the resources or know-how to do properly. A project using an experimental method will not get published if you did not control all the variables and remove all possible alternative explanations, even if the results are interesting.
- Educate yourself on emerging research methods that are more culturally competent, consistent with the practice of psychotherapy and especially those that value the voice of those whose voices have been marginalized. These can include participatory action research, arts-based research, feminist-based research, indigenous-based research, and any method based in critical theory (Caldwell & Johnson, 2012; Chambers, 2008; Clifford, 1994). We don't need to buy into only engaging in positivistic research methodology, especially since those methods have in some cases been used to exploit and harm the people they study.
- Use research strategies that honor and privilege somatic experience (Todres, 2007), such as embodied reflexivity in research (Finlay, 2005; Hein, 2004), embodied data transcription (Brooks, 2010), embodied data analysis (Chadwick, 2012), embodied writing (Anderson, 2002) and embodied data presentation methods (Denzin, 2003; Spry, 2001).

## Conclusion

Good research is essentially about developing a 'research mind,' which is highly related to a 'clinical mind.' More than anything, it involves an attitude of curiosity, open-mindedness, skepticism, self-monitoring, and thinking systematically and critically. The actual research methods follow from these. For instance, several currently successful therapies like Cognitive Behavioural Therapy (CBT) and Dialectical Behaviour Therapy (DBT)<sup>2</sup> started by having therapists giving their clients questionnaires before and after sessions that asked about what worked, and what didn't, and why: another name for that process is 'pre-test' and 'post-test'.

<sup>2</sup> DBT combines standard cognitive-behavioural techniques for emotion regulation and reality-testing with concepts of distress tolerance, acceptance, and mindful awareness, largely derived from Buddhist meditative practice (Linehan and Dimeff, 2001).

Over time, because they were willing to modify their work in response to feedback, their research became more elaborate and extensive and funded by grants, to the point where these therapies are now considered ‘evidence-based’. Somatic psychotherapists can also start simply – taking courses in research, working together, supporting the work of university-based training programs, and by familiarizing ourselves with cutting-edge methodology that centralizes social justice issues and does not need a lot of resources beyond our embodied, clinically-informed, research-minded selves.

## BIOGRAPHIES

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# Let's Face the Music and Dance: Working with Eroticism in Relational Body Psychotherapy: The Male Client and Female Therapist Dyad Danielle Tanner

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## Abstract

The purpose of this paper is to present two cases documenting eroticism in a male client–female therapist heterosexual dyad. This phenomenological study will reflect upon the experiences of the researcher, in order to gain a deeper understanding of the human phenomena of erotic transference and countertransference in therapy. It will examine the theories of the aetiologies and common factors in erotic and eroticised transference. It will also seek to explore the therapeutic value of working with erotic transference, which is a naturalistic event, within the conceptual framework of humanistic principles and relational body-psychotherapy. Additionally it will examine the significance of the use of touch in erotic transference and countertransference.

*Keywords:* erotic transference, erotic countertransference, touch.

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## Introduction

### 1. Touch and Seduction: The Seduction of Therapy

There is an inherent seduction within therapy: the intimacy of the relationship behind closed doors, the privacy, the confidentiality, the deep exploration of our inner world and the mystery of it, all potentiate the seduction.

The relational-humanistic approach holds that growth, healing and self-actualisation is facilitated by participation in the therapeutic relationship, characterised by key interpersonal conditions, namely mutual respect, warmth, acceptance, genuineness and empathy. A relationship is formed.

The very nature of psychotherapy invites the client to re-experience feelings of dependency, helplessness, and vulnerability (Kalsched, 1996). Who would not resist the unassailable threat of therapy, the insistence of another that we shine a light onto the memories and feelings that we do not want to talk about and that we do not even want to think about? By choosing to look, unblinking into our own past, psychotherapy is an act of great courage on the part of our clients; that we are willing to go there with them, creates a shared intimacy.

When we listen carefully and attentively, not only with our ears but our whole body, when we have our client “in our hands,” the quality of our attention may recreate a



transferential longing and, as Winnicott (1960, 1965, 1990) discovered, holding can repair a rift between what they experienced in early life and what should have happened.

In the bonding between mother and child, there is also a seduction, a seductive and erotic quality to their relationship, which is not perverse or inappropriate, but occurs in a natural and spontaneous way. The client may fall in love with the therapist, recreating the primal seduction. Hopefully, with care, the illusion may fall away but the love that a client offers up is to be heard and the therapist can be appropriately reciprocating without acting upon this love.

Historically, there has been an assertion that male clients rarely experience sustained erotic transference in the male client- female therapist dyad (Lester, 1985; Goldberger & Evans, 1985; Kulish, 1984, 1986.) and that female therapists do not experience sexual arousal in the countertransference with their clients, of either gender (Orbach & Spector Person 1993), cited in Schaverien, 1995). I have found, from my own personal experience as a relational body psychotherapist and from the growing body of research, evidence that disconfirms this. Indeed, contrary to these earlier views, some research suggests that erotic charge and sexual arousal are commonplace, 'ubiquitous and presumably normal' (Tower, 1956, p. 232), regardless of the genders involved (Schaverien, 1995; O'Connor & Ryan, 2003). Not only is sexuality ubiquitous, but Eros has myriad different aspects and forms and erotic transference many meanings, which are multiplied when considered in an intersubjective context.

When it is acknowledged that not only maternal or nurturing feelings can exist within this dyad, but also sexual ones, then therapists can own their own sexual impulses and become more aware of the risk of acting on these impulses or transgressing the boundaries of the therapeutic relationship. This is essential when we are using touch. Without a more open dialogue, therapists risk creating both repression and re-enactment, to the detriment of the therapeutic encounter.

This paper seeks to contribute to the dialogue that was initiated in Asheri's UKCP conference presentation in 2004, 'Erotic desire in the therapy room, dare we embody it? Can we afford not to?' In this courageous and exciting presentation Asheri highlighted the role that erotic charge played in her body psychotherapy practice and the therapeutic value of working with erotic transference and her own countertransference (Asheri, 2004).

This paper advocates the appropriate use of touch within the erotic field. It challenges the psychoanalytic 'understood' that we should insist that 'however urgent' the clients desire is for 'actual bodily contact, the work [should] remain exclusively within the realm of fantasy and words' (Koo, 2001, p. 31.). I offer my own tentative exploration and experiences of working with touch whilst erotic transference and countertransference is present, with illustrations from my client practice. This paper seeks to demonstrate that touch, in many of its nuances, from the playful to the affirming, has a place when working in the erotic field. This is in the hope that other practitioners will engage in an exchange of experiences so that they can more effectively and collaboratively learn how to engage with eroticism and erotic charge in their practice.

From a body psychotherapy perspective there are moments in therapeutic situations when it would be unethical to withhold touch. Not touching can have a powerful detrimental effect. It can be counter-effective and can create a negative transference dynamic, in that the client can regard us as a 'cold, withholding parent figure' (Wilson & Masson, 1986, p. 498), which can further concretise past trauma, and 'deter psychological growth' (Wilson, 1982, p. 65).

Whilst I fully acknowledge that psychotherapists have a responsibility to exercise caution when using touch with clients who have experienced physical or sexual abuse I do not believe it should be prohibited. However, there are contraindications to touch, which apart from certain medical considerations, encompass clients who are showing high levels of paranoia, hostility or aggression, or are highly sexualised or demanding of touch/ sexual touch (Durana, 1998, Zur & Nordmarken, 2011) or when the therapist finds their own erotic countertransference too overwhelming.

## 2. Defining Erotic Transference

Freud first attempted to define erotic transference in his paper, *Observations on Transference-love* (1915), a highly influential and often reviewed paper. In this paper, he examined erotic transference as a phenomenon that occurs when the patient openly declares that she has 'fallen in love' with the analyst. Hence, erotic transference is a theoretical construct from which to understand erotic charge and sexual feelings in therapy.

More recently, erotic transference has been defined as, 'any transference in which the patient's fantasies contain elements that are primarily reverential, romantic, intimate, sensual or sexual' (Book, 1995, p. 505). Schaverien (1995) broadened the original definition of erotic transference by the introduction of the term, 'eroticised transference'. Erotic transference is viewed as a natural phase of the therapeutic process, which reveals past behaviours with regards to relating to others, which are not necessarily sexual. Thus, given that the erotic needs of the client can be emotions and thoughts that are not necessarily sexual in nature and do not lead to the desire for sexual gratification from the therapist, erotic transference could then be seen as part of any therapeutic context. On the other hand, if eroticised transference is seen as a delusional form of transference, symbolisation is lost, as with any difficulty to understand the symbolic nature of transference dynamics, not just the erotic. Therefore, the transference is experienced as something real. The client may start to demand gratification, which could potentially destroy the therapeutic alliance and the potential for therapeutic growth (Schaverien, 1995).

Mann (1997) proposed that erotic transference, despite its association with sexual excitement and erotic charge, is not purely physical but psychological. He determined that we as humans have a psychological component to our sexual experiences, in that the erotic charge is not physical arousal alone. More contemporary views, like that of Garrett (1999), supported the idea that erotic transference is a frequently occurring phenomena and warn that to view it as an unique or rare occurrence can lead to a skewed perspective that has the danger of leading to a sexual relationship between therapist and client.

In body psychotherapy, Reich (1933) believed that it was the repression of our emotions and sexuality that lead to psychopathology. He took Freud's work on libidinal energy and suggested that it was a real, tangible energy, discharged during emotional expression and sexual orgasm. He believed that not only did parental or societal rejection of a child's expressions of emotion or of sexual love lead to internalised repression, but that this was accomplished by literally tightening our muscles, binding the energy and creating a conflictual, internal 'bioenergetic' tension. Transference, whether erotic or not, was viewed as an artefact of an armoured state that would fall away. Eroticism was no longer just an intellectual idea or feeling, but an embodied, felt sense. Reich believed that erotic aliveness is present between parents and their children, and between therapists and clients. He was not afraid to tread into the darker realms of the impassioned body in therapy (Cornell, 2003).

### 3. Erotic countertransference

Searles' (1959) groundbreaking paper opened the way for analysts to explore their own erotic countertransference and Davies (1994) eloquently wrote on how the therapist may be daunted by erotic transference and their own countertransference and how she used her own bodily states of awareness to comprehend the erotic subtexts within a clinical encounter and finally transform an impasse. She described how fear may be induced in the therapist when confronted with erotic transference, in that the 'universality of incestuous oedipal fantasy and boundaryless, preoedipal erotic terrors is lost within the horror and incomprehensibility of actual incestuous enactment' (p. 153). Davies surmised that, within this powerful transference field, the therapist could lose touch with the distinction between thoughts and actions. I feel that the real threat is not that we'll throw ourselves at our clients but that we'll struggle, out of fear, to engage with our clients' erotic transference (Wrye, 1993).

Soth (2002, p. 126) felt that the therapist should be 'rooted in a continuous awareness of their own somatic reality' to inform their therapeutic practice. Somatic countertransference is an essential element of understanding erotic countertransference in body psychotherapy, as it is 'the therapist's awareness of their own body, of sensations, images, impulses, feelings, and fantasies that offer a link to the client's process and the intersubjective field'. (Orbach & Carroll, 2006, p. 64). Field (1998), described how feelings in the therapist of countertransference can include drowsiness, erotic and sexual arousal and trembling/ shaking, and as well as physical pain, tension, nausea, numbness and feelings of suffocation (Stone, 2006).

Recent research indicated that most therapists, at some point in their professional lives, experience sexual feelings towards a client (Ladany, et al, 1997; Pope et al, 1993, 2006). However, empirical studies have shown that acting out this desire is not widespread (Fisher, 2004). Yet, if therapists honestly engage with the experience and their feelings they can use their own erotic countertransference as a guiding tool in their therapeutic interactions (Asheri, 2004, Davies, 2013, Gentile, 2013, Slavin, 2013).

### 4. Aetiology and Development of Erotic Transference

Much has been written about the role of resistance in the development of erotic transference and the aetiological factors that may contribute to erotic or eroticised transference. In childhood, we acquire a way of living our love. Through interactions with others a pattern of expression and experience of emotions is formed. This pattern is replicated throughout our lives as we form relationships with other individuals. Transference love is a thread that connects the present to the past. Traditionally, erotic transference has been seen as a defence against internalised conflicts. However, I would argue that it is not simply resistance but also an expression of the client's deep desire for growth and transformational change, and that it is, 'potentially the most powerful and positive quality in the therapeutic context' (Mann, 1997, p. 10).

In my practice, seduction has been a key element in the emergence of the erotic transference. Laplanche (1989) described the seductive quality or erotic interplay that is present in the relationship between mother and infant. There is a seduction that occurs within the dyadic relationship: the primal seduction. In a healthy relationship between mother and child, this erotic charge would not shame or be acted upon, but delighted in and celebrated.

The seductive quality of this early relationship is unspoken, experienced pre-verbally and leaves us with a longing for this mystery and excitement (Weatherill, 2000). The therapeutic setting, with its perhaps unconscious seduction, nurturance, attention, and above all,

mystery, will re-enliven this yearning: 'the basis of the primal relationship with the other is one of primal seduction, and the basis of the relationship with the analyst reactivates that relationship' (Laplanche, 1989, p. 60). Clients pursue the therapist in the belief that they have the ability to transform their outer and inner world. We become their transformational object (Bollas, 1987).

Seduction and trauma are common 'genetic factors' in the development of eroticised transference (Koo, 2001, p. 30), as is 'sexual seduction in childhood' (Blum, 1973, p. 67). Bolognini (1994) further states that eroticisation defends against separation and abandonment and is a dramatic attempt to, once again, merge with the 'Oedipal object'.

## 5. The Use of Touch in Psychotherapy

Initially in his work, Freud recognised the importance of touch, massage and stroking to facilitate catharsis (Ventling, 2002) and allowed his patients to touch him (Breuer & Freud, 1895). However, Freud later held that touch stimulated sexual feelings and voiced his concerns about the dangers of touch, in particular, with regard to ethical violations by therapists who transgressed into the realms of sexual relationships with their clients. Yet, although Freud's 'rule of abstinence' and prohibition on touch has dominated the psychoanalytical world, there have been notable exceptions. Ferenczi (1933, 1953) used therapeutic contact, as did Balint (1968), Winnicott, (1965) and Little (1990). Winnicott and Little (who herself had been held by Winnicott during periods of psychotic anxiety) both felt touch to be compassionate, important and therapeutic within the therapist/ client dyad. Indeed, their case studies illustrated that touch provided a stabilising and orienting function for their clients (Maroda, 1999). Furthermore, Mintz (1969) stated that it 'seems absurd that any qualified psychoanalyst should be so carried away by contact with a patient, however attractive, that he (or she) could not refrain from complete gratification. Such an impulsive person would not be safe on a dance floor' (p. 371). Mintz (1969) described how both Fromm-Reichmann and Searles used facilitative and nurturing touch in their work with even deeply disturbed clients to good therapeutic effect.

However, touch remains a highly controversial and emotive issue in psychotherapeutic work. Maroda (1999) wrote about how touch is often seen by the psychoanalytic world as having an edge of exploitation, or being indicative of the clinician's failing verbal skills. It is even construed as a vulgarity. Instead, in the psychoanalytic 'heavenly scenario' there is no engagement with the body whatsoever. The therapist comes to a perfectly timed and executed interpretation, which is followed by the patient's illuminating insight, like mental cogs shifting seamlessly together. There is a metaphoric meeting of mind-mind, not body-mind.

The present paradigm that any touch is the first step on the 'slippery slope' towards sexual relationships is based upon an enduring and erroneous belief, which is an obstacle to an actual understanding of the importance of touch in therapy. The belief that all forms of touch are sexual is embedded within our western culture, and this prevalent belief is reflected within the field of psychotherapy (Zur & Lazarus, 2002).

## 6. The Historical Background of Erotic Transference

Freud's paper, in 1915, arose from his need to manage the unruly child of the analytical situation: erotic transference. In summation, Freud proposed that therapists should practice sexual 'abstinence' with their clients. Historically, there have been many prominent therapists who have transgressed this rule and acted upon their sexual feelings towards their clients:

Carl Jung had sexual relationships with at least two of his clients, Sabina Spielrein and Toni Wolff. Whilst Otto Rank had relations with Anaïs Nin, whose wild sexuality was inspiring, if tumultuous and sometimes bitterly painful. Other client/ therapist partnerings include August Eichhorn and Margaret Mahler, and Frieda Fromm-Reichmann and Erich Fromm (Coen, 1996; Gabbard, 1995; Tansey, cited in Schames, 1999).

There has been a growing body of interest by psychotherapists in erotic transference and countertransference which has been mirrored in the media's attention to this phenomenon. Erotic transference in psychotherapy has become a subject of popular culture. In 1909, Sabina Spielrein wrote in a letter to Sigmund Freud:

“Four and a half years ago Dr. Jung was my doctor, then he became my friend and finally my ‘poet’ i.e., my beloved. Eventually he came to me and things went as they usually go with ‘poetry’. He preached polygamy; his wife was supposed to have no objection...” (Carotenuto, 1982, p. 93).

The David Cronenberg film, *A Dangerous Method* (2011), explored Carl Jung's prolonged, sexual entanglement with his patient Sabina Spielrein. This positive transference is portrayed as edgy, sexually exciting, risky and potentially dangerous. Spielrein was a disturbed young woman whom Jung first encountered in a mental asylum and who soon became his patient. Later in the film, they are portrayed as engaging in a lively, sadomasochistic, sexual relationship. In one scene, a corseted and half-dressed Spielrein is depicted being spanked by her former psychoanalyst: a woman ‘undone’. Similarly, Jung is shown in the throes of a psychotic breakdown after his treatment of Spielrein. Jung's inability to tolerate transitional spaces, erotic transference and his own countertransference was in my opinion, much more dangerous when unexplored or dissociated from.

Television series, such as ‘The Sopranos’, which follows the protagonist's relationship with his therapist, as well as the HBO series, ‘In Treatment’, both explored the issue of erotic transference in therapy. This exploration of erotic dynamics and the presence of erotic transference and countertransference has in part contributed to the normalisation of this phenomenon. Yet, there remains an ambivalence. No one touches. Gutheil and Gabbard (1992) highlighted the current trend to politicise ‘sexual transgressions by therapists’ and that a few ‘bad apples’ (Gabbard, 1994), are hindering useful, systematic investigation into eroticism in therapy. A lack of systematic investigation of eroticism in therapy hinders not only the client's development but also that of the dyad and the therapist.

## 7. A Literature Review

The profession's fear of erotic transference is perhaps reflected in the paucity of literature on the therapist's own erotic countertransference (Tansey, 1994). We should all remain aware of the reality that erotic transference is a ‘hot’ topic and requires careful navigation, and that sexual transgression by therapists from all theoretical persuasions does occur (Sarkar, 2004). However, the fear of erotic transference and the belief that touch leads down the ‘slippery slope’ towards sexual enactment between client and therapist, may well be preventing the use of a potentially healing modality and a generative dynamic (Fagan, 1998; Smith et. al., 1998).

What was illuminating during a literature review was the lack of written matter in regards to the male client erotic transference to female therapists (Koo, 2001). This dearth may indicate that this is a rare phenomenon. However, rather than substantiate this assumption, this paper suggests that it may be insufficiently represented as a result of gendered bias of a profession while practised by many female practitioners, is still bound and thereby limited

by paternalistic and masculine guidelines and ancestry. The professional status of the female therapist has been hard won in an inherently chauvinistic domain. Freud patronisingly referred to Speilrein, an eminent psychoanalyst in her own right, as the 'little girl' or the 'little authoress' in his writings to Jung.

There may be little written on this particular dyad due to the embarrassment of the female therapist, that they may be viewed as being exhibitionistic or seductive, or the threat that if women are being sexually objectified, whilst at the same time being questioned as to their efficacy and worth as a therapist, it may devalue their therapeutic or professional standing.

Erotic countertransference is challenging, frequently uncomfortable and often a source of therapist discomfort and a scenario that therapists may be choosing to avoid. With few resources or an open discussion of how we, the therapist, can navigate these dark and often tempestuous waters, there is a danger of drowning or not even stepping onto the boat.

Erotic transference is a common event in my practice and is not gender specific, despite the literature's suggestion that male clients do not or rarely develop full erotic or eroticised transferences. Within my practice, I have also experienced the extreme of eroticised transference. However, even in these exceptional situations, there is, as my client pointed out, the possibility of making it through this 'strange situation' due to our 'mutual respect, trust and faith;' the faith that I had in him, which allowed us to traverse this complex intrapsychic landscape to 'break the spell' of idealisation and transference longing. He also felt 'pride' in himself, in that I had so much faith in his ability to do so.

## 8. The Practitioner's Theoretical Orientation

I practice both Deep Bodywork (neo-Reichian body psychotherapy/ Postural Integration), and IMT (Integrative Mindbody Therapy), two modalities that utilise touch within their frameworks. IMT brings together relational psychotherapy, with bodywork, breath work and naturalistic trance and, therefore, uses touch, when appropriate, within the therapeutic and reciprocal encounter, recognising the intersubjectivity that is inherent within the dynamic (Rolef Ben-Shahar & MacDonald, 2011, Rolef Ben-Shahar, 2012, 2014). In relational body psychotherapy, there is an understanding that the innate complexity of the human spirit necessitates a creative approach to psychotherapy. In IMT, there is a core belief that not one single model or theory is comprehensive, or far-reaching enough to heal our wounds.

Throughout my practice, I have touched. I have engaged with bodywork throughout my professional career, first as a remedial body worker, then as an acupuncturist and now as a trained relational body psychotherapist. I have spent my career literally, 'hands on'. I have placed or had placed my hands on thousands of human bodies, from a myriad of cultural contexts, encompassing genders, sexual persuasions, ages and religions, from a black Pentecostal to a lesbian Jewess, from newborn to octogenarian, in life and in dying.

I subscribe to a humanistic theoretical orientation, and I passionately believe in the value of touch, both as a therapeutic intervention and to meet the fundamental human need to be touched. Within my own therapy, I have received touch and have touched my therapist. I have had the immense good fortune of having teachers and supervisors who not only support my touch-based practice, but also themselves believe in the legitimacy of touch as a tool within the therapeutic field.

I have used touch in trauma work, where a client with early trauma would inevitably have broken or invaded boundaries. If I had listened to the voices of risk management and caution I would have missed a hidden treasure. I trust that the human body and psyche has the plasticity and resilience to learn through experience and relationship, and that touch,



which is contained, appropriate and safe, also invites the possibility of it becoming normalised. Many contemporary writers on body psychotherapy support touch as a means to strengthen boundaries, not violate them (Hartley, 2005) and argue that 'touch can play a valuable role in developing and validating surface boundaries and a more secure sense of self' (Warnecke, 2008, p. 6). I welcome the stance that not only considers touch to be an important therapeutic tool, but also goes one step further towards an approach that normalises touch within psychotherapy and challenges psychotherapeutic practice, which, a priori, forbids and bans the consideration of touch.

Is there a place in the therapeutic world where we can normalise touch and embodied eroticism/ Eros? As a woman, I am aware that gender difference can foster an environment in which touch to and from a man can engender feelings of power inequalities and sexualisation. However, appropriate therapeutic touch can also allow a man and a woman to stretch out across the gender divide and meet with mutuality, equality and connection as well as safely explore these imbalances and cultural divides.

This paper seeks to explore the importance of touch. It will also look at the themes of seduction, and eroticism, in order to ensure both therapist and client feel safe within the interaction, without being overwhelmed by transference material or dominated by fear.

## 9. Touch and Intention

Relational perspectives of touch need to be addressed whenever we engage. If we touched with the intention of creating erotic charge, this would indeed be problematic and unethical, but if, within touch and the transference field, erotic charge takes shape and seductiveness become evident there is an opportunity to work with it, to allow it. We can celebrate erotic charge, as Samuels (1993) suggests in his theory of 'erotic' and 'aggressive playback', or utilise the transformational power of the erotic (Mann, 1997). Even within the erotic transference the client may recognise the containment. This containment may even make its creation possible. Therefore even if the client falls in love with you his therapist, while still being 'in touch', he recognises that the therapist is, in reality, inaccessible.

We should be aware of our client's perception of touch, especially if there is the possibility of early childhood violations and, therefore, a confused dialogue around touch. Some therapists consider touch of any kind to be inappropriate with clients who have been abused through violations of the body. However, many therapists and somatic therapists believe that a client will have great difficulty in fully recovering from such trauma if only verbal or cognitive approaches in therapy are used. Hunter & Struve (1998) held that therapeutic efforts to help 'a client heal from touch-related wounds ultimately ought to include experiential approaches that directly access the body and that provide the client with real-life opportunities to feel non-abusive touch' (p. 218).

Clients traumatised in childhood are often unable to make distinctions between affectionate touch and sexual touch (Ball, 2002), and 'healing is unlikely to occur if this positive and appropriate touch remains only an idea or intellectual concept' (Hunter & Struve, 1998, p. 218). In a study by Horton et al. (1995), it was found that sexually abused clients felt that touch repaired self-esteem, trust, and a sense of their agency, especially in regards to boundary and limit setting and asking for what they need.

There is both a need for us to acknowledge our client's aliveness, their sexuality, their child and their adult, whilst maintaining clear boundaries. We hold clear boundaries, even when they are being challenged by a seductive client whose needs and wants should be honoured, separated and acknowledged without shaming.

The instincts, impulses and desires of the client will all provide intricate complexity for the therapist, especially as these all relate to largely unconscious erotic touch biographies. As therapists it would be unwise to engage with touch when we are cautioned by our own internal boundaries, or when our client's boundaries are diffuse or their sense of reality poor or with 'regressed, dependent patients with ill-defined ego boundaries' (Kertay & Reviere, 1998, p. 28). Each individual is unique, and the therapist should give careful and thoughtful analysis in each situation as to how appropriate touch would be. Clients can still be physically held by themselves, reminded of their own touch and of the physical outer boundary of their own skin.

### 10. The Ethics of Touch

Within the therapeutic arena, there is an ethical consideration. For touch to be clinically sound it needs to be boundaried, and the therapist requires sufficient insight into their own motivation for touch. Adequate supervision will enable the therapist in their endeavour to be able to recognise and manage transference and countertransference. No matter how courageous or emotionally available the therapist, Eros, with its skilfully laid 'tender trap' and all its complexities (Hedges, 2011, p. 67) requires supervisory input in order not to become ensnared by the powerful erotic/ psychotic projections in the countertransference.

The client should feel empowered enough to be able to know if they want to be touched and be able to say so and this is enabled through constant negotiation and underpinned by the therapist's trained understanding of touch. Totton (2003) explored the professional aspects of touch, and legitimate touch, as well as navigating the challenging issues of regression, re-traumatisation, false memory, transference and counter-transference that can arise when we touch.

When two biographies meet, a new story or a 'third space' is conceived. It is the therapist's responsibility to work ethically, with respect and transparency. In relational psychotherapy, touch can convey re-assurance, playfulness or provide grounding and re-orientation; but touch can also evoke, even within these parameters, feelings of excitement, aggression, possessiveness and eroticism in both the therapist and the client. Rather than rejecting these shadow emotions, they can be seen as an opportunity for deeper exploration, of working through these darker feelings. In relational work, we no longer embrace the tenet of neutrality. It is no longer possible to be just 'nice and tidy' therapists as this doesn't allow the other to work through their own feelings of eroticism, rejection, hatred or rage. If, during therapeutic work with erotic transference and countertransference, we, as therapists, treat ourselves with enough loving kindness, in that we ensure that we receive enough external support, both professionally and personally, and love in our outside lives, it will be easier to work in this universally challenging and rewarding scenario. Touch requires a degree of self-awareness in the therapist, a willingness to ensure that we are acknowledging our own needs for touch and connection and that we take responsibility for ensuring those needs are met well away from the therapeutic space.

Therapists work within a profession that cultivates and encourages intimacy. We provide a facilitative environment for growth, and we may offer ourselves up as objects at the beginning of the therapeutic journey: an object of transference. And yet as a relational psychotherapist I will bring my subjectivity. Relationality is essentially being professional in our humanity, even fighting for our humanity, not completely agreeing to be an object, or increasingly resisting to be 'just' an object for the client. We slowly expose our clients to their own subjectivity in the belief that if they can 'see' us, even for just a moment, then they can do also do that for themselves. If I as a therapist abandon my own personhood, abandon my own countertransference as irrelevant, then why would my client ever believe that theirs is worth holding onto?

When we are working relationally, intersubjectively, we have to take responsibility for the transferential field: both for the impact that we have on another and the impact they make on us. The thoughts and the feelings that arise are relevant to the field, are not solely our personal thoughts and feelings, but are also responding to the reverberations of relationship. This accounts for some of the reasoning for the therapist to bring some of their own material, without being insensitive or inappropriate.

When we work with the body, when we touch, we become more visible to the other. This visibility can be uncomfortable, and it can enhance the possibility of great eroticism or seduction to occur. Feelings that arise may be uncomfortable, or unpleasant. We can experience a sense of seduction, of strong sexual charge within the touch. If we allow these feelings a voice, even normalising instead of rejecting them, we embrace a wider world. Otherwise we risk declaring these parts forever unacceptable.

When we are working with touch and specifically with a client's libido, with their sexual energy, with a sense of empowerment, compassion and celebratory respect, we engage in a journey towards a healthier re-emergence of their sexuality, a sense of their self and the establishment of a more balanced and fulfilling sexual relationship. That I can be alive, and I can fully feel the erotic charge of the other in my own body, that I can attune and resonate to my clients' eroticism and be excited by their sexuality, whilst being able to recognise and hold a boundary where I do not succumb to this sexuality, enables my client to also witness another taking self-responsibility for their own sexual charge.

Contextually, I am aware to some extent that my physicality will also have an impact upon my relationship with my clients. I am an attractive woman in her late thirties. There will be clients (male and female), who are going to be attracted to me, regardless of their former relationships/history, and I need to acknowledge that this will be part of the dyad, in all senses. Most clients will notice a well-dressed and sexually expressive woman (comfortable and capable of enjoying that space), in front of them answering the door (whether consciously or unconsciously).

There are many possibilities for the therapist who might consider working in this way, but who may need a slower movement towards it. For example, a therapist may invite witnesses into the therapeutic space, or have a same sex assistant or helper. In addition to clients signing a consent form that explicitly mentions the use of touch, I feel that consent is a moment-to-moment process that I often refer to throughout my work with a client.

## 11. Case Vignettes

### Case 1

James was a 45-year-old man. He was a perfectionist, controlled and over-defended. He had first entered individual and later group therapy several years ago as a result of the emergence of intrusive thoughts and the dawning realisation that as a child he had been sexually abused. Through the very nature of the sexual abuse, with its secrecy, denial and projection he had manufactured another reality. He had forgotten everything for the sake of his abuser. He re-entered therapy in order to explore his relationship, and sexual and intimacy difficulties within it. He felt that he was obstructed in his capacity to engage with his sexuality and this was causing problems with his partner who felt both alienated and frustrated. He had shown enough ego strength in the beginning of therapy to suggest that touch could be used, when appropriate.

When I began working with touch with James, the touch was at first tentative and slow, a constant negotiation. He was a survivor of early childhood sexual abuse, so I felt that it was

important to imbue in him a sense of his own internal and outer boundaries. I also recognised that I had a place for him, a space for him in me, a womb or 'matricial space', (Chetrit-Vatine, 2004, Schwalbe, 2013). I felt a state of being for the other, in which there was a sense of responsibility, vulnerability, proximity, contact and sensibility in the caress (Lévinas, 1974). I felt that, in our work together, I had a willingness to open into his reality and to embody a space or a new way of being, and that touch became a bearer of messages.

When I engaged in touch, I would mindfully lay my hands on his body, on a part that we both felt to be safe and then I would wait until I could feel him connect to the touch; often it was as though he was standing waiting for me. The quality of touch, in the therapeutic space, quickly became soft, hypnotic, and his connection enveloping. I felt that his body wrapped itself around my hands. The quality of his desire felt like a pre-oedipal holding, a baby holding my gaze, rather than the oedipal demand of wanting to have me. After a few months, our touch would often be playful; he would nuzzle my hands with his face, place my hands on his face as if he was demanding that I see, be curious, know who he was.

Our playfulness and our laughter dissipated his defences and his struggle for control. Winnicott, for whom playfulness was an indicator of mental health, felt that 'psychotherapy has to do with two people playing' and that the therapist's work should be directed towards bringing a client, 'into a state of being able to play' (1971, p. 38). Farrelly and Brandsma stated, 'the ability to laugh, temporarily regress, lose control, and then reintegrate may be seen as a cardinal sign of wellbeing' (1974, p. 127). Winnicott (1971) further theorised that play lies between subjective fantasy and reality and although he may have omitted erotic play in his writings, his theories on playfulness were integral in later works on erotic play by Benjamin (1995) and Gentile (2013) who drew parallels between play and erotic play. Gentile (2013) also supports the theory that play, when initiated by a client, allows them to become an 'agent' of their own therapeutic action that 'play is experimental agency'. The very act of playing for a survivor of sexual abuse becomes an act of reclaiming, of seizing back the controls.

The omnipresent and subtle role of playfulness, as an attitude, in the clinical situation, allows for a dyadic meeting on the edges of the boundaries between reality and fantasy. Ehrenberg (1990) wrote that playfulness often assumes a sense of mutuality that can give pleasure to both people involved and can meet the client on a multitude of layers. Playfulness can encompass humour, irony, affectionate teasing and co-created fantasy, and if skilfully utilised, it also has the power to break through barriers of communication and shame.

The playfulness also allowed for a different dynamic, one that invited seduction and I was aware that, had I chosen, I could have closed down this avenue for us both. I questioned whether this dynamic was a fragment of a re-enactment of an earlier seduction. I witnessed the transition from desire to play, from play to growing intimacy and then eroticism. However, as Davies (2013) warned, play can be 'impossible' for some survivors of sexual abuse as the child could have found fantasy swiftly moving into 'a terrifying and unknown reality', where imagination became 'a gateway to terror' (p. 176).

The dance of seduction began. There was a continual negotiation of external boundaries, of reinstating what he, scathingly, referred to as 'the rules'. Gifts, cards, poems, songs, music. Was it appropriate to listen to the story, the poem, when I had returned all other gifts? As he pushed the external boundaries, I struggled to hold and preserve them. My work with James became a focus of my supervision. I wondered at his attempts to invade my boundaries, of the intensity of my feelings of confusion, of feeling lost in the rupture of my own internal

boundaries and the movement to repair and regain my sense of self, in his drive for merging and symbiosis. Was this how it felt for him, to have to defend his own boundaries against the passions of an adult?

The erotic transference began with a gradual intensity of feelings, initially of a desire for more intimacy, more sensuality and then he began expressing feelings that were often, disconcertingly, reverential. These progressed towards more sexual feelings. His fantasies were at first understood, by him, to be unrealistic; but at times the transference became highly eroticised, his fantasies became more lucid, preoccupying and irrational. These fantasies became verbalised demands for love and sexual fulfilment. He had difficulty focusing on any appropriate insight and questioned whether he was attending the sessions for the therapeutic work or just to be physically close to me, hoping for any reciprocity.

Throughout this time, which lasted for many months, James appeared distressed and bewildered. He experienced hallucinations, an image of my face appeared to him in the sky, and he often had vivid dreams of me. He was unable to connect the intense sexual feelings that he had with any of his own past behaviour, he could not make sense of the situation and he felt disorientated. Throughout his life he had been controlled and measured in order to enhance his own sense of safety in the world. With the encouragement of my supervisor, we stayed together in this uncomfortable place, on the edge...

The quality of our contact had changed. Within two years the touch had moved between tender, nurturing, or affirming contact to playful, and then our touch became more challenging. It became charged with 'the push and pull' of seduction and invasion, as we struggled to make sense of our relationship, within the context of the therapeutic dyad and his own entangled history of incestuous abuse. During sessions we discussed his imagined sexual involvement/objectification of me. He would imagine kissing me, holding me, of 'making love' to me and of me carrying his triplets (I was pregnant throughout this period).

Asheri (2004) describes how the transition for the pre-oedipal eroticism to the oedipal can manifest in changes the quality of touch. Now when he moved into my hands, I no longer felt the sensuousness of his nuzzle, the soft suck of a child on the breast, but instead the pull of a man wanting me closer. I felt smothered and disorientated. I could no longer feel the erotic, subtle charge of the child, the quality of our touch no longer felt nurturing or maternal.

Over the course of this challenging time, he said that he was able to 'throw off the wet blanket' that had dampened his sexual drive throughout his life, as a result of the abuse he had experienced. He felt 'wildly alive' and spontaneous. I began to withdraw. As he engaged more and more with his sexual drive and charge I was more hesitant about working with touch, I would have less physical contact, or I found that I used one movement, for example, a hand on his back, or I would sit, my back to his, as he spoke. I stepped back, not to abandon him or reject him but to encourage his engagement with the outer world.

As a mother of three children, I have moved through this transitional stage with my eldest son as he stepped more into his oedipal stage. As my son engaged more with his own erotic charge, as his caresses have become more sexual and his interest in my body more than motherly, I have tenderly moved his hands away, yet I have remained his gentle support, recognising that the 'path to intimacy is not forged between [us] directly, but rather emerges in the symbolic anchoring of ineffable desire' (Gentile, 2013).

As I stepped back James's anger emerged, I became the object of hatred, the rejecting mother - James glared back at me. I inwardly winced, and I suddenly felt very clumsy and awkward, as if I'd been caught in an illicit act. 'But this is me,' his voiced was raised, 'this is not my child,

my teenager, this is me, a man, I know how I feel, I love you, and I want you and I feel you inside of me.'

We had been engaging in an angry tango for weeks; I had ignored the man in the room, constantly reminding him of the child within, and the unavailable or abusive attachment figures that he had experienced in his childhood. I was suddenly and acutely aware that I had done so in order to avoid meeting his adult sexuality and the power of his phallic drive. I felt shocked, confused and guilty. I noticed my reticence to bring the subject into my own supervision, my own desire not to see him and his demands to be seen. From my own biography, I could see how I would draw comfort in having a non-threatening boy rather than a stormy man.

What also became clear was the concrete relational stance that he held. He had an intractable belief that I would change my mind, that he could shape me to his desires, and that I would succumb to his seduction. He often related to me the story of his current partner, whom he had persuaded to engage in a relationship, one that had born three children, even though when they had first met she had insisted that he wasn't her type and that she had no romantic interest in him. I often wondered in supervision if this was the same construct that his abuser had forced onto him and that this stance was a destructive re-enactment (Slavin, 2013).

James and I continued together for two years. We struggled through the difficulty of erotic transference and my own countertransference, a period he was later to describe as an 'emotional crucifixion'. It was only when I reached out to him, that one small movement of me placing my hand on his heart, and touched him that we both understood. 'You can move your hand if you want, you don't have to stay there', he said, 'I'm not ready yet, to let you go'. I replied. Our dynamic transformed when I engaged with my own erotic counter-transference, when I meet him as a sexual adult woman and when I accepted that he too had a place in my heart.

Our therapy ended soon after this session, although he was to return over a year later. When he returned to therapy he was no longer in love with me, he was intrigued by the dynamic that had occurred between us, by his 'infatuation', but he no longer felt in the midst of its hold. It was to re-occur occasionally, but it no longer held the sway that it had before. He felt that that one moment of touch allowed him to integrate his feelings of rejection and that he was loved and worthy of love, 'since that moment I have felt valued, loved, I have started to take care of myself'.

Throughout our work together, I had had experiences of eroticism, arousal, fear and overstimulation, which at times had left me bewildered and silent. This tumultuous episode was the epicentre of our struggle, him acknowledging his feelings and the grief and acceptance of the reality of our relationship, of the love between us, and me acknowledging the man before me, not just the abused, disconnected or neglected child.

A discussion of this vignette with James will follow after the second case.

## Case 2

Peter was another man in midlife who sought therapy during his divorce. He had come into therapy bewildered. His marriage had dissolved as his wife felt unheard and disconnected in their relationship. Every time she attempted to make connection, he withdrew into silence. He had a history of secrecy, and adultery in all of his adult relationships and he came into therapy to understand what had happened in his marriage break-up. He also experienced pain in most of his body, had severe digestive pain and raging eczema. We have worked together over the course of five years and continue to do so. He is a robust, compact man, who has spent his life outdoors; he builds houses and prefers to work alone. As a child, he lived with an emotionally absent mother,



an uncommunicative father, and a sexual perpetrator within his family. There were no avenues of safety, no one to protect him. His abuser was there alongside him throughout his childhood. Every game of rough and tumble, every playful interaction had the potential to become sexual.

At first, these sexual interactions, which began when he was seven years old, were 'just a bit of fun and sometimes I wanted to'. Later as he advanced into adolescence, he started to avoid his abuser and 'push him away'. He felt that it was 'wrong', but had no one to speak to and the abuse was hidden. Peter felt alienated in his own peer groups. He despised school and 'all the children in it' as it seemed they wouldn't be able to understand or would reject him if they did know. They didn't seem to have the anxiety that he felt all the time. He spent his teenage years, once he realised what had happened to him, feeling unclean and holding the thought that he harboured a dark secret and possibly a venereal disease. His shame became embodied and deeply entrenched, and he was silenced. He had difficulty making eye contact, he sat hunched and curled, and we spent many sessions saying very little to each other.

The development of touch with Peter was very different; it never became easy. It grew at such a different pace from the work with touch that I had engaged in with James. At first Peter allowed me to use touch. He encouraged me to, 'just go ahead and do it', and it was only when I noticed that he disappeared in the interaction that I stopped. He was dissociating, splitting off or freezing when I came near; I had become a threat. Touch can either help or perpetuate dissociative tendencies, and I risked re-traumatising him as he defensively responded to me as a remembered threat (Rothschild, 2000). Our touch is now very minimal.

When I withdrew my touch then the erotic charge became alive in him. However, touch remains crucial as it is also the string that binds us, for as he describes, 'it's the only tether that holds me to life'. Our work with touch has become a carefully choreographed tightrope walk.

I also became aware of my own feelings of wanting to guide him, to feel the almost irrepressible desire to manipulate him, to re-model him. I recognised the seduction of his malleability. He came to know of his impact on me. In my own history I have been wilfully manipulated, and I was horrified when I experienced this desire to push myself inside of him, to shape him and to feel aroused. I felt a surge of energy move up my body and into my chest. I experienced a burning sense of shame around my desires.

It was after careful consideration that I shared my own countertransference with Peter. It was 'a moment of truth', which contained both hope for the integrity of the relationship and risk. Slavin (2013) and Renik (1999) both support that, as therapists, we may disclose feelings that may appear to be difficult and unsettling, and I felt that it was imperative to his growth. It was, as Ogden (1995) defined, one of those moments where I had to 'face the music'. His reaction was one of surprise, not that I would feel that way, but that he could make enough of an impact upon me to initiate these feelings. This surprise gave way to his suppressed rage, 'that everyone just uses me; they're just all out to get what they can'. For the first time, I saw his rage uncoil. I felt the rage that had often placed us into a stupor. Slowly over time, he has come to recognise his part, his self-responsibility in this dynamic and to develop his autonomy, his own will. If I hadn't acknowledged the seduction and the erotic transference, and my own countertransference of wanting to penetrate and dominate, I could have denied both of our biographies.

It was after this moment that we began to speak about the layers of armour that he felt he had. Hidden under the soft, malleable exterior, there lay not one, but two walls of defence. We also began to speak of his own erotic attraction to secrecy. Today I glimpse his inner world, but I am always aware of his almost impenetrable armouring. Underneath his passivity and apparent pliability was a hardened interior through which no one has yet entered.

## 12. Discussion of the Vignettes

These two men were very different; they each had different developmental experiences, pathologies and very different kinds of erotic transferences/ Eros. Rather than comparing, it may be more helpful to contrast these two cases.

Earlier developmental infantile patterns of erotic constructions and transferences were evident in the second case. Peter struggled to be alive, he felt that often he did not have the right to exist and he experienced bouts of severe, numbing depression. He struggled with his inner conflict of wanting connection and his habitual movement toward social isolation, dissociation and disconnection. He continues to re-enact his original trauma through a loveless, 'secret' and long-standing affair.

I would also find that I would collude with Peter's own horror of eroticism. I noticed his reluctance to deal with erotic material and his persistent distancing from his own sexual feelings and any form of intimacy. However, despite this resistance he has been able to relinquish, at times in our relationship, infantile patterns in favour of a more mature erotic attachment that was less dependent on incestuous repetitions.

The outcome in James' therapy was reparative, in that it was boundaried, but it also allowed us to internalise a 'mutual loving desire' (Davies, 1994, p. 153), which was an important factor in strengthening James' ego function in that he felt that his love was reciprocated. But within that, there was an embodiment of the necessary disappointment of having his desires refused and the consequential feelings of loss and grief. If I had chosen not to engage with the eroticism which enlivened both of us, by avoiding the 'erotic horror' (Kumin, 1985) due to my own resistance of the transference material, the dynamic would have remained a blind spot and a lost opportunity.

In recognising my own somatic experiences, I allowed the other to know what it is to live in their own body, to begin to separate their own subjective experience out from the other, in relation to another, in the therapeutic environment that was safe from sexual invasion, from parental rejection, silence or shaming. I had to recognise my own and his desire, without assuming it to be based solely in infantile and unconscious drives (Samuels, 1993).

In our relationship, there had been a developmental movement from idealised pre-Oedipal sensuality and love, an amorphous, full body sensuality, to an eroticised, conflictual Oedipal drive (of erotic power and physical desire), which finalised with a stage of integration and transformation. It felt that these stages moved from an initial entrancement to an illusion of love and then through to an understanding and acknowledgment of the real love that existed between us (Asheri, 2004).

I felt that our work with physical contact allowed for an intimacy and an exploration of the playfulness of a child's sexuality, without the adult acting upon it. Our work together encompassed many forms of touch. Totton (2003, p118-123) explored and categorises the various types of touch: touch as comfort, touch to explore contact, touch as amplification, touch as provocation and touch as a skilled intervention. And then there's King's (2011) conceptualisation of Rolf Ben-Shahar's (2010) addition, of a sixth form of touch: touch as relational affirmation. King (2011), delineated how 'touch as relational affirmation can support, develop and deepen the therapeutic endeavour' (p. 109).

A boundary was held where it had not been before. At times, the transference felt overwhelming, acquisitive, even devouring. At times I was lost in his call for more. There were moments, on his part, of a weakened sense of reality when he was no longer content with the substitute of fantasy.

When I understood the client's sexual feelings to be based purely in the mother-child transference dynamic it fostered regression. When I acknowledged the powerful sexual atmosphere, I could feel for the first time, his sexual arousal; I could no longer reduce the erotic charge to the desires of an infant. It would have been humiliating to us as adults in the room. There had to be an acknowledgement of the adult who desires sexual intimacy, in both of us, as well as the infantile sexual demands. There was a need to move fluidly between both of these transferences, not merely relate to one. It demanded fluidity from me, from object to a container to an 'other' and my pertinent feelings of wanting to protect, hold and be present ensured that there was not a re-traumatisation or a re-enactment of his original body story. For this to be possible, for me to adopt this flexibility, I relied upon the anchoring and use of supervisory input to navigate these muddy waters. I needed the solidity of a skilled witness for me to stay centred.

### 13. Commonalities

I noticed that the male clients who developed erotic transference neurosis all had close physical relationships with their mother, even for those whose mothers weren't emotionally available, whilst at the same time having absent fathers, within a conflictual or dysfunctional parental relationship. Therefore, the onus was placed on maternalistic, often consuming or idealised relationships with women. The erotic transference was often very quick to develop: 'as soon as I heard your voice', 'after a few weeks I knew that I loved you'. They had poor male role models: idolised, superhero fathers who it later transpired were cons, emotionally weak, absent or sexually abusive. There was repeated disappointment or rejection from father figures, or the threat of male violence. Often I would notice that there was intermittent abandonment from the mother, either unintentionally through ill health or emotional dissociation, or the threat that they could leave if their sons weren't 'perfect', that they had had to prove themselves 'worthy of love'.

By working through the eroticism, my clients were able to transform their 'outer' relationships. Being able to have an open dialogue of the eroticism that was present in the therapeutic relationship enabled my clients to come to term with, or at least to have a greater understanding of, their defensive or ill-fated patterns of behaviour in their other relationships. In James' case, his desire for control, and his anger at being objectified and for wanting to merge with another was preventing deep intimate relationships or sexual fulfilment; and in the second, Peter was able to examine his resistance and fear of intimate relationships and an unexamined aggression, even an impulsive, hatred of women.

Aside from the two presented cases, of my male clients who exhibited erotic transference they had the commonality in their early life relationships, of missing, unstable or inconsistent self-object experiences (Kohut, 1972). Both of the men presented in these cases yearned for connection, the contact that they had enjoyed only sporadically, or at a high cost to their own sense of self (Rappaport, 1956). Through the therapy work, they were, sometimes, able to recognise their urges to merge and their desire to fuse once again into a symbiotic relationship. At times they were able to see that their desire for engaging in a sexual relationship with me, their therapist, was a re-enactment of the early parental relationship. I also experienced periods of their hatred or anger as they spurned these interpretations of their 'love'. Their strivings were often an attempt to stave off the dreadful fear of separation, of aloneness. However, I would argue that our experience was also intersubjective; there was a shared feeling of mutual regard and love. It was also an opportunity to discover that they could be loved in ways that were

different from the way they experienced their primary love. They began their own external journey. They were able to engage with more meaningful human relationships and greater intimacy.

In the sessions, I never perceived a sexual threat, or a feeling of predation. Instinct and impulses often guide me when I have felt this threat, and they have helped me to discern whether or not it was safe enough to engage erotically. There have been times in my practice when it has not felt safe enough, where I have chosen to not touch, and have stayed seated in my chair, not even wishing to move to the mat on the floor that I often use. I have stayed seated, with clear spoken boundaries, restricting physical contact. I have found clear, direct honesty to be compelling in these interactions which I would have found overwhelming at the beginning of my practice. I have stated to a male client that I did not want to have sex with him, nor would we ever have sex, which was much more 'real', and for us in that moment, more progressive than re-iterating rules and codes of ethics. All of which sounded strangely hollow when faced with his forceful demands and drive for sex. As a woman, I do not think it is always possible to work with these powerful feelings and referring clients on, with whom I do not have the resources to work, has been a newfound skill.

The calls for sexual engagement, from these two men that openly spoke of their feelings, were more demands for loving touch, physical proximity or closeness than sexual intercourse (Swartz, 1969). I feel that the ability to make this discernment and to remain anchored to this reality is pivotal to engaging with eroticism. I was also surprised by the passivity of both of these clients. Often in their positioning they would immediately lie down, and in the touch they both preferred to be very passive, this would often be a point of discussion. I had an expectation that in the erotic transference, they may attempt to sexualise the contact in an effort to remain in control, but the control was more often verbal. James was a skilled craftsman in intellectual 'battle'. Neither man made a conscious effort to use touch as a vehicle, to be either prescriptive or directive in the touch. The seduction was much more subtle, unspoken, thus not only did touch not disturb the process of symbolisation, but it was quite the opposite. It also supported symbolisation.

Among the clients that experienced eroticised transference, there was a commonality, an intractable belief and a role reversal that if they were able to persuade me of their love, then I would change for them. This presented an ongoing challenge as they resisted any attempt by me to engage with therapeutic insights for a considerable time. It was a humbling experience.

I also questioned my own part in the dynamic, as to whether touch, due to its physical intimacy, was also curious as to why, within the eroticisation, my clients chose to stay in the realm of love fantasy, rather than sexual fantasy. Perhaps my own sexual inhibitions were subtly preventing the client from explicitly exploring sexual fantasy or imagery; instead they chose to use romanticised, veiled or shadow imagery.

#### **14. Working Relationally with Touch and Eroticism.**

It would not be within the remit of this paper to do a comprehensive review of relational therapy; however there have been a few principles that I have found helpful and have guided me in my work with these two men.

By utilising a relational approach the therapist and client are in a position to recognise the erotic dynamics, imagery and experience brought from the past of both participants. These experiences are necessarily repeated or enacted in some form in the therapeutic relationship and the limiting, internalised object-relation structures of erotic feelings, sex, sexuality and gender

become known and therapeutically explored.

The core of working as a relational therapist is that it is seen as a joint adventure, as an opportunity for two human beings to develop their intersubjectivity and to reduce the client's vulnerability to the shadows of past relational trauma and dysregulated affect (Bromberg, 2011). Therapy enables an enactment of the shadows of the past and co-creates a new experience. Healing and growth are non-linear but depend on our relatedness. The relationship between the therapist and the client informs the therapeutic process, therefore, there has to be a willingness of the therapist to allow and not deny the eroticism in the room.

By working within a relational frame there is a consideration that erotic transference does not exist in isolation, rather it is actively and continuously co-created with the therapist, and therefore it calls for a collaborative approach that acknowledges the real relationship. The evolving dynamics or erotics of the relationship allows for the possibility of a 'new space and new tension', and of a 'dance' of joint negotiation towards mutual regulation and transformation (Hedges, 2011, p. 41).

Erotic encounters are culturally positioned, gender informed, and socially constructed interactions (Nagel, 2003). They are also alive, not static in nature and therefore present a dynamic movement in the therapy relationship that allows the therapist access to the client's intimate transactions.

If we are not prepared to be seduced and to 'psychologically seduce' a client then we may not be their best 'match' (Maroda, 1999, Forrester, 1990). Such encounters are contextually placed and unique to the particular dyad involved. The two-person dyad inevitably creates interpersonal dynamics that stem from unresolved experiences. These re-enactments are happening at both subtle and more evident levels of awareness and require careful attunement to the shifting nuances in the therapy room. The interweaving of subjectivities creates a complex picture that requires care.

In the work our body informs the process. It becomes an instrument with which the therapist can attune and resonate to the other, to contain and tolerate this experience. The therapist becomes aware of and is guided by their own bodily sensations, impulses and feelings, and those of the other, of transference, counter transference and the possibility of a movement and an opening toward an 'I-thou' relationship (Buber, 1937) where 'man becomes a self. And the fuller it's sharing in the reality of the dialogue, the more real the self becomes' (Buber, 1957). We become an embodied therapist engaging in the present moment (Stern, 1998) thereby encouraging and facilitating this in the other. This fluidity also allows a shift from the hold of past distress. The therapeutic relationship provides the other with a sense of self, and a validation of the self; and touch can, when it also takes into account the transference dynamic, hold greater meaning than mere physical contact.

In relational body psychotherapy, the therapist touches the parts of the other that have been disowned, abandoned, hated, or unconscious. The contact can seal the fractured parts of the self and create a more cohesive sense of the self. Touch has immediacy and an intimacy and when it has warmth and compassion, it can be relationally affirming (Rolef Ben-Shahar, 2010). It is this intimate edge, which is characterised by both a developing therapeutic intimacy and the client's growing edge that can lead to greater self-awareness and aliveness (Ehrenberg, 1992).

## 15. The Pitfalls of Defensive Practice

The issue of touch can instill anxiety, if not terror, within the therapy profession. Society fears that touch can lead to uncontrollable or unruly feelings and behaviours and in the

psychotherapeutic world there has been a developing concept of holding 'appropriate' therapeutic boundaries (Totton, 2010). However, fears of litigious assault may be quelling our instinctual and creative impulses in therapy as well as our professional resolves and ethical intentions. Fear freezes and immobilises us. As therapists, if we are reacting defensively in our practice to an unseen threat, we may not be meeting the needs of our clients. Guidelines may form an important parameters to ensure a sense of safety, and a therapist without boundaries can be potentially harmful. But rigidly held, dogmatic boundaries that do not flex to the individual needs of our clients may be counterintuitive and at the cost of warm and genuine connection. By not touching, out of fear, we are adhering to a belief that our client is a potential hazard to be circumnavigated and possibly reinforcing a belief in them that touch is inherently threatening or dangerous, or they themselves are.

When I use touch in my practice I am informed by my understanding that, without infantilising the other, my client also embodies their inner child. I hold this knowing within my body knowledge and support that part of them in my work. I am not informed or led by risk management or regulation but by the reality that, 'here is the adult and the child'.

Laplanche (1989) recognised the dimension of mutuality in mother-child relations; but he speaks of 'a child whose psyche and body are open to the other, capable of being influenced, seduced', where, there is no mutuality. On the contrary, there is clear asymmetry between the child and the adult. Relationalists (Aron, 1996, Hoffman, 1998 and Mitchell, 1997) all advocate a movement towards mutuality. When we engage with a relational model there is a movement from asymmetry (the transference relationship that can occur between the therapist and client) to mutuality, when we engage with our client both as a child and an adult. Stern (1998) discusses how mutuality allows us to reach the 'now' moments of transformation, to move away from habitual patterns and constellations of the past into the present moment. It has been through creative and spontaneous touch and movement that I have been able to come to these moments.

## 16. Conclusion

Erotic transference and countertransference are important in psychotherapy. However, this paper has its limitations in that multiple sources of evidence were not used, but only the author's experience as a therapist. It would be difficult to draw conclusions from two cases, and further investigation is warranted. This enquiry may be furthered by interviews with the clients that the author used. Further elucidation of rupture repairs, supervisory content and touch nuances utilised would further assist the therapist who is considering engaging in this work.

I believe that erotic charge is a naturalistic event which is an innate part of our aliveness. It is our sexuality, our creativity, our passion and our willingness to connect. When we work responsibly and ethically (held by another, such as a supervisor or a therapist) then we can work with feelings of sexual arousal in ourselves and the other. We can recognise that the motivation behind the desire to seduce may be the deep desire to connect. If we ignore erotic charge we can miss an important therapeutic opportunity, and if out of a fear we ignore or dilute it, we risk a re-enactment further down the therapeutic road.

Touch is important in healing the very violations that were aetiological in the development of erotic transference. Touch communicates a safety and a stable and consistent experience of nurturance that was insufficiently experienced in the earlier lives of our clients. Eroticism



within therapy can provide an opportunity for our clients to be alive in their sexuality, without the danger of violation.

As a profession, if therapists are prepared to engage with a more open dialogue including their own eroticism in practice, we do not risk abandoning our client or ourselves. Breuer, driven to distraction by Bertha Pappenheim, (better known as Anna O.), gave up any further analytical work with 'neurotic' cases as he found it impossible, without his activity and the conduct of his life being 'completely ruined'; and he vowed never to subject himself 'to such an ordeal' again (Grubich-Simitis, 1997, cited in Britton, 1999, p. 26). Professionally, it is important that erotic transference and our own countertransference are dealt with effectively. Jung after his treatment of Spielrein, appeared to suffer from a psychotic breakdown and continued to develop erotic transferences, or act upon his own countertransference, to his female patients (Covington, 2001).

If we can acknowledge that our own erotic psychosomatic arousal and the fantasies that are associated with it, without guilt or shame, we can access crucial, raw therapeutic material, with significance both for our client and ourselves. A strong enough therapeutic relationship can withstand an awareness of eroticism and the acknowledgement that it is just that, and that sexual arousal and excitement will fade, without the need to act upon it. It has the potential to teach tolerance and acceptance of what is and what will pass.

I would argue that erotic charge is an embodiment of connection, of life force, and that without it an essential ingredient is absent. Eroticism is one of alchemical, or 'explosive forces' that are a prerequisite to enlivenment. Erotic charge in our clients and in our own embodied self, is naturalistic, often inevitable and a desirable catalytic agent for transformation and life-enhancing change.

For a client who has experienced early childhood violations or sexual abuse, seduction can become a mode of resolving internalised conflict. Their sexuality would have been shaped by their traumatic experience and the need for control can become a central issue. Seduction may be a vehicle for control, a means of controlling the unknown. Through necessity, the child learns that seduction is both animated and powerful, in that it can entrance another. The real pain of loss during childhood has been transmogrified; the erotic and enigmatic longing for the other has been transformed into revenge against the other.

Eroticism can be chaotic and anarchic. However, acknowledging that seductive eroticism comes from loss serves to give voice to the clients child-self and can allow the therapist to also see how alive, playful and yearning Eros can be. If, as Rosiello (2000) posits, we can recognise that these erotic feelings come from a childhood fraught with confusion and conflict we can engage with both humility and compassion for both erotic transference and our own countertransference.

Therapists can become proficient in the language of touch, seduction, and eroticism, through training and concurrent supervision in touch, sexuality and the unconscious. They can protect themselves and their clients through clear communication and appropriate self-disclosure that is neither gratuitous nor burdening to the client. The intricacies and risk of working with sexual imagery and dynamic re-enactment that arise in the transference-countertransference engagement have long been confused with the destructive sexualisation of the relationship and the 'slippery slope' of sexual acting out and I believe this arena requires further definition and separation. Through educational foundations and practice we can become more fluent in the body's language, and we can better meet the greater complexity of the seductive client.

## BIOGRAPHY

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## Relational Body Psychotherapy (Or Relational Somatic Psychology) Aline LaPierre

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### Abstract

This article discusses the concepts, and methods that characterize relational body psychotherapy. Beginning with the evolution of the role of empathy in the object relations and humanistic movements, continuing with the development of the principles of attachment in the seminal work of John Bowlby and Mary Main, it is with the emergence of relational psychoanalysis as it replaced therapeutic neutrality with the centrality of the therapeutic relationship as an agent for change, that the way finally opened for body psychotherapy to embrace relational psychoanalytic principles. The relational approach has created opportunities to introduce embodied clinical applications into the broader field of psychotherapy and psychoanalysis. Relational body psychotherapy is explored from the perspectives of (1) transference dynamics and the importance of therapeutic resonance; (2) a theory of bodymind organization that views the body as engaged in an ongoing dialogue that includes somatic flow and pulsation, cognitive organization, and relational interdependence; and (3) an attuned and collaborative therapist-client relational matrix that supports the importance of the body in restoring the capacity to love and in activating the conditions that facilitate the emergence of Self. This article is inspired by four publications I found most helpful in understanding the origin, depth, and breadth of relational body psychotherapy, or, as it is called in the United States, relational somatic psychology:

- *From Broken Attachment to Earned Security: The Role of Empathy in Therapeutic Change*. The John Bowlby Memorial Conference Monograph Series (2014), edited by Andrew Odgers.
- *Talking Bodies: How Do We Integrate Working with the Body in Psychotherapy from an Attachment and Relational Perspective?* The John Bowlby Memorial Conference Monograph Series (2014), edited by Kate White.
- *Touching the Relational Edge* (2014) by Asaf Rolef Ben-Shahar.
- *About Relational Body Psychotherapy* (2012), edited by Courtenay Young.

*Keywords:* body psychotherapy, connection, embodied transference, emergence, empathy, somatic psychology, relational matrix, relational body psychotherapy, therapeutic resonance, therapeutic relationship

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*We live in a relational matrix  
within ourselves, with each other, and with our planet.  
Any break in connection within this relational matrix  
is experienced as stress or trauma.*

Over the past two decades, relational psychoanalysis has emerged as a new tradition of thought and clinical practice. It has become an influential force within psychoanalysis, leading the movement away from classical Freudian drive theory towards a developmental model grounded in a wide-ranging mix of influences. Primary among them are attachment and object relations theories, and self psychology. This change has been accompanied by a corresponding shift in clinical practice away from neutrality, abstinence, and anonymity and towards an interactive vision that places the relationship between the therapist and patient at the center of the therapeutic work.

Relational psychoanalysts believe that the desire to be in relationship is the primary human motivation. They argue that personality emerges from the matrix of early formative relationships with parents and caregivers and that, consequently, our desires and urges cannot be separated from the relational contexts from which they arise; our early relationships shape our expectations about how our needs and desires can be met. As a result, relational theorists have come to the conclusion that the formation of identity is largely organized in relation to others. Throughout the lifespan, we attempt to recreate our relational patterns in a way that conforms to what we learned as infants.

Although there is a contemporary tendency to minimize the contributions of psychoanalysis, most of the significant theoretical advances in the field of psychology have had their beginnings in its rich and controversial tradition. In the case of relational body psychotherapy, the path begins in the humanistic movement and in the now-historic revolution set in motion by the cooperative work of psychoanalyst and psychiatrist John Bowlby and psychologist Mary Main. In addition to this deep connection to the principles of attachment theory, relational body psychotherapy was also strongly influenced by relational psychoanalysis. In his important book *Touching the Relational Edge*, Dr. Asaf Rolef Ben-Shahar notes:

One of the reasons for the current blossoming of body psychotherapy within the general field of psychotherapy concerns the conceptual and clinical openness brought by the relational turn in psychoanalysis. Relational psychoanalysis shattered the sterile fantasy which typified the first decades of psychological treatment. (2014, p. 10).

In her preface to Rolef Ben-Shahar's book, Jacqueline Carleton points out how the links between relational body psychotherapy and psychoanalysis connect two worlds that have traditionally been estranged:

Psychoanalysts reading interpersonal neurobiology began to realize that the body held information inaccessible by words alone. In the meantime, body psychotherapists, tired of their own small world, had begun to explore and incorporate ideas and techniques from psychoanalysis, especially and most fruitfully, relational psychoanalysis. (2014, p. xvi)

Rolef Ben-Shahar observes that the rise of relationality in psychoanalysis has brought about a cross-fertilization with contemporary body psychotherapy, resulting in a new generation of body psychotherapists interested in and able to use psychodynamic terminology. The 2012 John Bowlby Memorial Conference "Talking Bodies: How Do We Integrate Working with the Body in Psychotherapy from an Attachment and Relational Perspective?" is an illustration of

the growing movement toward greater integration between therapists trained in a relational psychodynamic tradition and those who come from a body psychotherapy tradition.

Relational psychoanalysis and relational body psychotherapy mutually enrich one another: whereas relational psychoanalytic thinking provides a fertile theoretical foundation to the interested body psychotherapist, relational body psychotherapy offers practices that translate relational concepts into embodied clinical application. Relational psychoanalysts are faced with the fact that including the body and bodily interventions in the therapeutic dialogue challenges traditional clinical practices. Relational body psychotherapists who no longer want their work marginalized are challenged to base their clinical interventions on well-founded theory. Rolef Ben-Shahar cautions:

To reintegrate their position in the psychotherapeutic community, body psychotherapists can no longer resort to the naive and spontaneous stance which has characterized the first few decades of body psychotherapy; as do psychoanalysts and psychotherapists of all schools, they need to position themselves authentically and responsively with their clients, and take responsibility for their clinical interventions (2014, p. 59).

### The Role of Empathy in Relational Psychotherapy

*If it is bad human relations that created the problem,  
then it must be good human relations that can provide the cure.*

—Harry Guntrip

Research into the primary parent–infant relationship shows that the development of empathy in children is essential to their capacity to form satisfying relationships as adults. In response to this finding, the 2011 John Bowlby Memorial Conference monograph addresses the theme of empathy in clinical practice. The conference examined the proposition that just as empathy is essential to a child’s capacity for secure attachment, empathy is also an essential relational skill needed by a therapist to help a client move from an insecure attachment to the achievement of earned security.

### Cultivating Empathy

Before going any further, let’s look a little closer at what empathy is and is not. Sue Gerhardt writes:

Many people think of empathy as some sort of cosy . . . ideal of mothering, and perfect attunement, and being nice. Some people have argued that therapy based on empathy is a kind of “safe analysis” where there are no ethical dilemmas, no sexuality, no challenges. The analytic therapist Andrew Samuels is one such, who calls it, rather evocatively, “a ‘milky’ worldview” (2011, p. 11).

Empathy has been misunderstood: it has been seen as coddling patients and meeting their demands by colluding with them. A more sophisticated understanding of the term may help to counter these misconceptions. Gerhardt describes three levels of empathic relating, showing that it is both a natural response and a capacity that we need to cultivate.

- *Emotional contagion.* At its basic level, empathy is described as a bodily resonance that happens naturally when people share feelings with each other. This bodily resonance is widely believed to be generated, at least in part, by mirror neurons. By activating the areas of our brains that respond to the body language of others, mirror neurons give us

a sense of how others feel and generate similar behaviors in us. This type of empathy is an evolutionary development that requires no effort on our part.

- *Affect attunement.* This level of empathic responding is also mostly automatic and unconscious. When affectively attuned, an individual instinctively adjusts his or her response to mirror how another feels. For example, if a client comes into a session conveying sadness, a therapist might adjust her voice to a gentle, low tone, thereby letting the client know that his inner state has been recognized. For the most part, affect attunement happens unconsciously, but therapists can also choose to consciously use it to give clients nonverbal feedback that lets them know they understand their inner state.
- *Empathy.* Using both bodily resonance and affect attunement as a base, empathy proper is more complex and includes a cognitive element. When we empathize, we consciously draw on our own experiences and self-awareness to imagine what someone else may be feeling. We give priority to feeling along with the other person, while at the same time remaining aware of our own feelings.

Empathy is deeper and broader than attunement. Attunement happens moment to moment as a sensitive caregiver regulates a child's current emotions and responds to his or her immediate needs, whereas empathy is a response to the uniqueness of a whole individual and his or her personal history. Empathy takes time and effort to develop because we need to have acquired a memory bank of encounters with people and have enough self-awareness to draw on those memories. To be capable of empathy, children require empathic caregivers who can consistently help them identify and name their emotions, accurately read their inner states, and translate their inner experiences into a coherent narrative.

When babies and young children do not experience empathy from their caregivers, it is difficult for them to respond empathically. Instead, they react without awareness of their own feelings and without thinking about the impact of their behavior on others. The psychology of the parent becomes the psychology of the developing child. Adults who were on the receiving end of non-empathic parenting as children in turn believe that punitive parenting will teach their children to behave and know their place in a hierarchical society. In this way, lack of empathy contributes to the generational transmission of developmental and relational trauma.

Gerhardt points out that psychoanalysts who were themselves parented without empathy set the tone for decades of analytic assumptions: "Analysts regularly referred to their clients as 'babies' who needed to grow up or 'victims' who needed to take responsibility for themselves" (2014, kindle location 402). Empathy and identification with others were seen as unsuitable behaviors for professionals. In Gerhardt's words:

This more relational perspective makes it clear that the twentieth century style of psychotherapy, as a power relationship where the superior therapist tries to force the patient to grow up, is as outdated and unhelpful as parenting which insists on deference to authority and overly strict disciplinary practices (2014, kindle location 592).

Because empathy is not a symbiotic merging with another, it requires that a therapist have a well-defined separate self. Being empathic requires clarity, good boundaries, maturity, trust, confidence, and compassion. Empathy does not develop without appropriate modeling, and its presence cannot be taken for granted; it is a quality of being that psychotherapists can offer only once they have experienced it themselves. A psychotherapist's own attachment history affects his or her ability to generate the experience of a secure base for a client.

Relational psychotherapy involves the creation of a relationship that provides a secure base for the client. The following qualities are at the heart of secure attachment and equally at the heart of a psychotherapy that is relational:

- *Sensitivity.* Sensitive therapists tune in and are able to understand what clients are feeling, joining them in their pain as well as their joy.
- *Self-regulation.* Therapists generate confidence when they are available to support the regulation of their clients' emotions, particularly in times of distress. One of the main obstacles to the development of empathy is the caregiver's own difficulty with self-regulation; hence the importance of the therapist's personal development and capacity for self-regulation.
- *Responsiveness and mutual feedback.* Therapists must be willing to own their empathic failures and repair misunderstandings. Clients can be retraumatized by being seen in a negative light and judged, by being held at arm's length or when feeling unsafe to express their needs. Again, quoting Gerhardt:

In particular, an empathic narrative recognizes that it is not the client who is negative, but the relationships that the client has experienced in the past, and the relational patterns that he or she has internalized. Therapy based on modern developmental understanding recognizes that our selves are really the emergent properties of actual relationships. (2014, kindle location 587)

### Working with the Body from an Attachment and Relational Perspective

*... therapists need a model of non-verbal communication  
based upon acceptance of intrinsic affective states and their communication  
by active contact between bodies in all degrees of intimacy.  
—Colwyn Trevarthen*

The presentations of the 2012 John Bowlby Memorial Conference center on the importance of the body in the relational perspective. As stated by Kate White, the monograph's editor, the aims of the 2012 conference were three-fold: (1) to explore the growing role of the body in relational psychoanalysis and psychotherapy over the last decade; (2) to update our thinking about the relationship between the body, attachment, and trauma; and (3) to support a greater integration between therapists who come from a body-oriented psychotherapy tradition and those who have been trained in a relational and psychodynamic tradition. White notes in her introduction:

Perhaps relational approaches to psychoanalytic psychotherapy have underplayed the central role of the body in constructing experience and the shaping of our internal worlds. The child's longing for the body of the mother has always been implicit in attachment theory. Yet perhaps in reaction to the excesses of certain classical theories, and because of its need to achieve scientific respectability, the body and by implication touch, the sexual and the erotic have been under theorized (2004, p. xxiv).

Questions addressed during the conference included:

- How do we anchor the new understandings we are gaining within the framework of attachment theory?
- How might the integration of these ideas about the body change what we do in the consulting room?

- What impact might this focus on the body have on the therapy relationship?
- Can we maintain and respect the place of a secure, attuned attachment between therapist and client, and its healing potential, at the center of our therapeutic work?

In support of bringing the importance of the body to the foreground, key contributors from the somatic field were invited, among them were Roz Carroll, who presented the opening address; Pat Ogden, who gave the conference's John Bowlby Memorial Lecture; and Nick Totton, who gave a paper on the theory and practice of relational body psychotherapy. *Talking Bodies* (White, 2014) contributes to the interdisciplinary dialogue on the role of the body from a relational perspective. The 2012 conference builds on the 2003 conference, titled "Touch: Attachment and the Body," in which Susie Orbach reminded us, "Our personal body unfolds and develops its individuality in the context of its relationship to and with an other and other bodies" (2004, p.23). Orbach emphasized that the body, just as the psyche, struggles to come into being, and put out a call to retheorize the relationship between body and mind.

The links between attachment theory and various developmental and relational approaches are continually evolving. For readers interested in further researching the roots of relational psychotherapy and exploring how these inform the theory and practice of relational body psychotherapy, the following are some of the significant contributors mentioned in this Bowlby monograph:

- Mary Main created the Adult Attachment Interview to study the unconscious processes that underlie the attachment styles identified by Mary Ainsworth in her Strange Situation procedure.
- Daniel Stern brought support from the perspective of infant observation and developmental psychology.
- Beatrice Beebe demonstrated that each parent–infant dyad creates a distinct system of mutual influence and regulation, which is reproduced in the narrative between adult clients and their therapists.
- Susie Orbach studied the body in its social context and considered the construction of bodily experience and sexuality in the therapeutic relationship.
- Stephen Mitchell proposed a relational matrix that links attachment theory to other relational psychoanalytic theories.
- Allan Schore presented important developments in the new field of neuropsychanalysis, describing the emerging theories of how in early life, the developing brain is shaped by attachment experiences.
- Bessel van der Kolk showed that posttraumatic stress is a developmental trauma disorder as well as a single-incident shock experience. He was the first to consider the impact of trauma on the entire person, integrating neurobiological, interpersonal, and social perspectives.
- Arietta Slade pioneered attachment-based approaches to clinical work with both adults and children, which include the development of parental reflective functioning, the relational contexts of play and early symbolization, and how the attachment system functions to regulate fear and distress within the therapeutic process.

### **The Hardwired Desire for Connection**

In his presentation, Nick Totton defines what a grounded understanding of embodied



relationship involves. We are born, writes Totton, with a hardwired imperative to form relationships. Totton's *Embodied-Relational Therapy* (ERT) is an approach based on the perception that we are all embodied and relational beings and that to survive and thrive physically and emotionally, we need relationships with others in all stages of life. Bowlby had postulated: "While especially evident during early childhood, attachment behavior is held to characterize human beings from the cradle to the grave" (1979, p. 129). In line with Bowlby's thinking, Totton aims to move our understanding of embodied relationship beyond infant-focused early attachment to consider the nature of social bonding throughout the lifespan.

As do attachment-centered and relational psychoanalysts, Totton anchors his work in the fact that anyone who closely observes infants can witness their huge capacity and desire for connection. Anyone who has taken care of a baby has experienced the storms of grief and despair with which they respond to disturbances in relationship. Babies, writes Totton, arrive in this world eager and expectant to form relationships, expressing their eagerness through their gaze, facial expressions, voice, and movements. This eagerness is implicitly present in our bodies:

Our bodies tremble and vibrate with urgency to connect, soaring and swooping between peaks of bliss and troughs of agony and despair, visibly expanding and contracting with the responses we receive. These earliest relationships literally form and shape us and all our future relationships; throughout our lives we can experience the deepest wounding and the deepest healing in relationship (2014, p. 43).

Our adult capacity for connection and attunement carries the imprint of our early attachment experiences. This is as true for psychotherapists as it is for their clients. The capacity for connection and attunement within a therapist–client dyad depends on each member's early attachment experiences; each dyad is unique. Consequently, it is important that relational body psychotherapists bring to conscious awareness their own early attachment and developmental experiences and the effect those experiences have on their adult capacity for empathy, connection, and bodily presence. It is essential for relational body psychotherapists to have an awareness of and openness to their own bodily experiences. Body psychotherapists, writes Totton, have hopefully worked through their own relationship with embodiment to the extent that they can regularly find comfort in it and communicate this comfort to their clients. Totton sees a therapist's capacity to track and use his or her embodied experience as the central competence to successful body psychotherapy:

... as practitioners we commit to our embodied response in order to form a living, two-way relationship, which becomes the crucible of change and growth. Our body bathes in and soaks up the embodied presence of the client; we catch fire from them; we breathe them in and metabolize them; we reverberate to their rhythms, and our own rhythms shift to meet them (2014, p. 44).

For Totton, embodiment and the relationship between client and therapist are inseparable and are vital elements of the therapeutic process. It is this state of "mutual co-arising where each continuously affects and conditions the experience of the other" that reveals the history, patterns, and belief systems at work. We need bodies to relate, and we need to relate to become embodied: relationships are first and foremost bodily events. Relationship requires a dance between two feeling bodies and two embodied psyches that create and condition one another.

### **Embodied Transference and Countertransference**

Totton notes that transference and countertransference are bodily phenomena based on the implicit—that is, out of awareness—activation that allows us to create "an echo in

ourselves of what we perceive happening in the other” (2014, p. 49). We are all familiar with the concepts of transference and countertransference. However, its somatic aspects are not as frequently discussed. *Embodied* transference and countertransference refer to the way clinicians and clients experience each other’s physical states within their own bodies. Totton and Priestman write that:

Transference is thus not only a psychological, but also a bodily process, a function of implicit procedural memories of childhood relationships, learnt complexes of physical response held outside consciousness and in part repressed from consciousness (2012, p. 39).

For example, beyond natural empathy, body psychotherapists develop their capacity to consciously track shifts in gut feelings, breath, heart rate, and bracing patterns both in their clients and in themselves. In conjunction with supporting their clients’ ongoing emotional and cognitive reflective processes, relational body psychotherapists allow themselves to be guided by their own interoceptive body-based responses. Irish psychologists at the National University of Ireland (NUI) Galway and University College Dublin measured body-centered countertransference in female trauma therapists. Their research was based on the theory that to understand their clients’ internal experience, therapists use their bodies somewhat as empathic tuning forks. Using the Egan and Carr Body-Centered Countertransference Scale (2008), they found high levels of the following body-centered countertransference experiences:

- Sleepiness
- Muscle tension, shakiness
- Yawning
- Unexpected shift in body, heart palpitations, sexual excitement
- Tearfulness
- Headache
- Stomach disturbance, nausea, churning stomach
- Throat constriction

Embodiment allows a body psychotherapist to distinguish between a response that is their own subjective experience and a response that is empathically driven by the other.

All human beings are impacted on a bodily level by the feeling states of others, whether they recognize them or not, whether they welcome them or not. How can relational body psychotherapists make a clear distinction between an upsurge of their own material for which they must acknowledge ownership and their internal experiences as a reflection of the client’s material? What allows clinicians to assert with certainty that they are responding to their clients’ arousal levels? For the relational body psychotherapist, making this distinction involves complex terrain.

### **The Multidimensionality of Relational Body Psychotherapy**

Roz Carroll (2014) tells a story about neuroscientists Chiel and Beer who compared the feedback loops between the brain, the body, and the environment to the relationship between improvising jazz musicians. Brain and body, self and other, nervous system and environment riff off each other as do jazz musicians, influencing and responding to each other in a complex weaving of interrelated responses.

The jazz ensemble metaphor illustrates the understanding that a psychotherapy that would be relational and inclusive of the body is multidimensional. Relationality involves the capacity to think and hold multiple perspectives: to perceive the other’s body and to feel one’s

own body as sources of emotional engagement without falling into the oversimplified view that the brain is the conductor of the orchestra or that it controls the actions of the body. Relational body psychotherapy must take into account the many dimensions of relationship:

- The internal relationship clients have within their own bodies and minds.
- The internal relationship therapists have within their own bodies and minds.
- The capacity for secure attachment and the quality of the relationships clients have with their loved ones, their environment, and the people they come in contact with, including their therapist.
- Therapists' own capacities for attachment and relationship in their own lives and with their clients.
- The dynamic interactions among all of the above.

From our perspective as clinicians, it is a complex and challenging task to listen simultaneously to the client's words, gestures, prosody, pulsations, movements, etc., while monitoring our own physiological and feeling responses, all the while formulating our thoughts within the context of an empathic understanding and developmental-relational framework. In addition, this multifaceted process, much of which happens outside of our consciousness, requires spontaneity and discipline, and involves sensitive timing skills that range from recognizing split-second perceptions to incubating slower reflective responses.

### Touching the Relational Edge

*The road between vital experiencing and dying inwardly  
is paved with disappointments in love.*

—Wilhelm Reich

Asaf Rolef Ben-Shahar, in his book *Touching the Relational Edge*, asks a simple but key question: “What is it that makes relational body psychotherapy different from other bodywork or body psychotherapy modalities?” (2014, p. 61). In the process of formulating an answer, he gives us an in-depth understanding of the history, concepts, and methods of body psychotherapy. For this reason alone his book is a valuable contribution to the theory and practice of body psychotherapy: a gem for psychotherapists and psychoanalysts who want to orient themselves to the field of body psychotherapy, as well as for body psychotherapists who wish to have a clear overview of their field. As a result of integrating the features that link relational body psychotherapy and relational psychoanalysis, Rolef Ben-Shahar has developed a complex understanding of both fields; this allows him to raise important questions about the sometimes heightened, emotional charge that takes place in an embodied body psychotherapy practice:

- How important is the therapeutic relationship in body psychotherapy?
- How weighty are transference dynamics in the work?
- What is the role of the therapist in the therapeutic relationship?
- What complexities enter therapy when clients lie down on a massage table or a mattress, and may take off some of their clothes?
- What happens to the therapeutic relationship when touch is a possibility?

Before going deeper into Rolef Ben-Shahar's complex relational model, I want to briefly review some of the influences that connect relational psychoanalysis with relational body psychotherapy from his perspective:

- *The use of psychotherapeutic terminology.* Body psychotherapy was exiled from psychoanalytic practice because it did not fit the orthodox analytic principles of earlier times. Today, following the emergence of relational psychoanalysis, it can rejoin the analytic discourse and contribute valuable somatic skills and conceptualizations that support a greater integration of developmental psychology and neuroscience into clinical practice. Relational body psychotherapists use a terminology that is understood by the broader psychotherapeutic community and work to bridge the divide created by their distinctive embodied view of clinical interventions. They extend the expression of their professional expertise beyond what, in the past, has been the marginalized world of body psychotherapy and bodywork.
- *The centrality of the therapeutic relationship.* The therapist–client relationship is held as central to the therapeutic process. Therapeutic interventions stem from the client’s needs, are mindful of the internal state of both therapist and client, and tend to the growing therapeutic relationship. It is the client’s process within the therapeutic relationship that governs the use of bodywork techniques.
- *A two-person psychology.* Relational body psychotherapists work with transference and countertransference from a psychological as well as from a somatic perspective. To quote Rolf Ben-Shahar:

The therapist is not perceived as an external spectator assisting the client’s change, but an active participant in a process of change that takes place in the therapist as well. By recognizing that her presence impacts and creates change, the psychotherapist converses with her clients and discusses issues of influence and power between them rather than ignoring or avoiding such important matters (2014, p. 61).

### The Relational Matrix

Rolf Ben-Shahar (2014) proposes that meaningful relationships operate on four dimensions: a basic functional dimension, a more complex transference dimension, an empathic humanistic dimension, and a fourth dimension created by the interactions of the first three: *a relational matrix*. The following takes a closer look at these four dimensions of meaningful relationship within the therapeutic setting:

1. *A functional dimension.* Every relationship fulfills a need: we need to discover ourselves, we need to feel worthy, we need connection with each other, and we need to belong to a social structure. When two people enter a relationship, however simple or complex, the functional dimension is usually the first filter. The therapeutic question in the functional dimension is that of a service provider to a consumer: “*What can I do for you?*” In all relationships, the functional dimension requires some degree of mutuality in which service, interdependence, mutual needs, and utilitarian gain are exchanged so that both parties benefit from the interaction. In the same way, in the therapeutic relationship, the functional dimension requires mutuality: clients pay their therapist in exchange for attending to their needs, and in return therapists receive worth for their expert service. Therapists specify their functional rules: fixed time, set fee, cancellation policy. In turn, clients expect a positive outcome for their investment.
2. *A transference dimension.* The psychotherapeutic relationship is an intimate connection in which clients talk about their deepest issues. They bring to sessions their past relationship history, in particular, the way they have internalized their

attachment figures. In the transference dimension the therapeutic issue is: “*Who are we to one another, and how did we come to be so?*” Therapist and client explore who they are to each other: parent–child, siblings, lovers, friends, abuser–victim, etc. What characterizes the transference dimension is the willingness and commitment to name these influences and work with them consciously. The transference relationship is not symmetrical in that it has some power inequality; it is nonetheless a two-person mutual encounter that demands the full presence of both therapist and client. Within the transference dimension, clients can revisit and reframe formative experiences by which their personality developed.

3. *A humanistic dimension.* In this dimension, there exist genuine moments of connection that take place beyond function, role, history, or transference. From a humanistic perspective, the therapist affirms: “*I am here with you.*” Whereas the previous two dimensions are asymmetrical and involve power differences, the humanistic dimension is a place of equality embracing and going beyond asymmetrical continuums. It is an invitation to relationship that demonstrates a longing within all human beings for connection. It touches into what Rolef Ben-Shahar (2014) describes as “surrender to a wider mind” within which it is meaningless to speak of me and you as separate.
4. *A relational matrix.* The surrender to a wider mind creates yet another order of connection: one in which relationships are, again quoting Rolef Ben-Shahar, “. . . reciprocal and asymmetrical, saturated with transference projections yet holding potential for true meeting of souls, full of implicit unspoken agendas yet embedding transcendence of ego-centered utility” (2014, p. 327). At its most profound, the therapist–client connection transcends the functional, transference, and humanistic dimensions. These three dimensions, embedded in the heart of relational body psychotherapy and of relationships in general, form a matrix that is more than the sum of its parts. This matrix is multifaceted and inclusive of the therapist’s and client’s capacity for attachment, self-organization, mutual regulation, and agency as they engage their growing awareness and the re-creation of their world.

### Mirror Neurons

Recognizing that observing the activity within one individual influences another’s nervous system was a startling finding that captured the relational imagination. Mirror neurons were discovered in the 1980s and 1990s by neurophysiologist Giacomo Rizzolatti (1996) and his research team at the University of Parma, Italy. Rizzolatti and his team studied the neurons that control the hand and mouth actions in the macaque monkey. They noticed that the same neurons that were active during grasping were also active when a monkey simply observed a researcher reaching for food. It was further observed that an emotionally meaningful stimulus was required for the mirror neurons to become active. A mirror neuron therefore, is a neuron that fires both during a subjective action, and when that same action is observed performed by another and has emotional meaning.

The existence of the mirror system has generated a great deal of excitement, research, and speculation. Functional magnetic resonance imaging (fMRI) research has not only shown that humans have a mirror neuron system but also suggests that they have a much wider network of brain areas with mirroring properties than was previously thought. This wider network includes the somatosensory cortex and is thought to allow an individual to feel an observed movement. Before venturing too far in conjecture, it is important to remember that mirror neuron research

is still the subject of speculation and that widely accepted neural or computational models are, even now, in development in the scientific community. Nonetheless, this research is fascinating and the following list summarizes the hypotheses under investigation:

- Having identified brain regions that respond both to an action and to the observation of an action, researchers believe that the mirror system could be the physiological mechanism that couples action and perception.
- Mirror neurons allow us to understand other people's actions and to learn new skills by imitation.
- By stimulating our observation of other people's actions, mirror neurons contribute to theory of mind and to the development of language abilities.
- The mirror neuron system helps us understand not only other people's actions but also their *intentions*: for example, discerning if someone picks up a cup of tea planning to drink from it or clear it from a table.
- Mirror neurons may be the neural basis of the human capacity for empathy, resonance, and even transference. Mirror neurons appear to be the physiological mechanism that allows us to identify with one another and to feel what the other is feeling in our own bodies.

The question as to whether we feel empathy, resonate, imitate, or simulate one another's behaviors is because of mirror neurons remains open. Nonetheless, empathy and resonance, independently of their connection to the mirror neuron system, are essential skills central to relational body psychotherapy.

### Resonance

Empathy goes by many names: resonance, somatic resonance, attunement, entrainment, vicarious introspection. Even though each of these states has distinctive attributes, they have enough similarities that they are frequently used interchangeably. They all refer to a natural transmission of sensations, visceral reactions, emotions, images, and thoughts from one person to another. Seemingly, the term resonance is widely used in body-centered therapy whereas empathy is preferred in psychotherapy.

The definition of resonance closely corresponds to Carl Rogers' definition of empathy: a primarily nonverbal and emotional experience during which the internal states of one person are sensed in another's body. Resonance is not only the domain of therapy: we all experience resonance in daily life. Loewald describes the process of therapeutic resonance:

The resonance between the patient's and the analyst's unconscious underlies any genuine psychoanalytic understanding and forms the point of departure for eventually arriving at verbal interpretations of the material heard or otherwise perceived. The analyst, during that internal journey, in his effort to stay sane and rational is often apt to repress the very transference-countertransference resonances and responses, induced by the patient, that would give him the deepest but also most unsettling understanding of himself and the patient (1986, p. 283).

In the spirit of psychologist Edward Tronick and his colleagues (1998), who differentiated between individual and dyadic states of consciousness, Rolef Ben-Shahar (2014) further defines our understanding of resonance by proposing that we have two types of bodies:

- The first body is our skin-bound physical body: it is a closed system that does not require contact with another for us to experience it.
- The second body is an open system that only comes into awareness when we are in relationship with another. It comes to life—is switched on—by experiences of



attachment and connection. This second body resonates when in dyadic states and is an aspect of the humanistic dimension of the wider mind. It is complementary and in dialogue with the skin-bound first body (2014, p. 96).

Resonance is an excellent diagnostic tool that therapist and client can use to experience the relational field, particularly to bring to awareness nonverbal and unspoken communications. A useful working premise for the therapeutic use of resonance is to consider that as soon as we enter a mutual field with another, nothing purely belongs to us any more; when we are engaged in a relational field, thoughts, feelings, images, and sensations no longer arise in isolation.

According to Regina Pally (1998), mirror neuron and neuroscience research suggests a link between resonance and emotion. Not only does emotion coordinate an individual's relationship within themselves, it also helps to connect minds and bodies between individuals. Thus, as a biological regulating function within and between individuals, emotion is an important component of the resonance that facilitates social interaction. An authentic emotional engagement between client and therapist organizes their attachment experience and allows previously unformulated inner states to come into awareness. Healing takes place in shared and emotionally alive moments of meaning.

### **Cultivating Therapeutic Resonance**

Using resonance therapeutically is a complex skill. Rolef Ben-Shahar suggests that resonance cannot be perceived cognitively but requires somatic attention: intellectual means alone do not give access to the capacity to be aware of the subtle currents of resonance. He writes:

... the main way to feel into the intersubjective space (and intersubjective body) is through body sensations. We feel our wider bodymind through our six senses (the familiar five senses and proprioception), through our own body. To simplify the argument: when we are attentive to our own bodies, we can feel the other alive and moving through us. This implicit knowing . . . is, so I believe, resonance—our connection to the other through the interface of our own body (2014, p. 153).

Even though resonance is a natural phenomenon, body psychotherapists must consciously cultivate their relationship to their body in order to insure their safe use of resonance as a therapeutic tool. Courtenay Young explains:

The quality of this relationship to our body also determines how “embodied” we are; whether we truly inhabit our body, live in it fully and operate from the center of its being; whether we are aware of its subtle nuances and thus whether we use our body as a finely tuned instrument—and take care of it; or instead, whether we “use” it purely as a physical shell, an organic vehicle, to carry our head around, so that it is something that just needs to be fed, watered and maintained occasionally . . . (2012, p. xi–xii).

Given that the greater portion of bodily communication is nonverbal, relational body psychotherapists rely on their personal relationship to their bodies to sense and feel their clients' inner experience and receive their unspoken communications. Therefore, just as psychotherapists are required to undergo their own psychotherapy and analysts their own analysis to explore their patterns of thought and feeling, likewise body-centered psychotherapists must develop a carefully honed relationship to their bodies. In order to accurately observe a client's body, to be aware of the somatic transference and countertransference, and to be present in the here and now with fitting somatic interventions, they must be attentive to and

aware of their own sensory and energetic channels both interpersonally and intrapsychically. To meet the responsibility of working directly with a client's body, body psychotherapists must know their own.

### Compassion Fatigue

Therapeutic resonance does have its risks and when used unconsciously, can pose serious problems to a therapist's well-being. Relational body psychotherapists, drawing heavily on neurologically based empathy and resonance, must be aware of the possibility of mental and physical exhaustion: They must pay attention to their level of compassion fatigue, to the exhaustion of burnout that can affect their quality of life, and to the more serious vicarious traumatization, that is, becoming infected by another person's trauma. In her book *Help for the Helper* (2006), Babette Rothschild has laid out a sound program for concrete self-care strategies that help psychotherapists avoid the very real dangers of compassion fatigue and maintain their capacity to remain open to their clients without suffering the effects of vicarious exhaustion and traumatization.

### Transference, Countertransference, and Body Psychotherapy

Following the realization that there is no such thing as an objective observer and a subject unaffected by the observation, modern physics has undergone a paradigm shift. The fact that it is not possible for an observer to observe a system without changing that very system brought into question the belief in rigorous neutrality, abstinence, and anonymity. As a result, the approach of traditional psychoanalysts who see themselves as scientific observers of patients who are their subjects has come into question, as has the self-assured presentation of interpretations delivered in a manner seemingly without personal emotional response—as though the analyst were free of countertransference.

The need for a paradigm shift also applies to body psychotherapists who see the body as something to be “done to” and, working under the assumption that they know what their client's body needs, impose somatic interventions that are intended to break through body armor or somatic resistance. According to Michael Soth (2012), transference issues have not been sufficiently recognized in body psychotherapy. Soth believes that the traditional body psychotherapeutic agenda of breaking through body armor leads clients to experience their therapist as being like the very person against whom their armor was first developed; in psychoanalytic terms, the therapist is experienced as a “bad object.” Robert Hilton (2012), co-founder of the Southern California Institute for Bioenergetic Analysis (SCIBA), notes that in many bodywork modalities, the presence of the therapist is not acknowledged since it is assumed that healing occurs by release of body tension and does not involve a relationship with the person facilitating the release. The early Bioenergetic model for example, did not allow for the mutuality of shared experience between therapist and client. The assumption that the body heals itself ignores issues of attachment. Working to awaken sensory-motor amnesia or facilitating the expression of blocked emotion does not replace a client's relational need for a “good object” with whom early loss can be repaired. From a relational perspective, the therapist is an integral part of the work. In the words of relational psychoanalyst Stephen Mitchell, “The emphasis is now on interaction, enactment, spontaneity, mutuality, and authenticity” (2005, p. ix).

Courtenay Young states what is perhaps obvious when he writes in the preface to his edited book *About Relational Body Psychotherapy* (2012) that in body psychotherapy, the

relationship to the human body is not just a relationship to the client's body; the therapist also has a body. Young reminds us that including the therapist's body and how therapist and client relate to each other's bodies, is a relatively new focus. Transference dynamics between psychotherapist and client can no longer be discussed solely within an impersonal conceptual framework; there is an undeniable relational flow within the therapeutic interaction.

The complexity of the sensitive relational matrix has not been well understood by either psychoanalysts or body psychotherapists. The relational approach invites all therapists to move away from classical neutrality and open themselves to being vulnerable, to disclose their own experiences, and to tread common ground with their clients. Hilton emphasizes that the therapist's authenticity is a key healing agent:

The countertransference of the therapist—how he or she influences the client or patient—is critical in this process of becoming. When the therapist experiences what he is trying to get the patient to experience, the patient gets better. This happens when the therapist can ask himself, “What feelings does this client create in me that I am resisting acknowledging? Is it fear, anger, sadness, longing?” And almost always that is the feeling that the patient is resisting experiencing with you (2012, p. 2).

We all live within an energy matrix that is impossible to avoid. From a relational perspective, transference relationships are co-constructed. Everything we have experienced in our past relationships is present with us from the onset of any new relationship: we all carry our mothers, fathers, siblings, friends, teachers, heartbreaks, and expectations. Because psychotherapists and clients alike bring their past histories into sessions, the dynamics of transference and countertransference are inevitably present regardless of the therapeutic model used. Sharing, identifying, and disentangling past from present—clarifying the biographical matrix—becomes a process of collaboration to uncover the meaning that underlies transference patterns. It is ill-advised, indeed impossible, to treat transference and countertransference as separate issues. They are like the two faces of the same coin, inextricably bound to each other.

In the initial phase of therapy, clients learn to trust that their therapist will reliably hold their inner process. To heal their childhood wounds, clients seek a particular kind of relationship with their therapist; if the nature of the relationship is not addressed in ways that clients can use for self-recovery, they will find ways to adapt to the therapist's model just as they adapted to the dysfunction of their family system. They become the “good” client who does what is expected. A relational psychotherapist who is sensitive to the transference will sense clients' unmet needs, bring their internal working model to awareness, and challenge their misperceptions in the here and now. Relational therapists gently stretch their clients' ability to trust; they encourage them to explore the transference responses that are based on attachment and relational traumas—their expectations that the therapist will be critical, uncaring, and punitive, as well as their idealizations.

From the therapist's perspective, countertransference responses are no longer kept hidden. In the hope that new ways of being may be modeled, psychotherapists and body psychotherapists who practice from a relational stance are willing to be seen—to be examined and analyzed by their clients. Revising internal working models within the transference and countertransference dynamics helps both therapist and client expand their relational options. The emphasis is on creating new relational patterns rather than on presenting interpretations intended to bring insight.

## Self-Disclosure

Relationality does not mean that self-disclosure is done without professional discernment, that therapeutic goals are neglected, or that it becomes a central focus in the therapeutic work. When to share, what should be disclosed, how much to share, and when to hold back are questions that need serious consideration. Hans Loewald (1986) wrote that freeing ourselves from the fantasy of non-influence does not grant thoughtless sharing. A strong yet flexible therapeutic frame must remain along with the freedom to connect from the center of one's being. For example, how does a relational therapist respond when a client asks a personal question? There was a time when personal questions were reflexively turned back onto clients with comments about what these questions might mean to them. No longer a blank slate, relational therapists may choose to reveal some aspect of their lives, perhaps an arduous lesson learned through personal pain that can serve as a point of reflection or inspiration.

## Google and the End of Anonymity

In this discussion on transference and countertransference, we cannot ignore the fact that Google, YouTube, Facebook, and all other forms of electronic connectivity have all but swept away the therapist's anonymity and attendant mystery and power. That clients now have access to Internet information about their therapists blurs the boundaries between the personal and professional and changes the nature of the transference relationship by putting therapist and client on a more even playing field. Googling, of course, goes both ways. Clients' electronic histories are also available to therapists, so the experience of evaluating a client with fresh eyes is coming to an end—further support for establishing a more mutual and relational basis for treatment.

The transparency of information now available serves as an antidote to authoritarian therapies and humanizes the therapeutic relationship. For many clients, having access to information about a therapist is liberating—rather like Dorothy in *The Wizard of Oz*, pulling back the curtain to discover that the therapist/wizard is a mere mortal.

On a different note, the ever-present electronic connectivity brings new appreciation for the privacy of the dialogue that is the heart of relational psychotherapy. The therapist's office offers a quiet place for intimate conversation, a place where secrets, reflections, fears, or confusion never leave the room and are never subject to a possible hacker's violation.

## A Relational Bodymind Theory

To function in our ever-changing world, we work to create order out of seeming chaos; to reconcile our internal needs against the all-too-often-indifferent outer world, we impose our personal preferences on reality. In our attempts to create a safe life in which our needs are met, we set limits and we create personal boundaries; however, at the same time as these limits and boundaries protect us, they also limit our lives.

Informed by the philosophies of several major thinkers, in particular, by the formative psychology of Stanley Keleman (1985, 1987, 2012), Rolef Ben-Shahar proposes three major channels of organization through which human beings, for better or for worse, organize their lives: (1) somatic, (2) linguistic-cognitive, and (3) relational:

1. *Somatic organizations.* Somatic organizations—such as how we breathe, digest, think, and act—shape our very existence. Ideally, when we are somatically organized—when we are regulated and feel a sense of mastery in our body—we are flexible enough to

respond and successfully adapt to the changing conditions of our inner and outer worlds. We are in harmony with our environment. Maladaptive somatic organizations create barriers that separate us from our experience, from relationships, and from our environment; they can become rigid character armor or they can cause retreat and collapse, further diminishing our responsivity and our aliveness. Rolef Ben-Shahar points out that working with somatic organizations and the knowledge of how to reorganize maladaptive somatic patterns are probably two of the most important contributions body psychotherapy has brought to the broader field of psychotherapy.

2. *Linguistic and cognitive organizations.* Language is another way we organize our world. The ability to organize the narrative of our personal story is a marker of successful development. For example, individuals who enter therapy with a disorganized, difficult-to-follow narrative also usually struggle with an associated fragile sense of self and inability to differentiate feelings from thoughts. Our sense of reality and our cognitions are interactively informed by our linguistic development and allow us to (a) make distinctions between what is real or illusive; (b) continually reorganize what is meaningful to us; (c) orient ourselves to the past, present, and future as well as to self and other; and (d) mediate between the flux of reality and our capacity to contain and tolerate its flow.

3. *Relational organizations.* The success or failure of our early attachment process becomes the relational matrix that continues to influence our adult reality. Throughout life, notes Rolef Ben-Shahar, engaging in relational shifts, that is, participating in and leaving relationships, is an important means of developing our identities:

The qualities of our identity-formation and our ego-strength are dependent on our capacity to open to different orders of relationships, to surrender our individual self to the creation of a dyadic self, a familial or organizational self, and a social self. Our character, personality, and identity are therefore in ongoing dialogue with our real and internalized attachment figures (2014, p. 83).

Unless we learn to consciously open to the wealth of relational possibilities available to us, we remain encased within the limitations of our childhood attachments. Expanded forms of relationship are challenging to those who exist within rigid skin boundaries that sharply separate them from the world around them and do not give them access to the wider relational mind.

Thus, relational body psychotherapy presents a theory of bodymind organization that sees the body as engaged in an ongoing dialogue that includes somatic flow and pulsation, cognitive organization, and relational interdependence. It neither attempts to reduce therapeutic work to cognitive insight in the hope that new awareness will somehow materialize into connection, nor does it impose somatic interventions in the hope they will transform into consciousness.

## Emergence

Emergence phenomena are at the heart of relational therapeutic approaches. The concept of emergence is used in various sciences, but the focus here is on its significance as it manifests in the therapeutic relationship.

The principle of emergence refers to something new and unexpected that arises out of a collaboration. An emergent structure arises as a result of *the combined focus of individuals working together*. Emergence requires interactive cooperation; it does not appear when individuals act

independently of one another. Relational interactions set in motion a complex chain of processes leading to the appearance of a new order that is more than the sum of its parts. Physician Fritjof Capra explains: “Emergence results in the creation of novelty, and this novelty is often qualitatively different from the phenomena out of which it emerged” (2002, p. 36).

### The Emergent Self

When an organic process such as a relationship reaches a high level of attuned interaction, new, original, and unpredictable characteristics, that were not present before the interaction began, appear as emergent qualities of Self. Emergence is neither causal nor linear; for example, a mind that emerges from a body cannot be explained only in physiological or neurological terms—it requires more complex circumstances that include, among others, secure attachment, supportive education, creative dynamic interaction within attuned connection.

Broken, betrayed, abused, or neglected attachments trigger conditions that preclude emergence; instead, they foster an absence of connection, the disappearance of self, and the withdrawal from embodiment. This departure from connection is the very opposite of creative emergence.

Facilitating healing change involves being present with clients as they explore and engage in loosening their rigid states and awaken to their own capacity to open to unpredictable new ways of being. Emergence arises out of a necessary suspension of belief in one’s old ways, along with the faith that inviting attuned relationship and opening oneself to bodily experience will bring a positive outcome. It necessitates letting go of fear, control, or vigilance to allow the emergence of new experiences that can potentially bring gratifying expansion. Rolef Ben-Shahar (2014) describes this process as a surrender to flow, a process in which client and therapist together safely deconstruct rigidities, learn to tolerate unknown factors, and invite new organization, thereby opening to emergent dimensions of self. Because the surrender to flow is potentially risky, frightening, and disorienting, the guiding presence of an attuned therapist is a key factor. No one changes in isolation; a relational therapeutic setting offers a context wherein clients no longer do it all by themselves.

### Healing the Capacity to Love

In an interview with Nancy Eichhorn (2012), Robert Hilton spoke about the relational needs that accompany the development of the Self:

I find that, when my clients are facing the breakdown of their usual patterns of self-organization, they need me to hold the experience for them. They need to feel that I am present, *in just the way they need me to be*. They then have the freedom to find a new form of grounding and integration (p. 31, emphasis added).

Relational psychotherapists engage their clients’ desire to recover their capacity to love and be loved by modeling for them, in real time, the experience of empathic and attuned connection. Therapy, said Hilton, is not about technique, it is about relationship:

I knew, in some profound way, that I was to be a model for how she could be with her own pain. She was asking me to bear this pain of love and helplessness that she could not bear herself. I was now willing to be with her in her pain and not try to “fix” her (2012, p. 29).

Hilton (2012) explained that early bodywork modalities did not provide a bonding experience because it was believed that the body healed itself through releasing tension; therefore, working with the therapeutic relationship was not considered essential to the



healing process. For example, although the Bioenergetic model acknowledged that our original pain was due to a loss of love, it did not address the client's need for loving contact in the processing of that early loss. Hilton admitted that in his early years of practice, he repeated what he had learned from his trainers; he turned his clients' needs back on them and reinterpreted their needs through their character structure. Over time, he realized that he was using his training to conceal his feelings of inadequacy as a person, in fear that he would be found wanting. In this process, Hilton learned the following:

All of our interactions with each other are relational and somatic but not all of our interactions are therapeutic. They become therapeutic when we are able to incorporate the experience of love within them. To get there we must constantly open ourselves to the expression of our anger, grief and longing. We can only do that if in fact someone cares deeply enough about us to join us in that journey (2012, p. 5).

When relational body psychotherapists look at a body, they see the vestiges of the struggles to love and to be loved that implicitly remain in the tissues, organs, postures, sounds, and movements. With open heart, they share in the client's loss, realizing that it is when two people are attuned that they experience positive emotions, whereas it is their misattunement that gives rise to feelings of distress. Relational models, writes Hilton, "at their best, represent our meager, human but heart-felt attempts to reunite mind, body and soul and, in so doing, recover what we once had, or longed for and lost" (2012, p. 34). He writes poignantly of his first-person perspective of this work:

I am a privileged partner in another person's journey of life. My task is to wait, watch and wonder at the mystery of another being, like myself, in their struggles to be who they are or want to be. From this perspective, I have a deep felt body compassion for my fellow sojourner, which I describe as love (2012, p. 5).

Hilton has found that far from fostering dependency, clients who no longer panic about abandonment or fear interpersonal engagement inevitably move into the next phase of their individuation: They want to explore and test themselves in the world. When the therapist is present to somatically and emotionally "authenticate and hold the ground of their experience" (p. 31), they can tolerate the feeling of being on shaky legs and shaky ground as they explore the unknown.

### Conclusion

The Dalai Lama, in his book *From Here to Enlightenment* (2012), weaves his teachings around the theme of dependent arising, the belief that all things arise and exist only through deep interconnections; everything exists through its connection to and dependence upon other things. Love, compassion, and kindness all depend upon the experience of our interdependent relationships with one another. In this vein, Rolef Ben-Shahar offers the following moving passage that speaks to the healing potential of relational body psychotherapy:

The rupture of life occurring when the hand that feeds us is the same hand that deeply harms us, and threatens to destroy us, is irreparable for the child. The very core of organization, of identity, of self-sense, is torn apart. . . . It leads to a chaotic life of isolation and fragmentation, when life and love themselves are associated with fear and death. . . . The way back home, through the slow recreation of secure attachment, through the gradual separation of love from hate, from harm, goes through the body. Two people touching; two people are reminded of life, and hopefully, choosing to say yes, to allow it in, to embody it fully, to connect. . . . I am hopeful in witnessing how love can

penetrate the most painful and damaged of places, and remind it of life; that attachment and connection can reach beyond psycho-babble and diagnoses, beyond pathologies, and through defenses, and touch it (2012, pp. 261-263).

We hunger for the symbiotic connection that offers a place we can call home; we long for the heart-centered surrender that gives us relief from isolation. Yet, at the same time, we value our distinct individuality and we brace against surrender for fear that we might lose control of ourselves and our environment as an extension of ourselves. Our identity is therefore poised between the pulsation of expansion, by which we turn toward a loving other, and the contraction or retraction into isolation, by which we move away from a hurtful other. We must bring to consciousness how we live within the continuum of these two relational opposites.

The art of relational body psychotherapy is steeped in loving-kindness and compassion. Anchored in attachment and object relations theory—in the generation of a secure base—relational body psychotherapy brings knowledge of body-centered maturation that offers reparative experiences on verbal and nonverbal levels for all stages of development, at all stages of life. The therapeutic commitment is to the relationship; to the capacity of the therapist and client, together, to deconstruct the traumatized attachment patterns of the past; to the ability to construct new attachments in the present that can stabilize the disappointments, protests, and rage that arise as clients contact early abandonment, abuse, and/or neglect; to the trust that this therapeutic relationship will be strong enough to recognize and repair whatever arises. The therapeutic work takes place in two languages: the explicit language of words and the implicit wordless language of the body, in which preverbal and nonverbal experience are embedded and to which the therapist and client listen to hear what the body knows that the mind cannot say. Thus relational body psychotherapy is not a set of somatic techniques “done to” clients, but an alive, pulsing, and breathing interplay of moment-to-moment presence and mutual emergence active on somatic, cognitive, and relational levels.

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Aline LaPierre, PSYD, MFT, is the coauthor of *Healing Developmental Trauma: How Early Trauma Affects Self-Regulation, Self-Image, and the Capacity for Relationship*, and she has published numerous articles in peer-reviewed somatic journals. She was on the faculty of the somatic doctoral program at Santa Barbara Graduate Institute for 10 years. A graduate of Pacifica Graduate Institute, she also trained as a psychoanalyst at the New Center for Psychoanalysis in Los Angeles. She is the creator of *NeuroAffective Touch*<sup>TM</sup> and *Experiential Psychobiology*<sup>TM</sup> workshops supporting the development of embodied awareness for psychotherapists and bodyworkers. In private practice in West Los Angeles, she specializes in the integration of relational psychodynamic and somatic approaches.

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# Held Experience: Using Mindfulness in Psychotherapy to Facilitate Deeper Psychological Repair

## Shai Lavie

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### Abstract

This article explores how mindfulness-centered approaches can deepen psychotherapy and facilitate transformative experience. The author uses a case study to illustrate techniques and strategies drawn mainly from the Hakomi method of mindfulness-centered therapy, demonstrating the following clinical skills: immersing clients into present-time experience; engaging mindfulness to help clients tolerate distressing affective experience; and skillfully working toward core-level material. The author introduces the term *held experience*, which refers to a critical therapeutic event in which the client becomes able to witness a formerly distressing experience in a state of somatic mindfulness and self-compassion.

*Keywords:* mindfulness-centered psychotherapy, the Hakomi method, somatic therapy, held experience

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In one way or another, what brings most people to psychotherapy is the difficulty tolerating distressing internal experience. Acting out behaviors, relational problems, and addictions all share a common denominator in unregulated internal distress. Early failures in parental relational attunement and co-regulation are widely agreed to be a large factor in the etiology of self-regulation problems (Schore, 2003; Cozolino, 2006); this is why relational therapies (such as self psychology, object relations, and many other contemporary therapies<sup>1</sup>) attempt to effect therapeutic change by providing new experiences of relational attunement. In his groundbreaking book *The Mindful Brain: Reflection and Attunement in the Cultivation of Well-Being*, Daniel J. Siegel (2007) has hypothesized that mindfulness is a form of “internal attunement” which may utilize the same neural circuitry as relational attunement. Siegel’s proposal has powerful implications for therapy, in particular, that mindfulness may have a role in remediating early failures of parental attunement, empathy, and co-regulation. In this article I will present a case example to demonstrate this possibility. Drawing mainly from the Hakomi Method, I will illustrate how deep psychological repair can be facilitated by the simultaneous engagement of relational attunement and guided mindfulness. I will use the term *held experience* to describe the poignant therapeutic experience that happens when these two powerful elements come together.

<sup>1</sup> For example, Accelerated Experiential Dynamic Psychotherapy (AEDP), developed by Diana Fosha, “understands psychopathology as resulting from the individual’s unwilling and unwanted aloneness in the face of overwhelming emotions” which psychotherapy can remediate through “dyadic affect regulation of emotion and relatedness” moving towards “the experience of attunement” (Fosha, 2009, p.182).

### Mindfulness and the Immersion into Present-Time Experience

Jon Kabat-Zinn, an early pioneer in bringing the Buddhist practice of mindfulness to modern psychotherapy, has defined mindfulness as “the awareness that emerges through paying attention on purpose, in the present moment, and non-judgmentally to the unfolding of experience moment to moment” (2003, p.145). Mindfulness is now used in various contemporary psychotherapies to cultivate an observer self in service of disengaging from habitual reactivity patterns, and to enhance beneficial qualities such as self-compassion and the ability to be in the present moment (Germer et al., 2005; Shapiro and Carlson, 2009). In the Hakomi method, we define mindfulness in a similar way, as “a witnessing state of consciousness characterized by awareness turned inward toward live present experience with an exploratory, open focus that allows one to observe the reality of inner processes without being automatically mobilized by them” (Weiss et al., 2015, p.297). But Hakomi therapists also utilize mindfulness as a way of directly engaging and re-shaping our clients’ core-level psychological wounds (Kurtz, 1990; Weiss et al., 2015). To achieve these goals, we work slowly and steadily to strengthen the following elements: the therapeutic alliance and relational attunement, the client’s ability to be with present-time experience, the client’s sense of internal strength, and the client’s ability to be mindful of difficult experience. Let us now look to a case example:

*Carla, a 42-year old fitness trainer, bemoans that she is “addicted” to Facebook. “I look at my iPhone to check the time, then I see new postings from friends, and before I know it, an hour has gone by.” Carla is an eager client. But if I’m not careful, she can talk away the whole therapy hour, with a sense of not having gotten anywhere.*

*“This is just what I do”, she says with frustration. “When I’m anxious I just talk, talk, talk... that is, when I’m not doing Facebook or eating junk food.”*

*I have worked hard to help Carla become more aware of her bodily experience. I often ask her to describe in detail the sensations she is feeling, and to track how these sensations change from moment to moment. “When you feel anxious, how do you notice that in your body? Do you feel different sensations in your belly, your chest, your jaws, other places? How would describe these sensations? When you feel more calm, what in your body tells you so?” We take time to slowly study these internal experiences.*

When we become aware of bodily sensations, we are engaging parts of the brain responsible for interoception, or inward sensing, which include the ventral medial prefrontal cortex (VMPFC), the insula, and the somatosensory cortices (Damasio, 1994; Fogel, 2009). The VMPFC and other medial prefrontal areas, along with the insula, help regulate the limbic (“emotional”) brain: they wire with the limbic brain structures (such as the amygdala and the cingulate) where complex emotions are processed, and they work together to help modulate arousal levels, guide appropriate actions, and inhibit emotional expression (Fogel, 2009; Schore, 2009). These medial prefrontal regions are also deeply implicated in our capacity to be aware of our own feelings and the feelings of others (Siegel, 2007). According to Daniel Siegel’s theory of the mindful brain, when we practice mindfulness of emotional and bodily experience, we are literally building new neural pathways between the middle parts of the prefrontal cortex and the limbic brain (2007). These new neural pathways enhance our ability to self-soothe in the face of internal distress, and to tolerate strong emotions without acting out. Badenoch (2008) has explained these brain dynamics in a very helpful way:

“When our limbic circuits do not have strong integration with the middle prefrontal region, we are vulnerable to wide and sudden swings of emotion as limbic-based perceptual biases, rooted in implicit memory, repeatedly respond to internal and external triggers... When we mindfully attend to our state, we can sense the movement of emotion through both our subjective state and the flow of energy in our body. In this way, regulation of the body and of emotion go hand in hand. As middle prefrontal integration increases, the pathway between limbic activation and emotional response lengthens and becomes more complex, conferring a greater ability to keep our feelings from going to extremes. As this capacity strengthens, emotional responses will more quickly and easily return to balance even in the face of stress” (p.30).

In the Hakomi method, we build these new neural networks by continually endeavoring to immerse our client into their body’s present-time experience (Kurtz, 1990; Weiss et al., 2015). The body’s experience is often a new language for clients. We study impulses as they are experienced as subtle contractions in muscle tissue. We track sensations such as tingling, pulsing, and warmth. And we reference more complex sensory qualities such as spaciousness and compression. We might initially engage this new language of bodily experience to help clients immerse more deeply into experiences of calm, stability, aliveness, or other “resources.” As we go forward, we begin to engage experiences that are more troubling for our clients, moving towards deeper psychological repair and a greater experience of wholeness.

### **Held Experience: Engaging Mindfulness to Help Clients Tolerate Internal Distress**

*Last month Carla took a vacation in the mountains where she had no on-line access. She came back glowing. “I realized I don’t need my iPhone to be happy; I’m actually happier without it.” But this week, now back in her normal life, the old “addictions” have returned.*

*“I realize now that I turn to my iPhone, or to my refrigerator, when I have feelings I don’t want to deal with, when I’m scared because my daughter or husband is angry with me.” She tells me more about how both her mother and older brother often hit her, and how she freezes up inside when she feels anger directed towards her.*

Talk therapy can bring us this far — to a general historical understanding of the origins of anxieties and behavioral patterns. But this understanding happens mainly in the “thinking brain”, the analytical and conceptual processing centers which do not directly bridge with the “emotional brain” centers—the limbic structures and the upper brainstem (Schore, 2009; McGilchrist, 2009; Panksepp, 2012). So although Carla knows her daughter is not physically a threat to her, Carla’s emotional brain will react as if there is a real danger. Our clients will usually act out in some way to alleviate the distress, or to distract from it. It’s as if the nervous system is organized around a prime directive: “Avoid this distressing experience at all cost!”

The emotional brain takes in experiences, not conceptualizations. Cognitive understanding, by itself, does not give our clients what they actually need: an experience of being able to tolerate the underlying distress.

Of course, helping our clients engage the underlying distress is not an easy task. Our clients have spent (as have we!) much of their lives protecting against this distress. So a good deal of trust in the therapeutic relationship is needed. And, we have to build on our clients’ successes little by little, learning how to open to internal experience from mundane



annoyances to the deeper core wounds. Mindfulness-centered approaches give us powerful routes to access the underlying feelings in ways that are safe and effective, by engaging the medial prefrontal areas, the insula, and other brain areas which relay information down into the emotional brain (Fogel, 2009; Cozolino, 2006).

*In the past, Carla would become quite upset when talking about her childhood experience. "I just feel so broken inside when I think about this," she would often say, going into a familiar, hopeless place. For many sessions I have sat with Carla through her despair, inviting mindfulness only sparingly, usually towards the end of the session. But today, something is different. Carla seems less compelled into hopelessness. She seems more mentally alert and physically aligned along the centerline of her body.*

*I invite Carla to notice her current posture. "It seems like you are more aligned right now. Do you know what I mean by that?"*

*"Yes, I can feel my back is straighter, without my efforting to make it so. And my shoulders are more relaxed." Carla's voice sounds deeper and more settled as she describes how she now feels in her body. She also feels to me more relationally present, and more solid.*

*"Great, let's stay with this experience and notice more about it."*

When a client experiences a greater sense of cohesiveness (that is, a somatic /emotional experience of being connected to oneself), I do everything I can to immerse the client in this new experience. Why? First, because it is these moments that the client is actually experiencing a new sense of self; for example, a self that can be alert and strong in the face of challenges. By bringing an extended mindfulness to the new cohesive experience it becomes more available to the client as a place to which they can return. In the words of neuropsychologist Rick Hanson (2009), "The longer something [positive] is held in awareness and the more emotionally stimulating it is, the more neurons that fire and thus wire together, and the stronger the trace in memory" (p.69).

The second reason to immerse the client in the new, more cohesive experience is to build resilience as we move towards facing the underlying distress. Diana Fosha (2009) has described these more cohesive experiences as "positive somatic/affective markers" which "tell us that the transformational process is on track" (p.178) and give the client "the sense that even intense emotions are welcome and can be dyadically handled" (p.185). The client starts to trust the therapeutic process: more cohesiveness leads to a greater ability to tolerate difficult internal experience, which leads to greater cohesiveness. Along the way, the client can experience herself as stronger, clearer, and more alive.

*After a while, I ask Carla if she wants to stay even longer with the cohesive state, or to return to the challenging experience of her daughter and husband being angry with her. She is curious to return to the challenging experience. I ask her to notice what she feels in her body when she imagines one of them angry with her.*

*"There's a churning in my gut, and a tightness in my chest."*

*I invite her to stay with the sensations. "Just let yourself notice the churning and the tightness, bringing a gentle awareness around the sensations... Let me know what you become aware of."*

*"The churning has a reddish color, but it seems to slow down as I pay attention to it. The tightness in my chest is hard to stay with. My breath gets tight... I can definitely feel that impulse to eat, or to look at my iPhone. I know that's what I did last week when my daughter*

*was upset about what we were eating for dinner...” Carla launches from one story into another, from her daughter’s outbursts when she doesn’t get what she wants, to her husband’s disparaging comments, to all the cheese she ate immediately afterwards.*

This is challenging work. Many clients, like Carla, will launch into stories when they get closer to the actual somatic distress. The therapist must gauge (1) the client’s need to self-regulate in a familiar way (by going into a more cognitive mode), (2) the value that the stories may have for the therapeutic process, and (3) the client’s possible readiness to go beyond the stories and deeper into the distressing or resourcing experience. When there is an opening to do so, we are looking to move into this 3rd option, so as to bring more and more of the client’s internal world into *held experience*. I use the term *held experience* to refer to a therapeutic event consisting of two simultaneous elements: the therapist’s holding a deeply empathic presence for the client’s distressing affective experience, and the client’s witnessing this same experience, at the somatic and affective levels, in a state of mindfulness. I also use the term *held experience* to describe a client’s internalized capacity to be deeply compassionate and mindful of formerly distressing experience.

*I decide to gently steer Carla back to her experience. “Carla”, I ask, “can you tell me what you are feeling in your body now, if you tune back in?”*

*The body is rich with experience that rests often just below the level of consciousness.*

*She pauses for a while, and almost seems surprised by what she finds. “I’m starting to feel more OK with the churning sensation, and the tightness is not as bad.”*

*I notice that Carla’s legs, which had been very still, are now moving. “Notice what’s happening in your legs and feet”, I suggest.*

*“My legs feel energy in them, like they want to move...” she says. “They want to step out... I see myself in the house I grew up in, with my angry mom there, and I want to step out the door.”*

*I invite Carla to slowly imagine this movement towards the door, noticing each step, her hand turning the doorknob, and each detail of what happens.*

Peter Levine (2010), the founder of the Somatic Experiencing method, has emphasized the importance of completing self-protective responses, especially those that were truncated during traumatic events or recurring developmental traumas (see also Ogden et al. (2006)). If walking away from an abusive mother is something a client never actually got to do in real life, then having the experience of doing it now will be critical for trauma resolution. What is essential is that the new experience must include mindfulness of the physical sensations, impulses, images, and movements that go with it. The new experience (“I can protect myself”, for example) can then become a template for a new way of being in the world.

*“This feels good”, she says emphatically. “It’s like I’m doing something I never was able to do. As a child I just sat there and took the yelling, the hitting. But now I am walking away.” I invite Carla to stay with this as long as she can. She reports different sensations in her chest and belly. “I’m breathing more easily... and the churning sensation is less, much less.”*

In these moments both the client and the therapist experience a palpable sense of spaciousness. We are reaping the harvest that comes from “holding” an experience that in the past was only feared and run from. We have brought distressing experience into *held*

*experience*, and along the way, we have discovered new capacities for self-protection and self-awareness. Usually I will invite the client to “hang out” with this new sense of herself for a while. But I also want to make sure to leave time before the end of the session to return to the life challenge at hand, to see what has shifted.

### Working Towards Core-Level Material

*I invite Carla to imagine her daughter, angry again. To my surprise, she withdraws, curling her spine and tucking her hands between her legs. “Something just happened”, I say gently. “I feel an impulse to hit my daughter,” she says uncomfortably. “I would never do that, of course...”*

The process of psychological growth is unpredictable. Here I thought that we had just completed a nice segment of work... then all of a sudden we are finding ourselves deep in a new process, now working with a potentially violent impulse. It seems to make sense in retrospect — Carla has built enough cohesiveness that she is ready to move into another challenging area — but in the moment, it can feel quite disorienting. In the Hakomi method we teach that the therapist must be able to “turn on a dime”, to let go of any agendas or expectations and follow the organic unfolding of the client’s process.

*I say, “I know you wouldn’t actually hit your daughter, but would you be willing to allow this impulse to be here, and to just notice how you know it is here--where you feel it in your body?” Carla turns her attention to the impulse to hit. She describes an energy building in her heart area, “like a fist that will strike out”. We stay with this image, and I invite her to see the color of the fist, the size, and other details about it. More than anything else, I am communicating a non-judgmental openness to Carla’s experience.*

*Another shift happens: Tears well up in Carla’s eyes. “It’s like I can feel the grief that is underneath that intensity in my heart... **All those times that I couldn’t do anything to protect myself...**”*

*We stay with the grief, making room for the sensations that go with it. Her body undulates ever so slightly, as if allowing energy that had been stuck to pass through her. The grief has arrived on its own: We are following a natural unfolding that is generated from inside the client rather than by the therapist.*

Here we have begun to discover Carla’s core-level material: the early experiences of helplessness and lack of parental attunement that underlie her difficulties in self-regulation. In future sessions we will continue to open these doors. In this session, as is often the case, the arrival of grief is an indicator of profound transformation. For Carla, grief had been hidden beneath her anger, which itself was blocked by anxiety and acting out behaviors. The grief, like the other emotional states we have worked with, has now been brought into *held experience*. In other words, her grief is now something she can *hold*. I like to think of this in neuroscience terms: We are supporting the growth of new linkages between the limbic brain and the middle areas of the prefrontal cortex (Siegel, 2007), which can now better regulate and contain the affective state of grief.

*Carla shifts gears and remarks, unexpectedly, “I can now see that the iPhone isn’t an ‘addiction’ after all; it’s a compulsion.” She says this with a notable sense of clarity.*

I don't necessarily understand Carla's use of the terms "addiction" and "compulsion", but I think what she means is that her need to use the iPhone is not as entrenched as she used to believe. As Carla's nervous system builds more capacity to hold the underlying grief, the whole defensive structure changes. The anger that was so locked in begins to shift, the anxiety diminishes, and the problematic behaviors no longer have the same grip on her.

*I invite Carla to imagine the impulse to reach for her iPhone, this time making room for any feelings, such as anger or sadness, if they show up.*

*"When I let myself just notice my sadness, I realize I don't want the iPhone. I don't want the junk food either... I just want to know that I'm OK... And I feel OK... right now. "*

As you might expect, I next invite Carla to immerse herself in the sense of okayness — how she feels this in her body, and what happens as she stays with the sense of okayness. This time I will also add a relational piece. In the integrative phase of a session, the therapist can engage the client relationally both as another way of making the experience real for the client, and as a way of affirming the new sense of identity that emerges from the transformative experience.

*"You know", I say, "it feels really good to witness you in this place. I feel a profound sense of ease... and it feels very sweet." We exchange relaxed smiles, and then confirm our schedule for the next few sessions.*

This article has attempted to illustrate how mindfulness can be used in psychotherapy, in combination with the therapist's relational attunement, to remediate early developmental wounding. We can use mindfulness not only to disengage from habitual reactivity patterns and build general resilience, but also to guide clients into and through the unconscious organizing patterns that underlie their distress. By bringing more internal experience into *held experience*, clients learn to hold their deepest wounding with compassion and clarity, and to identify defensive *patterns* as *possible* but not necessary responses. This work can be highly effective, energizing, and rewarding, both for client and therapist.

## BIOGRAPHY

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# Transcultural Case Study, First Interview with a Chinese Client

## By Ulrich Sollmann & Wentian Li

### Translated by Elizabeth Marshall

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#### Abstract

A body oriented first interview in psychotherapy has a specific structure and praxeology. The article illustrates in detail a first appointment with a Chinese client. The important aspect of this circular-systemic process is the opportunity on the one hand to get enough relevant data, to find a diagnosis and a first indication. On the other hand the therapist can relate to and give feedback to the client and experience the client's reaction as well as the response of the client to the therapist's feedback. This is then translated into professional terms and is communicated in a narrative way. It is important to introduce the necessary transcultural perspective as the client is Chinese. This perspective is related to sexuality, shame, body-self, emotional dissociation, contact and relationship. All this is described on the basis of bodily expression: the practical relevance of body experience in a transcultural perspective. Finally this article is an attempt to understand psychodynamic aspects in terms of "body" (experience, expression, body-self and so on).

*Keywords:* shame, sexuality, transcultural, China, body psychotherapy

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Every practitioner, be he/she a trained body psychotherapist or a psychotherapist with a different background, who works with the methods of body psychotherapy is always concerned with praxeological issues. A detailed exploration of the question "How does what works, work?" has however only recently found its place in the professional literature. The structure of a first interview in body psychotherapy and a circular, systemic approach to the various relevant levels such as the biography, the initial assessment, reasons for seeking therapy, the therapeutic relationship, self-expression, (non-)verbal impressions, context, goal of therapy and so on belong to this rather heuristic perspective. I would like to present the first interview in body psychotherapy as a circular process between client and body psychotherapist with reference to a specific background. In this case it is an intercultural, or better, a transcultural issue. At this point I choose the concept of cultural relevance and not that of context or setting. With this I aim to emphasize the special significance in (body) psychotherapy of taking into account the "background" which may create a sense of identity. Context and setting seem to me on the one hand too vague as concepts, inducing an innate tendency to pay too little attention to contextual conditions. Too little attention because usually both parties are from the same cultural circle or live in similar contextual-societal conditions. When both participate in similar societal conditions, even if they vary significantly in specific details, this leads to a "reduction" in contextual



observation. This often arises understandably out of the many unconscious similarities, which people who are socialized in the same society or cultural circle acquire. Then we tend to pay attention to the (too) obvious contextual differences and special features and emphasize their significance in our practical work.

On the other hand observing events in psychotherapy in terms of an identity-creating background does further the psychotherapeutic attitude towards the whole process. Often the differences are (for good reason) constituent and therefore resistant to outside influence and should not be instrumentalized in psychological/psychotherapeutic terminology for one's own therapeutic culture. There are some differences which will remain different. The praxeology of (body) psychotherapy must align itself with this and review its own (body) psychotherapeutic concepts and theories with regard to their effectiveness. For what is effective, plausible and scientifically justified here may not work there, due to a different praxeology and cultural plausibility.

With Nazarkiewicz and Kraemer (2012) I see three relevant dimensions in meeting and working with different cultures:

- a) The intercultural approach (competence with regard to lifestyle: knowledge of the culture).
- b) The multicultural approach (competence with regard to the rules of play, patterns of behavior: a sense of the culture).
- c) The transcultural approach (competence with regard to cohesion: co-creating culture).

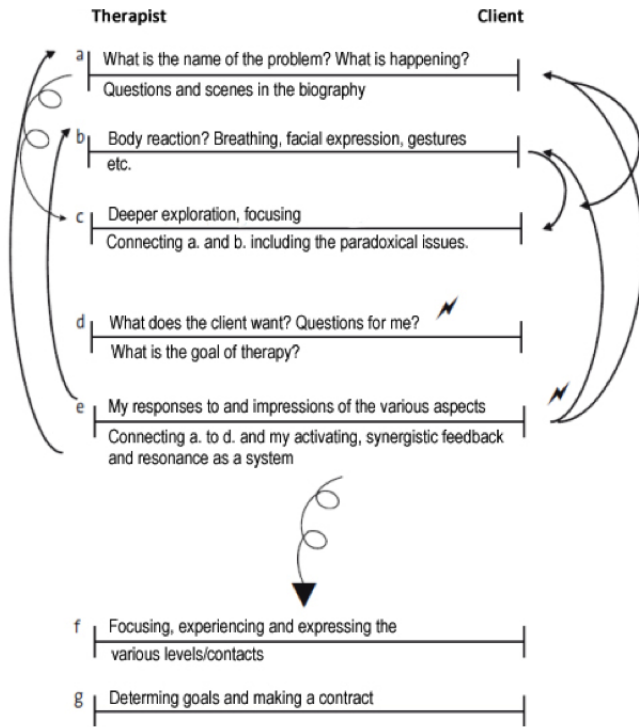
For psychotherapy as a narrative process there emerges from this three essential elements:

- Culturally varying concepts of self.
- Developmental concepts which arise from these.
- The idea and treatment of varying hybrid identities (or patchwork identities).

Writing about a cultural field of tension in therapy arose out of the fact that my client is a Chinese woman living in Germany and also out of the differences in therapy cultures of psychotherapy and body psychotherapy, which shouldn't be underestimated and about which much too little has been written from the point of view of praxeology.

The first interview, which I retrace here is a single event plucked out of the whole. It demonstrates the structure and the circular systemic approach. As one example of a heuristic approach it shows an essential aspect of body psychotherapeutic practice. However the interview I present here can also be used by psychotherapists of other schools, who wish to integrate working with the body into their own practice.

An experience at a workshop inspired this Chinese woman, who studies in Germany and will remain here for several years, to come for an interview for therapy. She is more interested at first in clarification and is not suffering from specific psychological stress, which would lead directly to therapy. The structure of the diagnostic procedure in such a first interview offers both a general framework and also open questions and possibilities for therapeutic response.



**a) What is the name of the problem? What is happening?**

This 22 year old Chinese woman has been living in Germany for just over a year. She studies art and design at a university. She says she has taken on a job for two months in order to “earn a lot of money” in a relatively short time.

She lives together with other women students from East Asia and feels quite comfortable, although she is lonely. Although she sometimes meets up with her ex-boyfriend, she has no relationship with a man at the moment. She enjoys herself with her ex-boyfriend; they go for long walks outdoors and talk about everything under the sun. It is important to her to talk to people and exchange views.

*From a cultural perspective Chinese students in Germany should allow themselves time to get to know the culture of this for them foreign country. These students often feel lonely, are homesick and stressed in two ways. Firstly they feel themselves as strangers in Germany; secondly they are used to living and acting communally. This is only possible in Germany if they are together with other Chinese, in a community which is naturally familiar to them. Then they cook together, talk, smile in a friendly way at Germans, but tend to avoid the necessary encounters and adjustments.<sup>1</sup>*

This client will soon transfer to another university, which will be more than 300 kilometers from where she lives now, so that she will be involved in a completely different environment. This doesn't seem to bother her, even though she is taking a step which will mean moving to a new environment without having any contact with the people there.

<sup>1</sup> Text in italics is the commentary by Wentian Li on the article by Ulrich Sollmann.

She has just finished her two month job in a Chinese massage studio, has now a month's holiday and will start to organize the move. She emphasizes, albeit casually, that Chinese women students often take these jobs in order to finance their studies in Germany. But this doesn't appear to be the only reason. She worked three days a week and often earned more than 500 Euros a day. She can't hide her pleasure at having earned so much, whereby she seems quite excited like a girl much younger than twenty two. She seems to me at this point so girlishly naïve.

*Often Chinese students have no serious financial problems. Either they come from families who are financially independent or they have a scholarship or grant. Perhaps this student's need to earn so much additional money comes from having been overprotected in the family. Most Chinese families have a 4-2-1 structure (four grandparents, two parents, and a single child). The child is inundated with affection and attention. Grandparents and parents do everything for the child so that it hardly ever has to make decisions. On the one hand the child is idealized, on the other emotionally overloaded and controlled, dependent and lacking in autonomy. This means it is extremely difficult for them to grow up. These difficulties present themselves especially strongly, when a Chinese person who grew up in a one child family leaves his/her home country and comes to Germany.*

*Being spoilt coupled with a relatively unconscious dependency makes it difficult for them to develop relational competence. Therefore in China money often takes the place of relationships, which are then formed through money. Money therefore functions as a substitute and a compensation. The need to earn a lot of additional money, despite being financially relatively independent, could be interpreted as an unconscious wish for relationship.*

She reports in detail about an experience in the massage studio, which impressed her deeply. They practiced erotic massage there, which she mentions in passing, as if she had helped out in a boutique. She got to know a man in the massage studio, with whom she had sexual contact, although she wasn't allowed to. She liked this man, but at the same time she complains, quite agitatedly, that he broke the rules of the massage studio by having sexual contact with her. She experienced herself as "somehow ambivalent" towards him, after she had stopped working there. The ambivalence had to do with whether she should have further contact with him or not.

*Chinese students know about "ambivalence" in relationships. This client had therefore made a conscious decision, knowing well the ambivalent relational style of her childhood and youth (as with many Chinese). But young Chinese people are often unaware of the effect of this ambivalence in a foreign setting.*

She is also ambivalent towards her own sexuality, in that she complains about the behavior of the man and becomes quite agitated, almost angry, with no relation to her own behavior in not rejecting his advances from the beginning. It seems as if her "reason" is complaining, while her body was aroused at the time. This arousal seems to be familiar to her, just as familiar as the criticism which she simultaneously levels at the man's behavior.

The client's description leads to three hypotheses:

- The client is obviously not familiar with the interplay of feeling sexual herself, expressing this feeling and relating to or distancing herself from a man.
- The client doesn't feel safe in her body-self, nor does she feel connected to herself or to her sexual identity (splitting off).
- The client can't perceive her ambivalence in the framework of psychodynamics, her own biography, or the specific sexual education of her culture (China). It appears as if she experiences herself unconsciously as "between" cultures.

### The Biography: Questions and Scenes

At the initial meeting she doesn't speak at length about her family and her background. She has a twin sister, her parents are half Jewish and both work in the academic field (engineer and nurse). She had a good childhood, but there was a "felt secret", which she hasn't been able to discover, but which stirs her up inside, because she hasn't yet found a solution to it. She understands this secret as a "hidden agenda", a "hidden story" in her family. It has come to have crucial significance in her life and as she emphasizes herself, she must find out more about it at some point.

*Usually such a family in China is characterized by the high expectations of the parents towards the child. The child experiences this pressure in all that it does, especially in learning. Chinese children can ultimately never satisfy their parents, as they are in the end only children and feel like children – they want to play, have fun and not always have to be as disciplined as the parents demand. This emphasis on discipline and on a hierarchical-moralistic structure creates a lot of tension, which is not easily resolved. Chinese children experience this as a kind of ambivalence coupled with low self-esteem. Normally the child cannot defend itself against the parents and the style of education.*

She is obviously agitated as she speaks about these things. She sits up straight in her chair, her voice becomes hard and she stares directly at me. In the counter-transferential phantasy I sense an urgency, which the client herself feels in her unsuccessful search to discover the secret. Her voice becomes louder than before. As I listen carefully to her I suspect a subtle anger towards the parents. Quite unexpectedly she ends her narrative about this experience with the words: "I must find out what happened and what it means for my life." Even though I probe gently, she is quite vehement in her decision not to say more.

Although she clearly feels herself as Chinese and has a strong and clear attachment to Chinese culture, she has decided to study in Germany. As I want to hear more about her identification with Chinese culture, there develops a mood in the counter-transferential phantasy, as if the client doesn't feel "at home" any more in her culture of origin. I deduce this from her reaction to my commentary about her home town, Beijing. As I had just been in Beijing we chat a little about it as an interesting and beautiful city. Although she agrees with my view of the city, she abruptly closes the topic, similarly to the closing of the previous topic, so that I get the impression she doesn't want to talk about Beijing as the place of her childhood, as her home. At first I'm unsure whether I should interpret this as her not wanting to speak about her past in China in general.

*One possible socio-cultural explanation for this behavior could be that successful and financially independent, rich people especially are not satisfied with their country. It often seems as if they have little cultural identification with their homeland, confronted as they are with the great discrepancy, the great cultural and economic divide, which is progressively worsening.*

*One could call this a "national inferiority complex". Chinese people living abroad tend to either almost patriotically defend their homeland or to distance themselves from it, in the hope of being accepted into Western culture.*

She is also ambivalent (or split) about her name. She has of course a Chinese name (I will call her Huan), but in the massage studio she worked under a Western name (I call her Mary). This is because of her wish to protect herself and her private life from her massage clients and is understandable – and yet Chinese people like to adorn themselves with Western names, which they add to their Chinese one.

In the course of our first encounter it becomes clear that she is unconsciously conflicted regarding both her Chinese and her European names. She describes this as follows: “My (massage) client (I call him Walter) met me at my workplace, so he only knew me and paid me under my “professional” name. When he came for the second time Walter disclosed that he liked me. Later he even said that he was in love with me. I had warm and affectionate feelings for him; sometimes I was even a little in love. I believed him, because I could feel the emotional resonance myself. Also the contact to him was light and easygoing, something I like to feel in myself, but which didn’t happen with other clients. After I had left my job there, he contacted me through my private E-Mail address, which I’d given him before, and I had contact with him under my Chinese name, Huan. Of course,” and now she seems very determined, nervous and a little too controlled, “I couldn’t accept his behavior at all. He should have respected the regulations of the massage studio of his own accord. He shouldn’t have had sexual contact with me at all. That things went so far was his *responsibility*. So now that I’m not working in the massage studio any more I clearly have to reject him. And anyway,” she adds, almost in passing, “He got to know me as Mary. For Mary it was okay that I had contact with him and developed these feelings for him. But as Huan I couldn’t and shouldn’t have feelings for him anymore. And he should do the same.”

*Many Chinese give themselves a foreign name. There are three possible reasons for this. Firstly the Chinese name is often difficult for foreigners to remember and to pronounce. Secondly people feel cool or chic when they have a foreign name and they have the feeling of being part of the foreign, idealized culture (partial identification). Thirdly, this can be the outward expression of an emotional split, whereby under their Chinese name they feel Chinese and unconsciously safer; then when they use their foreign name they slip without noticing into an idealized role. As long as the context and the structure of the relationship remain the same, as with this student, when she was officially working in the massage studio, things go well. But when she left, the structure disappeared and the emotional ambivalence became obvious in the relationship, which lead to her emotional and relational withdrawal.*

As I enquire further she tells me a few more biographical details; she was very happy with her decision to study art and design. She makes the impression on me that she is highly motivated, happy and satisfied with her studies. And she says she was always curious and wanted to take part in and express life.

She is linked up with many people through social media, but doesn’t live actively in these relationships. It seems for her that social media are more a sort of network in the background, which gives her a certain structure, but she prefers direct emotional relationships, face to face. She loves kung fu, likes to read classical and modern kung fu novels and identifies herself with two specifically kung fu aspects, her power and competence as a sword fighter and her role of being “good and noble”. With this she means to fight for something good instead of just base, egotistical goals.

She loves romantic music, not too loud and not too difficult.

*The immersion of this Chinese student in the world of kung fu novels, an illusory, idealized, world, leads to a double life of two extremes. In these novels there is only a good or a bad world view or value system. The world of these novels is clearly alienated from the actual life-reality of this student. She lives in her phantasy as a swordfighter and participates through idealized, imaginative role play in her self-confidence and identity.*

*Chinese children often fall prey to such identification behavior, as the high expectations that parents have towards their children leads to great problems in self-identification. Parents and*

*grandparents decide everything in the lives of the children. They determine the future, and Chinese culture, which is built on hierarchical relationships, supports this by emphasizing family duties, which arise out of the cultural identification. Chinese children do not get to know themselves, they don't learn how to reflect about themselves in contrast to the hierarchy and society in which they live. Questions like "Who am I?", "How will my future be?", "What will I decide to do?" are foreign to most Chinese children. A compensatory refuge is then the idealized novel- or comic-world (see also the Manga-world).*

### **b) Body reaction? Breathing, facial expression, gestures etc.**

The client is relatively tall for a Chinese woman. Also the strong, resolute way she has of shaking hands, which suggests self-confidence, is not typical for Chinese women. Yet my first impression of the person in my waiting room is of a more reserved, shy and delicate young woman, who does look me directly in the eye.

As we go into the therapy room together, she exudes non-verbal signals of both qualities simultaneously. She walks to her chair with strong, well-grounded paces, while she seems to hold herself back in the upper body, which seems energetically less powerful than her walk.

While we talk she looks at me openly and directly, even curiously, although her head is bent slightly forwards, which suggests that she is relating to me and wants to speak to me. Also her interest in my answers, my resonance signalizes this. Her breathing is rather soft and almost imperceptible, and yet she shows signs of vitality and possibly impulsivity. I can only deduce this from subtle signs when she gestures to express something or from a corresponding facial expression or an explicit movement. A certain gesture makes me suspect such a shy vitality in this client: whereas she usually sits back in a quiet way, she does reveal the "beginning of a movement", the "beginning of a facial expression" in various ways. The "beginning", which carries within itself the essence of an emerging, non-verbal impulse, a hesitant impulse, which doesn't yet dare to show itself, would in a visible movement or a visible facial expression be clearly recognizable as such.

Her eyes are alert, her gaze clear and in contact. The eyes are energetically sparkling as if she wants to take in everything that is happening to me as her partner in this conversation. The shine in her eyes doesn't change significantly in the course of it.

She answers my questions openly and at length, although she does have difficulty with the German language. Here again her reserved attitude comes out: she understands me much better than she lets on. Also when she speaks I have the same impression: I can understand her much better than she has expected.

She impresses me as very attentive, interested and "somehow" curious regarding possibly interesting aspects, important questions or comments which I bring up. In the process she seems spontaneous and impulsive, but at the same time fragile, shy, and reserved. Through the countertransference I can imagine that she has often experienced tension of some kind in communication and relationships with others. If this does appear after a while, she seems then to reveal her views and convictions more clearly if not unambiguously.

### **c) Deeper exploration, focusing**

She had decided to work in an erotic massage studio. Her occupation was a physical occupation. Not only did she offer *body to body* massage, she had *implicitly offered her whole body and her consent to this*. As a physical body she was always present for her clients. Her body could additionally always be bought.



In contrast to the implicit offering of her body she basically prefers, as she herself emphasizes, verbal communication. She says this is very important to her. She illustrates this with various examples from her work and again almost in passing she adds that she finds satisfaction in communicating. It also seems that she was somehow subtly reluctant to do the massage work. It seems that she prefers word to word communication, but that she had played her role in the body to body contact without obvious complaint. It wasn't a problem for her, she asserts, she only wanted to earn a lot of money quickly and apart from that there were clear rules and structures in the massage studio.

This client has obviously lived in two very different worlds during her work: in a world of conscious, rationally experienced (emotionally split off?) and structured "body-to-body-world" and in a more unconscious, wistful, "emotional-contact-world". The first is carried and informed by the decision to earn a lot of money in a short time. In fact it was clear to her that she had offered herself and her body for money, but she couldn't feel that she had offered her feelings and her sexuality like commodities.

The other world is more characterized by the young woman's deep, rather wistful belief, that relationship is not possible without contact, without mutual trust or without personal communication.

When after a stressful working day she worked with the client mentioned before, she could almost have fallen asleep in his presence. She had enjoyed his caresses, had closed her eyes, curled into the fetal position and forgot both the time and her surroundings.

She emphasizes as if she were waking from a scenic daydream, that she loved her job, without a doubt. In the same moment in the countertransference phantasy I have the impression that she had no conscious, perceptible clarity about the job, the kind of communication it entailed and her relationship to her male clients. Likewise it seems to me that she had no conscious feeling of her motivation in choosing this job. When I mention this, she assures me that she liked the job and emphasizes almost in self-justification that she had to earn some money, a lot in a short time, "and that's all, nothing else".

As I ask how she experienced the body to body contact in the massage studio, how she experienced herself, she suddenly complains, full of indignation but also of indisputable anxiety, about the behavior of the men she met there. Some of them were "good" to her, but most of them ignored her as a person and were only interested in the erotic massage. They had used her. As she speaks she stresses the words more, her voice rises, but is still ambivalent and subtly fragile.

Some of them wanted intercourse, although this was not allowed in the massage studio. She could generally always resist, but with Walter she couldn't, because he behaved differently. He was very careful, open, gentle, kind and "knowledgeable". She finds numerous, differentiated descriptions for Walter's qualities. "I couldn't reject him".

She had not forgotten the regulations but her body had been sexually so aroused that she couldn't stop it. On top of that Walter was there, so gentle and careful, yet with such a strong sexual desire. Respectful but at the same time using her. As she describes it, if she had insisted on the rules he too would have kept to them.

*By asking Huan for sexual contact the man seems to be expressing his needs, as do other men in Germany. His respectful and affectionate manner causes in her an ambivalent attraction. This ambivalence could be an interesting starting point for exploring whether there was a "traumatic development" in this student's childhood and whether this is connected to her experience in the family. This could lead also to exploring the inner psychic conflict between a sexually repressive*

*education and experience and a half consciously experienced sexual arousal and desire for fulfilment.*

She had enjoyed each sexual contact with Walter. The encounter with him had fulfilled her, which is why she had neither rejected him as a person nor had she refused his sexual advances. Until his last visit in the studio.

She is convinced that all the men had only used the contact with her to their own advantage, although she had sometimes felt quite good with some of them. But in relation to Walter, with whom she had sexual intercourse, she seems to be stuck in a dilemma. She shows a clear interest in this man, his way of thinking and speaking, also in his life, in interacting with him, in his touch and his gentleness. Her fragile ambivalence is reflected in a moment when she remembers, that she had also felt a bit used by Walter. At that moment she suddenly stops talking. Despite Walter's sensitive, caring and understanding manner, after she stopped work in the massage studio she wasn't sure whether to have further contact with him. She had though, a few days before she finished there, spontaneously agreed to see him again outside the massage studio, equally spontaneously she had communicated with him on the social media, curious and amused by the contact. After this they had seen each other in the massage studio, but they each felt that both levels of the encounter were appropriate.

*By giving her client her email address and communicating with him through it she seems to be living in another virtual world (the kung fu novels). The more clearly she experiences this, above all when she ends her work in the massage studio and begins a (possible) real relationship to her former client, the greater and the more intractable becomes the emotional conflict "in her heart". Now "the old structure of the massage studio" no longer offers any support or orientation.*

As I ask what happened after she finished in the massage studio, she spontaneously sits up in her chair. She reduces her movements and her facial expression and her eyes fixate me more clearly than before. Her voice sounds a little sharp and her whole habitus seems more resolute, as though she has to bow to the necessity of controlling the situation, of mastering it, of controlling herself and any emotional and sexual impulses or feelings, which could perhaps unconsciously emerge, even if only as memories.

*This seems to be a vitally significant question, as it seems to have made her more attentive and alert. Her non-verbal, body-language reaction is intense and spontaneous and can be interpreted as a sign of the importance of the theme. Also this offers the possibility of following up in a concrete and tangible way, in the here and now.*

I ask her how she had rejected his sexual advances, how had she tried to draw the line. Although she has understood my words, she gives me an astonished look as I ask, which has the subliminal message: how could you ask such a question! Huan obviously can't sense the meaning of the question or of the importance of boundaries as an emotionally necessary part of a relationship. In this respect her answer surprises me. Quite dryly she describes how it was her body which felt aroused, energized and "sexually curious"; it was her body (and not she herself), which had abandoned itself to the sexual experience with this man.

*She had obviously been physically aroused, but not emotionally affected or involved. Her intrapsychic and emotional defenses seem to dominate in the ambivalence of her mental state. At the same time these intrapsychic processes lead her into a defensive, childish position of dependency, which serves as a re-enactment.*

Her voice again sounds serious and hard, which is familiar to me from those moments when she reports something apparently "normal" from her life without showing any visible emotional involvement. Then the sound of her voice changes at that moment where she accuses Walter of having "used her a bit". The voice is now excited, almost angry and shows

emotional participation. Her glance changes too quite suddenly. Her eyes open wide and show an intensity of expression, which is connected to a change in her sitting position. She sits up straight and the emotional arousal and inner engagement are clearly visible, but through the almost rigid, fixed posture, there are only hints at the “beginning” of a possible, surprising movement. Only for a moment? Just my guess?

*The client had obviously decided to have a relationship with Walter and she knew from the beginning that it couldn't be a lasting relationship. The fact that she was nevertheless angry at him demonstrates the particular intensity of the intrapsychic conflict.*

Treading carefully and taking particular care in my choice of words I start to mirror for her the paradoxical signals and experience with Walter. I link the mirroring with a cautious commentary, which I relate more to the concrete events she has described, rather than to a psychological interpretation or analysis. Despite my caution it seems as if she can't follow me or my explanations. Her subtle perplexity and helplessness suggest that she cannot know and feel at the same time, what a relational dilemma is. Again surprisingly, she is visibly agitated and complains anew about Walter's behavior. Of course she hadn't spoken to him about it, but for her it was completely clear that when she finishes in the massage studio, then she ends her contact with Walter. She hadn't seen him again “in real life”, but had had contact with him for a while via SMS and E-Mail.

It seems as if she was flooded and overwhelmed by the unconscious feelings, which arose out of the paradoxical situation. We could interpret this as a sign that she is neither sufficiently grounded in her body-self, nor in her sexuality as a grown woman. She doesn't feel emotionally secure in her body or in her sexuality. Instead of feeling she was acting out (reactive behavior).

She acts out, reacts, instead of relating on a feeling level – this seems to be one of her central behavior patterns. This pattern includes defending against anxiety as a feeling part of life, in particular the anxiety she was experiencing unconsciously in the paradoxical situation and the anxiety as a Chinese woman, to be speaking to me, a stranger, and reflecting on this situation. In the end it is the defense against anxiety about her (felt) body and her sexual arousal and their integration.

With regard to this paradoxical relationship she couldn't see or feel two aspects of her experience or of her own behavior:

- On the one hand she is convinced that she had a “right” to complain about Walter, although she had never clearly repudiated his advances or rejected him. I show her how astonished I am at this and mirror her my impression of her astonishment at Walter's sexual interest in her. She knew from her colleagues but also through her own previous experience with other men, that the clients who came to the erotic massage studio could develop such a sexual desire. But it seems to me that she couldn't feel the relevance of this dimension. She had to make the experience with Walter feel “normal” for her. This is a consequence of the unfelt paradox and the inner logic of the reactivated psychodynamics triggered through the experience. And a consequence of the logic of Chinese cultural socialization: acting out instead of relating in a feeling way.

*Chinese society and culture are characterized by the emphasis on the collective and on hierarchical relationships. The wellbeing of the individual, of a single person, has to give way to the wellbeing of the collective, is subordinate to it. The feelings, wishes and interests of the individual are not only unimportant, but must be both internally and externally avoided, repudiated and*

*denied. This attachment pattern, initially a pattern of and within the family, then becomes a vital psychodynamic reality; for Chinese people abroad it becomes essential for survival. Children learn to hide their feelings in favor of a highly idealized image of the collective. For example feelings of homesickness when they are abroad, or longing for their own love choice, which is not accepted by the parents, are experienced or interpreted as weakness. When Chinese children later as students abroad are confronted with a different emotional climate, they react to this "other" by becoming reserved and silent, leading to serious psychodynamic conflicts.*

- On the other hand she can't find my question relevant or meaningful. If she could she would probably have decided earlier against working in such a massage studio, knowing as she did, that clients were likely to have a sexual interest in her. She seems unable to follow my view of events, but rather repeatedly blames Walter and clings to the idea, that she could earn a lot of money in a very short time, almost as if she were hypnotized. We could interpret this interplay of the various aspects as evidence of dissociation in her experience of what happened. This dissociation made it possible for her to work there. As she herself said, she did need to earn money for her studies. Many other Chinese people have the same problem when they are in Germany, but still we could analyze this attitude to money as the expression of a basic mindset. It often seems that they live relationships through money, through earning money, through the value of money. Chinese people are often avaricious about earning money. People in Europe or in Germany experience this behavior more as a breakdown in contact and relationship, more as egoism, obstinacy, disinterest etc. The consequences are then often misunderstandings, tension on a relational level and rejection on a transcultural level.

*The wish of Chinese students to earn some extra money is no different than in the case of German students. This could be (in addition to what was said above) a motivation for this client wanting to work in the massage studio. But it is another matter entirely that the work consisted of giving erotic massages. In China eroticism is under a strong taboo, especially in a "good, academic family". To break the bonds and traditions of Chinese culture by working in an erotic massage studio needs a special motivation. One explanation for this could lie in the repressive sexual education/development, but could also perhaps be found in Chinese youth culture and its sexualization. How can young Chinese people experience emotional, sexual and physical arousal as integrally connected, when they generally either don't have any sexual education or only in pornographic films on the internet?*

In addition to the dissociation as an intrapsychic process Huan is also at the mercy of this transcultural tension, the clash of two cultural realms of experience. She can therefore only find it difficult on an emotional and a rational level to perceive the paradox of her experience and to recognize its consequences. It is just as difficult for her to experience herself as emotionally and physically integrated and not to dissociate.

*This dissociation on the intrapsychic level is connected to her culturally conditioned identity and to the circumstances of living alone in a totally foreign country.*

#### **d) What does the client want? Questions for me.**

Whether Huan is interested in contact with me or in working on the themes she mentions isn't clear at first. We could interpret the fact that she had come to the practice to talk to

me and that she had spoken about these experiences, despite having split the feelings off, as evidence of unconscious motivation.

Also we could evaluate the fact that she had spoken about her interest in Walter during her time in the massage studio openly, in detail and in a more personal way than was usual for her, as motivation for therapy. It could at least be a wish to get to know herself better, to experience herself more consciously and to explore her experiences. This motivation can be seen as relevant and directed on the basis of her psychodynamics and also as the expression of an emotional resource related to her desire to confront herself specifically with this emotionally conflicted behavior. This conflict, which is also an expression of her character structure, is mirrored on various levels of her personality, her style of expressing herself and of communicating with and relating to me.

She doesn't directly ask me any questions which would show a possible interest in therapy. Instead she tells me in detail about the questions she asked Walter, which could be taken as a sign of such an interest. The questions she asked Walter could also be an expression of her interest as a young Chinese in learning more about German culture and lifestyle. In the countertransference I see these questions as a hidden wish for more support, for answers which are a help in dealing with reality and with practical life. She seeks answers and support from a former client; does she seek them from me too, possibly in therapy?

*The fact that she is not living in her own country, which means not moving in familiar circles, not communicating with people she knows and getting feedback from them, could have led Huan to see this first interview as a possibility "to just talk about herself and to be sure that somebody will listen".*

*So this is not yet a wish which could form the basis of a therapy contract. Other Chinese people behave in a similar way in a foreign country. If this is not just a single case, then it is a special challenge to engage with Chinese students in Germany in such a way that they can speak about themselves and feel themselves understood as they would be at home. This would give them some emotional relief and help them to develop greater competence in dealing with reality abroad. This in turn could be a starting point in broaching the issue of their desire for relationships. Such an approach would reveal the ambiguity, which we can conceive of as a relational behavior pattern expressing on the one hand "not the same as before" and on the other "not yet different".*

*"Not the same as before" would mean to become more conscious of the actual situation and to confront the difference between the China of one's feelings and the Germany of one's feelings. When accepted, this discrepancy would/could in a psychodynamic sense lead to emotional ambivalence. The issue of "not yet different" could be raised as being a part of their own real situation in Germany as well as being a possible partial identification, which could be developed in an emotionally meaningful way.*

From a psychodynamic perspective Huan's behavior could be understood as an unconscious partial identification with Walter. By asking him simple questions when he was in the massage studio, she was unconsciously hoping for a kind of emotional support through his answers. We could assume that asking these questions, which demanded cognitive answers, was for her a suitable way of trying to relate, even though she effectively couldn't feel this. Therefore the content of the answers that she hoped for and perhaps to a certain extent received, wasn't so important; instead the question/answer relationship gave her the possibility of relating to a man by unconsciously partially identifying with him. This partial identification is interesting in a psychodynamic as well as in a transcultural context. It enables her to contact his ability to express his feelings and his sexual desires by participating in them

without being consciously aware of it. Also it allowed her to relate to a man in a permissible way. This process seems to only have been possible under the conditions in the massage studio. In this context, which gave her a feeling of security, she could live the relationship through acting out rather than through feeling.

Outside this context, one could say, the dissociation protected her from emotional confusion, which most young people from China would likewise experience, as they all grew up in comparable conditions and are similarly sexually inexperienced.

The questions Huan put to Walter were relatively simple, but at the same time emotionally important for her:

1. Can you tell me more about your work?
2. How do you manage to be so gentle, affectionate and understanding towards women?
3. How do you approach women sexually?
4. Please tell me more about yourself and your life.

While telling me about the questions she asked Walter, she seems emotionally involved, sure of the significance the questions have for her and strong and expressive in her non-verbal body language. At the same time she seems curiously aware of the importance of her encounter with this man, as if she had a premonition that through it she would be entering a new and important phase of her life. Also, the experience of sharing all this with me seems to have an equally great importance for her.

I am starting to ask myself what her deeper intentions could be in regard to a possible therapy process. She herself says nothing about this, but in the countertransference I notice a curious “necessity” to ask her more specific questions. This countertransference impulse could be interpreted as an important mirroring of her unexpressed wish for therapy. Therefore I give her extensive feedback about her effect on me, which seems to me a basic requisite of a first interview in body-oriented psychotherapy. What do I notice of her when I am speaking to her? (How do I see her? How do I observe and experience her physical, non-verbal expression? How does the ambivalence in this expression reveal itself to me and how do I experience it?)

Together we begin to explore the dynamics of the tension she feels as a characteristic of the conflict she has described of working in the erotic massage studio and her decision to work there, which meant being confronted with the sexual desires of the clients and at the same time not wanting sexual contact with them. In the end however she did have sexual contact with one client. In the course of a possible therapy this would necessarily involve exploration of crucial aspects such as:

1. What was her motivation in working there, knowing that she would have to reckon with sexual wishes, although she didn't want sexual contact?
2. What made it difficult for her to refuse Walter's sexual advances and to draw a clear line?
3. How could she feel the relevance of the various aspects of this conflict and evaluate them meaningfully, in order to learn how to establish borders, or to sense the necessity for them?
4. How could she get to know her own bodily and emotional sensations and arousal processes in contact with herself?
5. How could she get to know her own inhibitions, her sense of modesty and her cultural conditioning about feelings, contact, and sexuality? How can she become so familiar



with this as an interaction of intrapsychic processes and cultural conditioning, that she could experience and relate appropriately to people in this “new” German culture, which she doesn’t know?

6. What is the family secret, that she had briefly but emphatically mentioned, all about? Was she traumatized as a small child and if so how? *In this instance a transcultural approach is indispensable.*

In this first interview of course we don’t look for specific answers to these questions. The first is to build up contact with this Chinese client, which is an important step in enabling us to establish a role- or contract-relationship with her. This is an absolute requirement for a possible therapy. Posing some of these questions without expecting an answer just yet, already promotes the mobilization of her incipient perception of her feelings and her physical expression. The interaction of these factors is an important, potential therapy goal, even though she hasn’t yet addressed this.

Enabling the client to establish a relationship to me as a person she can trust and to help her experience this as a necessary first step is already a first goal of therapy and as such a matching process, as is the transcultural matching. This first step is a heuristic approach in the here and now, which respects and relates to her cultural background, her education and experience on the one hand and German culture on the other. The heuristic method of sharpening awareness for the contact function relates to her body, the feelings involved, the work situation in the massage studio, the therapeutic relationship to me and the different cultural experiences she has herself had in China and in Germany.

Connected to this is a third possible therapy goal, which is becoming aware of, experiencing and grounding oneself in a good body-self. This includes the emotional relationship to the client’s cultural background, specifically her education in regard to sexuality as well as the corresponding cultural/societal customs of relating sexually to others, and developing awareness of this both on a haptic and on an emotional level. Using a transcultural approach means therefore utilizing Huan’s experiences in China as the “background culture” and her experiences in Germany as the “here and now culture”.

#### e) **My responses to and impressions of the various aspects**

At the beginning of our first meeting I encourage Huan to just speak freely about herself without any specific plan and without any questions from me.

This approach corresponds to free association in psychoanalysis in as far as the client can speak about herself as things occur to her. From a body psychotherapy perspective this also offers the opportunity of observing her non-verbal body language, an advantage always offered by a body oriented approach. In this way we obtain information which *appears not to be relevant*. Through this there develops a heuristic field of tension between what she expresses verbally, what she expresses non-verbally and also what seems to embody itself as an implicit exchange of perceptions in the incipient therapeutic relationship. This then becomes inductively a process-related scenic presence. Connected to this is the conscious perception of her non-verbal reaction, the bodily expression, as a significant, though not yet understood, style of behavior.

The invitation to free association and to spontaneous non-verbal expression also serves to build up the necessary trust for our further work together. It is also helpful to encourage both through questions and through my own behavior in a seemingly casual way, her noticing and

perceiving her often subtle “beginning” reactions. This allows Huan to begin to trust herself and her own often unconscious self-expression. This incipient decrease in (self-) control is conducive not only to free association, but also to her experience of herself in relation to me as a different person. To open oneself to another corresponds in a transcultural sense to making oneself “public”. Being “public” is seen in China as extremely shameful. If I had encouraged too much communication at our first meeting, this would have impeded progress.

*It is interesting in this context to look at how far Chinese students are accessible emotionally and communicatively. Even if they have grown up in the 4-2-1 family structure, there is still a great difference between the generations concerning how they accept and deal with the public domain. The question is how they can integrate their differing experiences?*

Against this setting of the transcultural disparities between China and Germany this approach is absolutely necessary. These differences often form a determinant background which remains emotionally unconscious and thus all the more potent. Understanding these background elements, especially the experience of self as a “self in public”, can help us to understand and appreciate both the experience of Huan as a young Chinese person in her own cultural socialization and the contrast with German culture. Particularly when working with Chinese people, showing respect for their culture and for the influence it has had on their own lives, their feeling and thinking, is a great help in building up a therapeutic relationship. The same is true of course for respect towards our own culture. The emotional/narrative approach allows me to gain a transcultural insight into the life story and the general living conditions of the client. At the same time I start to become aware of possible differences to my own, German, background and living situation. In the course of our encounter I can utilize these as possible, relevant disparities, so that these considerations have an important reality function, as it is often “dangerous” to think in categories of background, living conditions and cultural socialization too early and then to act, or treat, accordingly.

Huan presents a central, heuristic area of conflict insofar as we must not only evaluate and treat her sexual problems in the context of her cultural experience, but also on the level of intrapsychic dynamics and possible dissociative processes. It is much more important, and here we have the true heuristic art of body psychotherapy, *to keep both aspects adequately and respectfully in mind* – the cultural background and the identity which has been built up out of it on the one hand, and the dissociative processes within the psyche, whether cultural or psychogenic, on the other.

In summary this means: this transcultural approach to body psychotherapy takes place in an atmosphere of no longer culturally determined, but not yet sufficiently understood as a psychogenic or psychodynamic phenomenon.

The body-oriented approach proves to be helpful and necessary in establishing psychotherapy as a transcultural relationship. Both culture/society and one’s own body always have, next to their psychological, emotional aspect, a material, i.e. visible, tangible and mobile aspect, which provides concrete experiences of therapy and of life.

#### **f) Focusing, experiencing and expressing the various levels/contacts**

For me it is important particularly in the first interview to have enough distance from the client to be sufficiently open for my perceptions, but also for my own, phantasies and impressions, for my emotional resonance and the echo of my body (counter-transference). If I was very active there would be the danger that the client would experience me as controlling the situation and would be in danger of being overwhelmed. This is particularly a danger in

body psychotherapy, which shouldn't be underestimated, especially if therapists don't have enough experience of their own bodies.

The approach and the corresponding form of the therapeutic relationship is circular insofar as I thread my reactions into the flow of the clients' own questions and offerings in each situation which arises. I usually respond to the here and now, to the information which the client presents, whether verbal or non-verbal. My feedback is increasingly related to the simultaneously presented verbal and non-verbal signals and to the reaction of the client when I describe my impressions.

This protects me from the trap, which we can so easily fall into, of developing and acting upon a hypothesis too early. This would be a therapeutic mistake as, considering my own blind spots, I would be in danger of setting up a hypothesis without an understanding of the cultural background. A further danger would be, especially with Huan, that she would feel in a subtle way irritated in her relation to me and the trust which is beginning to appear between us would be disturbed. I am therefore open to all my perceptions, my observations of the whole relationship in the therapy room, especially the interaction between Huan and me, which existed right from the beginning, from the first impression. I am open too for aspects which don't seem meaningful or connected to each other or to the situation.

*The challenge here is for therapist and client equally to become aware of their own and of the foreign culture and to adjust accordingly. The art of transcultural therapy lies in developing at first in oneself and later in the client an increasingly conscious sense of the cultural differences and similarities on the one hand, as well as of the requirements of the real, often ambivalent situation, adapting to it while practicing restraint at the same time.*

*Language difficulties and the continuous need for translation mean that verbal communication is only of limited use, which means that the non-verbal, body language gains in importance. We can communicate thus in a concrete and visible way and understand its significance, especially if we also speak about it. I am increasingly strengthened in this approach to transcultural therapy by the experiences I gather working with it.*

In the last phase of the first session I become more active in that I offer Huan feedback about the various aspects of the here and now, of her behavior, our relationship as well as my experiences, my view of the situation and the ideas arising from it. I refer only to the situation at the first meeting for the following reasons:

- This condenses the first session into a shared experience.
- It condenses verbal feedback, reporting, experience, body openness and possible discrepancies or plausibilities.
- It brings together the situations we experienced in a narrative.
- It focusses scenic interaction of person, behavior and body expression.
- It provides transcultural feedback.

This openness stimulates, inspires and vitalizes the client with the result that she can show herself more spontaneously, with less control and self-consciousness. This step shows a partial identification with me, which in turn supports a synopsis of the information, signals and messages, which revealed themselves in the previous conversation and non-verbal communications. This synopsis links with the partial identification and offers a relatively conscious overview of possible problems, themes and ensuing treatment goals. This is also supported by her experience of the plausibility of therapy through our shared experience and through the feeling of developing mutuality.

Containing the whole session in this way enables us to filter out possible needs, implicit questions and problems by considering mainly her first impressions, her first presentations.

### **g) Determining goals and making a contract**

For the Chinese client, Huan, her specific experience and her conflicts (whether unconscious or structural) we can develop a complex initial formulation under the following aspects:

- The perspective of a traumatic development.
- The perspective of a structural character conflict, resistance, physical blocks, arousal processes and sexuality.
- The perspective of a transcultural experience.

Psychotherapy is an integrative process in a relational field, which should be open for the interaction of various perspectives, especially the explicit and implicit influences of the here and now. This calls for a continuous and conscious perception of the situation and one's own emotionality as therapist and of the countertransference reaction on a bodily, non-verbal level. It also involves dealing sensitively with the transference relationship. Ultimately this is for both parties a transcultural experience.

The transcultural familiarization can be expressed in the relative deconstruction of one's own, preconceived ideas and concepts about normality and asymmetries. We are oriented simultaneously towards the similarities and the differences of interaction, identity, boundaries and emotional expression either in public or in private.

At the first session we don't speak specifically about indications, even if we can implicitly recognize or deduce them. If I acted differently, in my experience, then I risk the client becoming irritated or I subtly endanger their contact to me, which could result in them breaking it off or even becoming emotionally overwhelmed.

Therefore I choose primarily central aspects of the process that has taken place in the here and now and condense them to a clear "story", so that single aspects and relevant perspectives can be seen in relation to one another. Clients have to recognize their own words, memories, expressions, complaints and their physical, non-verbal expression in the sense of a relational matching in this "story". This includes my feedback as well as my impression about possible future steps, whether these are therapeutic or possible plans for the clients themselves in their own daily life.

I differentiate four interlocking fields of observation for Huan, whereby if one aspect is in the forefront the others are continuously present in the background. This shows itself in a sensory openness also in the countertransference for everything that starts to develop spontaneously:

1. Encouraging conscious, sensory perception in the here and now of the therapeutic situation.
2. Careful exploration of the experience of a possible early traumatization (in her family) and corresponding verbal and body oriented interventions.
3. Structural, character-analytical work with her psychodynamics, including work with the psychic and emotional resistance, physical "blocks", dissociations and sexuality in the context of body psychotherapy concepts.
4. Including scenically transcultural experiences and communicating respect for both her own and for the foreign culture, especially the issue of shame and its representation in

Chinese and in German culture. It is implicit and unavoidable in body psychotherapy that this issue is always elicited and must be addressed. Therapy is always a “public place”. Body psychotherapy can never be separated from this public place and has therefore an indispensable access to the work with shame and in this case connected to Chinese culture inside and outside China.

5. One's own body in the therapy room is always present and visible, even if it is split off and we must speak of a felt and an un-felt body. Despite this, what happens in the therapy room works (un)consciously, emotionally in the client and is always visible for others – this means that others in the room can relate and react to it at the least unconsciously, emotionally.

The following therapy goals seem to me to be indicated here:

- First it is important to help Huan to develop a stable and secure body-self. This would improve the flowing, conscious sensitivity to her own body and the experience of this sensory self. Such a body-self would help the client to become familiar with a feeling of vitalization and the experience of arousal, whether emotional or sexual. She would then experience the body as capable of arousal, as excited and as sexually aroused.
- The therapy process uses primarily a body oriented, non-verbal approach and the corresponding experience of self and body expression in relation to the therapist. This body experience will probably allow access to pre-conscious or unconscious experiences, which took place in the family. If Huan can experience her anxiety about this family secret as a feeling of fear in the body, this could open up experiences which she can't initially remember.
- The body-oriented, psychodynamic approach makes it easier for Huan to present herself on the various levels of her personality and “in public”. On the one hand she will be encouraged to experience and express herself as a person, as a unity, which in its turn mobilizes the perception of dissociation as an intrapsychic defense. On the other hand this approach revives the (re)experience of shame, the inescapability of being seen (bodily, emotionally and relationally) “in public”. This aspect is especially important for the work with Huan and for working with Chinese clients generally. The experience of shame and guilt in society can then be observed on a personal and cultural level.
- The body-oriented, transcultural approach also allows us to focus on resources on a personal, an expressive and a cultural level. In the case of Huan the following resources could be important: elements of self-confidence and determination, strength of expression with the body, cognitive self-confidence, courage and determination connected to sensitivity and a feeling for sensual-sensory awareness and a conscious acceptance of her gender role.

## BIOGRAPHIES

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## Felt-Work

### Interview with Hilde Hendriks

#### Jill van der Aa

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**Jill van der Aa:** Hilde was commissioned to do a piece of felt-work for the wall of our friend's therapy rooms, representing the elements earth, fire, water and air. At the opening she presented a dance performance, reading the poem that had inspired her, accompanied by a singer. There was a video of her working with felt and a photo presentation of the process of creation.

I was intrigued by how much physical strength was required to create this beautiful work from this tiny woman. Coming from a sheep farming background I was also fascinated by the process of transforming wool into felt so I asked Hilde for an interview. We spent three or four sessions talking about her evolution as an artist.

**Hilde Hendriks:** I live outside a little village in a house overlooking some paddocks. I experience things intensely: when I see something, it is almost as if I am that thing. I had that as a child too. I would climb trees and look at an insect, or at a leaf blowing off the tree. I was not inspired to learn in primary school because all the subjects were in little pigeonholes and I longed to see the connections between them.

When I left school my real passion was to be an artist but I was refused entry to Art School because everyone was expected to be able to draw and that was not my talent. I was always searching for something more and came in contact with someone trained in Gabrielle Roth's five rhythms. My whole world was turned upside down. I discovered my body: the grace and power of expressing myself through movement that gave me so much space inside. I built myself a studio in the back yard to have a dance floor as well as room for my artwork.

While meditating one day I suddenly felt inspired to combine everything I had learnt, to develop my own form, to be my own teacher and to give lessons and teach from a need to share myself rather than from being a 'teacher'. I could pass on who I AM and what I DO.

Each year in the spring I would look out the window and see the lambs in the paddocks. I felt a deep connection with them and a desire to become a shepherd and then I met people who worked with wool. One day I was given a whole bag of freshly shorn wool to take home. Before doing anything I wanted to experience what it was like to lie in the thick fatty wool so I laid it all out, put on my best summer dress, lay down and went to sleep. When I woke up I started work and made my first piece just as it was described in a book I had read. From then on I kept on teaching myself. I would go to my felt-bench with wool, soap and water, always with a beginner's mind, as I do when I am dancing, and I would physically move and come into contact with the fibres of the wool.

There was one problem! The wool would always do something other than what I wanted. And the question was, "Would I take control, or would I let the wool show the way?" I had to practice not fighting because everything was happening inside me at the

same time; I could see the connections, the process and difficulties. I sensed a kind of wave movement in life. Each time again the same things came back – old pain that touched me deeply. Sometimes the pain felt so unbearable, the despair so enormous, as if I had gone back to the very beginning.

Eventually this created in me a point of no return. I decided to like whatever developed, without trying to control the process with my head. I took it as a challenge to get back into life, to look at the difficult places in myself, to become friends with them, embrace them as essential parts of myself. I experience myself through the creative process – I ask what it wants from me, looking, feeling, discovering, seeing how things move naturally inside me without interference, how I hang on to something, and what I can do with it at that moment. Working with felt I have to stay in contact with it and come from a place of innocence: blind-felting, feeling-felting, eyes closed and feeling the contact with the wool under my fingers. I call it playing. If I can play, my soul can fly. Like dancing - I can pull the sun out of the sky: it grounds me and gives rest and freedom. Previously I thought that everything was lineal – the outside world was in pigeonholes. Now I am the centre and I see from within how everything is connected.

Once I get an idea, I trace the form on the back side of some plastic. Then I fill it in with tufts of coloured wool and maybe mix it a bit with another colour or colours. I sprinkle warm water and soap over the wool and press the air out. Then I rub the plastic with soap and rub my hands over the plastic so that the soap goes in which also presses the air out. Rubbing very softly from the outside inwards I then explore the edges. The piece shrinks and is always smaller than the form that I have traced.

By making it wet each scale of the fibre opens up and then by rubbing it and mixing it with water the scales close so that they are in contact with each other in a different combination. From the loose fibres you make a new material. If you knit or weave you have to spin the wool to make threads. But not with felt – just water and soap and the fibres are re-formed through rubbing with your hands.

In the beginning I work gently, with a light touch, and then with the water, the air leaves and the wool shrinks and I begin to caress it, massage it, and I feel it getting firmer under my hands, combining the fibres in a new way and it seems to ask me to give it more power, more of my strength. It builds up from a very gentle beginning to soft, firm, firmer, sometimes rapid and harsh. And then when I feel that the combining has taken place, I roll it up and press very heavily on the roll. This takes a lot of physical exertion that I enjoy. It builds up slowly and asks me to distribute my own strength evenly. When I feel it is ready I throw it back and forth from hand to hand like pasta!

Washing comes next. Again I can feel the process taking place under my hands in connection with my heart. I listen very carefully to what this particular piece needs to achieve the result I want. Each time again I fall in love with my work. The very last stage is with vinegar to get the remains of the soap out. And lastly I rub the felt gently against my cheek.

I took the cover photo as I was rinsing the soap out of the earth/fire piece under the shower. When I took the photo, the earth and water elements came together. It was a bright summer's day when I started felting the earth/fire piece and just at that precise moment, as I was wetting the dry wool, a huge thunderstorm broke out and it began to pour with rain. The earth, fire and water elements came together. It felt like a message –as if the cosmos was saying: "It is all right!"

JILL VAN DER AA

## BIOGRPHIES

Hilde Hendriks Hilde lives in the Netherlands and has developed her own methods combining her two great passions, dance and felt-work. In her teaching she inspires others to develop their lives from their own creativity. She receives regular commissions to complete bigger felt works of art.

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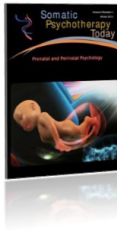
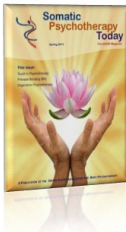
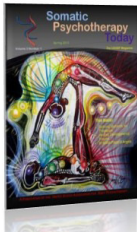
Jill van der Aa (1944) Jill was born in New Zealand but has lived since 1972 in the Netherlands. After a variety of occupations from teacher to actress she trained as a body psychotherapist. She organised the EABP conferences in 2001, ran the Secretariat (2001-2010) and subsequently joined the Board as General Secretary. She is managing editor of the IBPJ.

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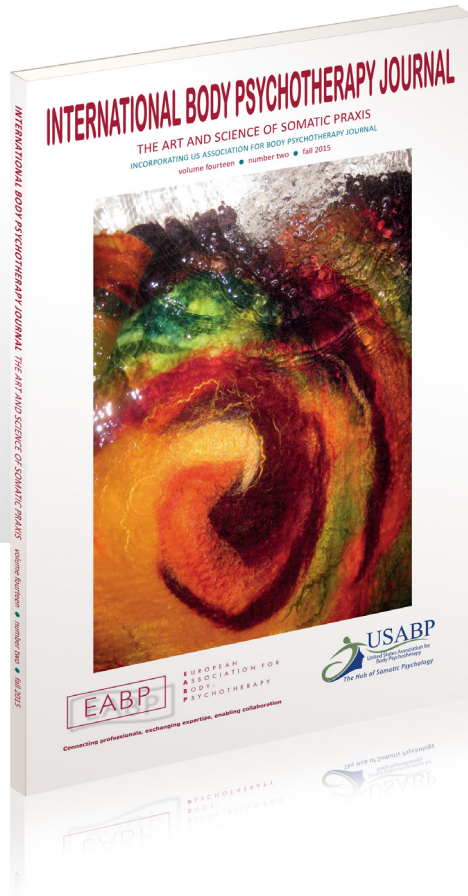


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