

The Body as a Resource in Psychotherapy

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Attestation

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Signature: _____

Date: _____

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Abstract

The notion of *the body as a resource* implies a relationship to the body as a source of wisdom, guidance, strength and creativity. This research project explores this notion within psychotherapy using a hermeneutic literature review to examine relevant literature from both psychoanalysis and body psychotherapy.

Body psychotherapy, and somatic trauma therapies, have a substantial knowledge base regarding the use and experience of the body as a resource. They privilege somatic awareness and experience, giving this a central place in the therapy process.

Historically, psychoanalysis has largely ignored this aspect of the body, despite Freud's initial focus on body based drives. However, contemporary psychoanalysis and psychodynamic psychotherapy, influenced by intersubjectivity, affective neuroscience and trauma therapy, are increasingly acknowledging the body. Somatic countertransference in particular is seen as an important resource.

This dissertation reviews literature from all of these approaches, comparing, contrasting and synthesising the wisdom they offer regarding the body as a resource; thus contributing to the growing cross-fertilisation between these historically separate disciplines. In keeping with its hermeneutic approach, it incorporates some of the writer's subjective responses to the literature.

This dissertation provides an account of the history of the body in psychotherapy, and examines the developmental basis for the body as a resource, with reference to psychodynamic and bioenergetic theory and affective neuroscience, before going on to describe how the body is experienced and used in this way, via three main themes: awareness, communication and shifting states. *Awareness* examines the centrality of embodied self-awareness to the topic, looking at practices which can develop and sustain this capacity. *Communication* describes an intersubjective approach to the body within psychotherapy, and outlines various understandings of somatic communication, particularly the notion of somatic counter-transference. *Shifting states* describes some somatic interventions used in body psychotherapy to generate therapeutic change. It goes on to outline three major approaches to somatic trauma therapy; and finally, it explores the notion of therapist self-resourcing.

This dissertation explores how therapists may use their body as a resource in their clinical practice, and how they may support clients to develop this kind of relationship to their own bodies. It proposes that an embodied, relational approach to psychotherapy facilitates the capacity to experience and use the body as a resource.

Chapter 1: Introduction to the Body as a Resource

The body has been thought about in many different ways within psychotherapy from its inception to the present day. Klopstech (2009, p. 14), in reflecting on some of these multiple perspectives on the body, names “the body of drives,...the medical (psychosomatic) body,...the moment-to-moment experiencing body,...the body as place of and container for personal history...the metaphorical body...”, among many others.

Amongst these myriad possible ways of perceiving the body, I am particularly drawn to exploring the experience and use of the body as a resource. My own experience in my personal therapy as well as in a range of somatic practices over many years has continually deepened my conviction that embodied awareness and movement are keys to psychic and somatic change and growth and are a fundamental part of finding wholeness. In my development as a therapist my concurrent training in bioenergetics¹, a form of body psychotherapy, and in psychodynamic psychotherapy, have generated an ongoing creative tension within me between these two different yet connected approaches, and a passionate interest in exploring how they can inform and enrich each other, both theoretically and in practice.

Ironically, in focusing on “the body” I perpetuate the very separation between body and psyche that I ultimately want to challenge and call into question. I agree with W. F. Cornell (2008), that in doing this I am “maintaining a cultural artefact and an artefact of the dominant attitude toward ‘the body’ over the course of psychoanalytic history”, when in fact mind and body are “in lived reality and neurophysiological processing a functional unity, no matter how persistently (and inadvertently) we split them apart in our language and theories” (W. F. Cornell, 2008, p. 32). This is also an inherent difficulty with the use of the term “body psychotherapy”, which, as Totton (2003, p. 26) points out “is body psychotherapy only in that it does not *exclude* the body, but treats embodiment as an intrinsic and important feature of human existence.”

The word “resource” took hold of me early in my research process when I came across a dialogue between Susie Orbach and Roz Carroll about the body in psychotherapy,

¹ Bioenergetic Analysis is the official name for this approach. It is also commonly known as “bioenergetics”, which is the name I will use throughout my dissertation. I will briefly describe bioenergetics in Chapter 3.

where there is a discussion about the way body psychotherapists “see the body as a resource” (2006, p.76). I sensed that this concept could provide a container and a focal point for the many amorphous ideas I had around my research at the time.

The word “resource” is defined as “a means of supplying a deficiency or need; something that is a source of help, information, strength, etc, (*and*) personal attributes and capabilities regarded as able to help or sustain one in adverse circumstances” (“Resource,” 2014), and comes from the Middle French *resourdre* “to rise up again” from the classical Latin *resurgere*. It is connected with the word *source*, meaning “the spring or place from which a flow of water takes its beginning” (“Source,” 2014). Understanding this explains why this word seems to encapsulate for me a sense of something life giving, vital and vigorous, more than its immediate definition indicates.

Within psychotherapy the word “resource” is used particularly in trauma therapy, where the work of building a traumatised client’s resources is generally considered to be a fundamental aspect of the first stage of trauma work, which Herman (1992, p. 155) names “establishment of safety”. Ogden, Minton, and Pain (2006, p. 207) state that “by *resources* we mean all the personal skills, abilities, objects, relationships and services that facilitate self-regulation and provide a sense of competence and resilience”. They go on to state that “somatic resources comprise the category of abilities that emerge from physical experience yet influence psychological health” (P. Ogden, Minton, & Pain, 2006, p. 207).

In the course of my research I also learned that within body psychotherapy, Lisbeth Marcher, the founder of Bodydynamic therapy, uses the notion of resources in a specific way. Marcher developed a detailed map of the patterns of muscle development, which she links with Reichian characterological development (Bernhardt, 1992; Totton, 2003). She works directly with developing body resources with clients, by focusing on specific muscles connected with their developmental deficits or trauma and combining psychological and sensori-motor work (Bernhardt, 1992).

Another word and concept that is central in my research is “somatic”. The words “soma” or “somatic” are often used interchangeably with the word “body”, and I will also use them in this way. The Oxford dictionary defines “somatic” simply as “of or

relating to the (or a) body; bodily, corporeal, physical” (“Somatic,” 2014). However, Hanna (1995), a somatic practitioner and philosopher, offers a fuller definition:

Somatics is the field which studies the *soma*: namely the body as perceived from within by first-person perception. When a human being is observed from the outside - ie., from a third-person viewpoint - the phenomenon of a human *body* is perceived. But, when this same human being is observed from the first-person viewpoint of his own proprioceptive senses, a categorically different phenomenon is perceived: the human soma. (p. 341)

This seems to me to be an important distinction, and regardless of which word I use, it is *this* body/soma, perceived from within, which my research is primarily focused on. I was fascinated to come across this explanation of the origin of Hanna’s use of the word “soma”, which comes from the Christian mystical tradition, and the New Testament. Johnson (1995) explains that:

Paul distinguishes between the Greek word *sarx*, which has the sense of “a hunk of meat,” from *soma*, which Paul used to designate the luminous body transformed by faith. Hanna argued that it was the sarcal body, gross and mechanistically conceived, separate from mind and imagination, that dominated Western thought and medicine. In his view, the teachers of embodiment practices were recovering a hidden sense of the wise, imaginative, and creative body.(p. xv)

For me this quote also highlights an important aspect of the somatic experience that I wish to explore. The notion of the body as a source of wisdom and guidance, as a vessel for spirit or life force, is more akin to the body as a resource than the mechanistic view of the body that has prevailed in western cultures since the Enlightenment, as I will discuss in Chapters 2 and 3.

Discussion

So, it is this sensorial, experiential, creative body that is the central focus of my dissertation, and my inquiry into my research question: “*How is the body experienced and used as a resource in psychodynamic and body psychotherapy?*”. In answering this question it has seemed important to stay close to my own sensorial experience, as I explore the literature. However, throughout the process of working on this dissertation, I have struggled both to bring my own somatic experience into the foreground, and to voice this struggle. I have come to understand this difficulty as both a key aspect of my own personal relationship to the material I am writing about, and as an expression of the

Cartesian split between body and psyche which underpins our culture and the culture of psychotherapy, as I will describe in subsequent sections.

Part of the difficulty lies in the challenge of translation. Just as the translation of certain concepts from one language to another may be impossible, at best only a rough approximation; translating somatic and energetic experience into language is fraught with difficulty. Stern (1998) writes poignantly about the loss that occurs developmentally as a child begins to acquire language and move into “the sense of a verbal self” (Stern, 1998, p. 162). Inevitably, the infant’s rich “amodal global experience” (1998, p. 176), is fractured, as language tends to bind experience to a single modality of sensation. Stern highlights the inadequacy of language, particularly prose, to capture significant aspects of human experience. Stern’s “Diary of a baby” (1990) is an example of a rare attempt to describe the sensorial immediacy of preverbal states using language. Fogel (2011) suggests that evocative language, and words that “resonate in felt experience” (2011, p. 185), such as in poetry or song may be able to evoke states of embodied self-awareness (a concept which I will describe further in Chapter 5).

Thus, the academic language that much of my dissertation is written in, is particularly ill-fitted to describe somatic and emotional experience. I have grappled with this difficulty throughout writing this dissertation, and have attempted to bring some other kinds of language into my writing, with rather limited success. I have included some reflections on my process and my emotional and somatic responses to the literature at the end of most chapters. I have sometimes included poetry and other quotes which seem to capture the essence of something which I am exploring. And occasionally I have chosen to write about my somatic experience in a freer, stream of consciousness voice which I experience as more embodied. I have italicized these few paragraphs for the purpose of clarity. I see these forms of writing as in keeping with the hermeneutic methodology I am using (as I will outline in Chapter 2), where my subjectivity as a researcher is central to the research process and findings. Smythe and Spence (2012, p. 21) state that in a hermeneutic study “knowing is an embodied experience, known by peace, joy, conviction, laughter and tears”.

Despite my inner sense of rightness about including these more personal voices in my dissertation, I have also observed my resistance to this. It has felt easier, and safer to

stay with the familiar academic voice while operating within an academic paradigm. I have not succeeded in including writing “from my body”, as much as I had hoped to. Johnson (2000) suggests that the experiential body practices of western academic life, which remain largely unexamined, nonetheless shape the kind of consciousness we engage in. He traces the origin of these practices to Christian monastic traditions, suggesting that western academic life “carr(*ies*) forward the old Graeco-Christian hierarchical notion of consciousness in which the inertly conceived ‘body’ is conceived as a distraction” (Johnson, 2000, p. 43). I have noticed this attitude playing out within myself time and again in the process of working on this dissertation, in the form of thoughts like “I don’t have time to do practices that connect me with my body”. I also find that the type of thinking I need to cultivate to write academically seems antithetical to being fully present with my sensorial experience; and vice versa.

I find Stern (2004) validating of my resistance and difficulty. He writes about the loss of “wholeness, felt truth, richness and honesty” in the process of making implicit knowing explicit and verbal. He suggests that there may be

a resistance operating to counter this loss- a resistance that keeps some experiences protected in their richly complex, nonverbal, nonreflectively conscious state? Perhaps it is an aesthetic and moral true-to-self resistance, an existential resistance against the impoverishment of lived experience. (2004, pp. 144-145)

This also resonates with my experience. I think in part my difficulty in bringing my whole self into this dissertation does relate to a desire to safeguard some precious aspects of my experience from the inevitably distorting, limiting impact of language.

However, I have also found that connecting with a voice that comes more directly from my body and emotions has enlivened my writing and my engagement with the material. I think about the notion of resourcing, returning to the source. Ultimately it is my embodied experience that is the source of my passion for and connection with this subject.

Chapter 2: Methodology

Philosophical Framework

Interpretivism

My research inquiry sits naturally within an interpretivist philosophical paradigm, as I will describe in this chapter. Interpretivism is contrasted with the “received view” of positivism, “a form of philosophical realism adhering closely to the hypothetico-deductive method” (Ponterotto, 2005, p. 6), which provides the theoretical underpinning of much quantitative research. Positivism assumes that a single, objective, external reality exists. Thus, objectivity, systematic observation, and testing hypotheses through experimentation and verification are hallmarks of this research paradigm (Grant & Giddings, 2002). Interpretivism (or constructivism) however, sees reality as subjectively constructed and experienced, assuming “multiple, apprehendable and equally valid realities” (Ponterotto, 2005, p. 7). Thus, interpretive research, which tends to use qualitative methods, looks for understanding of a particular context (Willis, 2007). It assumes that meaning is hidden, and that it can be brought to light through deep reflection (Ponterotto, 2005).

Positivism and the body

The dominant discourse of positivism, which emerged through the work of philosophers of the Enlightenment period, such as Descartes (Ponterotto, 2005), has also been instrumental in shaping the way the body is perceived and experienced within western culture. Cartesian dualism is widely seen as the foundation for the mind/body split that has been so prevalent in this culture, as well as within psychoanalysis (Leder, 1992; S. Shapiro, 1996; Soth, 2006; Young, 2006). Leder (1992) outlines the way in which Cartesian thought has shaped modern medicine. He describes the body in Cartesian thinking as like a corpse, and/or a machine, stating that Descartes replaced the prior, Aristotelian “vision of an animate, ensouled nature with that of nature as *res extensa* - a plenum of passive matter driven by mechanical forces” (Leder, 1992, p20). The human body is regarded as part of this “*dead universe*”. He also notes that Descartes’ ontology is “intertwined with a project of mastery” (Leder, 1992, p. 20), since a mechanistic view of nature allows humans far more freedom to tamper with it. This mechanistic worldview extends to the practice of medicine, where the body tends to be seen and treated in a mechanistic way leading to “depersonalisation, overspecialisation, (*and*) the

neglect of psychosocial factors in the etiology and treatment of disease” (Leder, 1992, pp.27-8). Leder envisions a medical model shaped instead by the phenomenological view of the “lived body”, espoused by twentieth century philosophers such as Merleau-Ponty. This view sees the body as “an ‘intending’ entity...bound up with, and directed toward, an experienced world” (Leder, 1992, p.25). Leder uses Merleau-Ponty’s term “intertwining” to describe the lived body, as it includes both the subjectively experienced, intending body and the body as a material object, transcending Cartesian dualism, “inherently ambiguous and double-sided” (Leder, 1992, p.27).

So, the discourse of positivism, and Cartesian dualism has been a dominant force in western culture, for several hundred years, and still holds sway over many of our implicit assumptions about the world. Because Cartesian dualism has shaped our way of relating to the body, the scientific and medical models, research paradigms and psychoanalysis, I encounter the shadow of positivism in every aspect of my research process and content, as well as in my own internal work of embodiment. In anchoring my research in an interpretive paradigm, I align myself and my research process with a non-dualistic worldview, an alignment which I need to return to again and again, as the external and internal pulls to a dualistic, positivistic view are constant.

Methodology and Method

Hermeneutics and Phenomenology

My research method is a literature review, utilising a hermeneutic approach. McLeod (2001) describes hermeneutics and phenomenology as the two essential epistemologies underlying all forms of qualitative research in the social sciences. A hermeneutic inquiry is a process of interpreting a text. Hermeneutics originated with the interpretation of biblical texts. It is understood that the researcher is part of a tradition, and that their reading is “informed and shaped by the values, beliefs and ‘prejudices’ of that tradition” (McLeod, 2001, p. 27). It is not possible to achieve a wholly objective view...only to become more fully aware of our “prejudices” and our particular context, and to expand and enrich our “pre-understandings”. Understanding grows through moving back and forth between one’s interpretation and the text and between parts of the text and the whole, in a hermeneutic circle. A traditional understanding of hermeneutics suggests that the text that is being interpreted should be available in the public domain, such that the reader of the research can engage with both the text and the

researcher's interpretation. This makes it a fitting approach for my literature review, since my sources are publically available. Likewise, the emphasis on the contextual nature of knowledge in hermeneutics, seems to be a good fit for exploring psychotherapeutic knowledge, which tends to be "holistic, nuanced, personal, contextualised, (*and*) incomplete" (McLeod, 2001, p. viii). Orange (2011) reflects extensively on the application of hermeneutics to clinical practice, where Gadamer's notion of understanding as a dialogic process that is unpredictable and always incomplete seems very fitting. Spence (1993) argues that the discipline of psychoanalysis has a great need to incorporate hermeneutic notions into its knowledge base, to more fully recognise and acknowledge that "our theory is often the projection of either our *Zeitgeist* or our personal history" (Spence, 1993, p. 1).

A phenomenological approach, in contrast, "seeks to set aside any assumptions about the object of inquiry, and build up a thorough and comprehensive description of the 'thing itself'" (McLeod, 2001, p. 56). Thus, phenomenology attempts to move beyond context. McLeod (2001) suggests that any qualitative research will combine elements of both hermeneutics and phenomenology, in a different balance according to the nature of the study. In my research I see phenomenology as particularly relevant to the tension I have described regarding bringing language to somatic experience, as phenomenology "pushes at the edge of language, trying to find words for what is beyond our everyday ways of speaking about whatever it is we are studying" (McLeod, 2001, p. 56).

Systematic literature reviews and evidence based practice

In undertaking a literature review I am mindful of both the requirements of systematic literature reviews (SLRs), and the philosophical, theoretical, political and practical issues that arise in transposing standard literature review procedures into psychotherapy research. I will outline some of these issues, discuss SLRs, and go on to describe the hermeneutic approach to the literature review which I am following.

Dixon-Woods (2011) notes that systematic review methods have developed primarily in the field of medicine, to safeguard against a lack of scientific rigour in reviewing, and undertaking meta-analyses of quantitative data. However, "there is often an uneasy fit between the frame offered by conventional systematic review methodology and the kinds of epistemological assumptions and research practices more usually associated with qualitative research" (Dixon-Woods, 2011, p. 338).

The “evidence-based practice” (EBP) movement has developed within health and social care since the 1970’s. EBP seeks to apply research evidence to health practice, to ensure that there is a solid scientific rationale behind treatment methods. Starcevic (2003) points out that evidence-based medicine has “acquired a powerful role of making ‘verdicts’ about what is good treatment and what is not”. He outlines the difficulties in applying EBP to psychotherapy. EBP primarily relies on the quantitative data of randomized controlled trials (RCTs), which are seen as the “gold standard” for measuring the usefulness of treatment. RCTs are not very suitable for assessing the effectiveness of psychotherapy, as they require strict diagnostic homogeneity of the patient group, a control group receiving a “neutral” treatment, a double blind research design, and standardised treatment procedures. All of these requirements are antithetical to the practice of psychotherapy. Starcevic proposes that psychotherapy should formulate its own criteria for assessing its usefulness, in order to move towards establishing “practice based evidence” (2003, p. 280).

Systematic literature review methods have been developed and refined as part of the EBP movement, in order to combine the data from many research studies. Generally these have concentrated on quantitative research, and combining the statistical results of studies to produce meta-analyses. This has enabled researchers to establish patterns in treatment effects that would not be obvious from reading individual studies. The traditional hierarchy of evidence used in literature reviews places meta-analyses at the top of this hierarchy, with RCTs second. Expert opinion is near the bottom of the hierarchy (Aveyard, 2010).

In contrast, interpretive researchers see “the thoughtful reflections of experienced practitioners...*(as)* a prized source of knowledge and understanding” (Willis, 2007, p. 110). This is in line with the strong emphasis within the field of psychotherapy on case studies, commencing with the work of Freud. The vast majority of the literature I identified on the body in psychotherapy belongs in the category of thoughtful reflections of experienced practitioners. Moreover, my particular research question: “How is the body experienced and used as a resource in psychodynamic and body psychotherapy?” is primarily an inquiry into the phenomenological experience of therapists and clients, as described in the literature, rather than an attempt to measure the effectiveness of body-based interventions. Aveyard (2010, p. 64) does note that “the

most robust form of evidence for addressing a particular research question will be determined by that research question”, and that in designing a literature review the researcher needs to develop their own hierarchy of evidence, in relation to the research question.

Aveyard (2010) notes a degree of confusion regarding the term “systematic review”. This term often refers to a review which utilises the methods of the Cochrane Collaboration, according to strict protocols, and involving a team of researchers. However, she suggests that “a literature review can be approached in a systematic manner even if the detail required by the Cochrane Collaboration is not attained” (Aveyard, 2010, p. 15). According to Aveyard, a systematic review (in the wider sense), includes a “well-focused research question, (a)well-focused searching strategy with comprehensive and explicit methods, rigorous methods of appraisal and synthesis of the literature” (2010, p. 19), and should be able to be repeated.

The hermeneutic literature review

However, Smythe and Spence (2012) challenge the assumption that there is one way to do a literature review that is common across all methodologies. They suggest that “a hermeneutic research study calls forth a particular approach to literature, which is distinctively interpretive” (Smythe & Spence, 2012, p. 13). They argue that a hermeneutic approach “goes beyond extracting knowledge from the treasure house (*of science*) for the purpose of making it available as research evidence”, instead they suggest that to “re-view” involves “viewing a-fresh” the “words, meanings and ... thoughts that arise” (Smythe & Spence, 2012, p. 14). They emphasise that “the nature of a hermeneutic review is that there are few rules to follow; rather a way to be attuned” (Smythe & Spence, 2012, p. 23). They see the process of engaging with literature as seeking “conversational partners (through literature) to compare and expand... (*one's*) emerging thinking” (Smythe & Spence, 2012, p. 21). The researcher’s subjectivity and prior understanding is assumed to be an integral aspect of the research, to be recognised and held in mind while engaging with literature.

This approach to the literature review seems appropriate to both the nature of my research question, the type of literature that I am reviewing, and to my own relationship to this research. Smythe and Spence (2012, p. 16) suggest that “the starting place when examining the meaning of a literature review is the reviewer. He or she stands at the

crossroads of all their fore-understanding”. I approach this research with a wealth of embodied experience of my own body as a resource, gleaned through many years of therapeutic and somatic practices that privilege somatic experiencing and non-verbal knowledge. I bring diverse pre-existing theoretical knowledge from bioenergetics and psychodynamic psychotherapy, and budding clinical knowledge. To claim, or to attempt, to be an objective observer in my research process would be impossible. Moreover, by invalidating my existing understanding, I would limit my capacity to engage with the literature as a full “conversational partner”. Rather, I seek to “recognise the ‘restless to and fro’ of the play between both...(*my*) own already-there understandings and those that may be seen or unseen within the text” (Smythe & Spence, 2012, p. 16). “It is the researchers’ relatedness to the literature that enables them to see the potential insights that lie within...One brings a willingness to be surprised, openness to difference and courage to make the leap into the space of thinking” (Smythe & Spence, 2012, p. 17).

I also see my inquiry as part of a dialogue between the literature and worldviews of psychoanalysis and body psychotherapy, representing two (or more) rather different conversational partners. Of course, both of these disciplines inform my pre-understanding, and both worldviews exist within me in various ways. At a more fundamental level I see my inquiry as an aspect of an ongoing internal conversation between my embodied, non-verbal knowing, and my intellectual knowledge.

Interestingly, a key source of inspiration for me during the months I was working on this dissertation, was listening to the poetry and reflections of David Whyte (Whyte, 2002). One of Whyte’s primary metaphors is the notion of life as a conversation. For example, Whyte (2001, p. 6) writes “life is a creative, intimate and unpredictable conversation if it is nothing else, spoken or unspoken, and our life and our work are both the result of the particular way we hold that passionate conversation”. The receptive experience of listening, and the shift to poetry was a welcome change from the reading and writing of prose I was doing for my dissertation, enabling me to lounge in a “sound bath” (Kimble Wrye, 1997, p. 366), in a state of reverie which allowed new insights to drift to the surface.

To facilitate thinking, Smythe and Spence (2012) advocate reading widely, including beyond one’s subject. They particularly recommend reading poetry, literature and

philosophy, which can richly enhance “the movement of thinking” (Smythe & Spence, 2012, p. 18), enabling the researcher to expand their thinking in unexpected ways which may allow for a depth of understanding which would not otherwise arise. They also encourage “inclining” towards particular texts, following intuitive pulls to read and re-read certain texts. They question whether the current trend in literature reviews of delineating the search terms and search engines used can engender “a false sense of security” in researcher and reader alike, whereby the research may be seen as rigorous, when “hermeneutic adequacy is more about the depth of thought rather than the narrow isolation of a technology driven search” (Smythe & Spence, 2012, p. 22).

Thus, although I have adhered to a conventional literature search process, making a substantial effort to search the literature, and establishing inclusion and exclusion criteria, as Aveyard (2010), Dickson (2005), and Wood (2003) propose; I have also endeavoured to maintain a hermeneutic approach to my engagement with the literature, “immersing...(*myself*) in the reading, searching, intuiting, thinking, talking, writing, letting-come process by which...(*I may*) discern what matters, and encourage readers to engage in dwelling, pondering, thinking and questioning” (Smythe & Spence, 2012, p. 14).

Literature search

Since I wished to explore the body as a resource in both psychodynamic and body psychotherapy, this required that I engage with two distinct, though overlapping, bodies of literature. In fact, although I undertook an extensive search of several major databases, most of the germane literature came to me in a much more hermeneutic way: coming across books in unexpected sections of the Auckland University of Technology (AUT) library, recommendations from colleagues and supervisors, browsing through reference lists in books and articles I had already identified, and hand-searching specific relevant journals.

The concept of “the body as a resource in psychotherapy” was difficult to translate into search terms which would capture all the instances in which the body is utilised in this way. Thus I used broad search terms, and scanned through titles and / or abstracts to ascertain which articles seemed relevant.

I began by searching the PsycINFO database which is published by the American Psychiatric Association and contains over three million references to peer-reviewed literature in behavioural science and mental health. I used the search terms: *body AND "psychodynamic psychotherapy" OR "psychoanalytic psychotherapy" OR "body psychotherapy" OR "somatic psychotherapy" OR (bioenergetic* ADJ6 psychotherapy)* and excluded non-English literature. This search generated 2,178 results, all of which I scanned briefly, applying exclusion criteria, finding that although, as Aveyard (2010) points out, reading the title of an article is not adequate to establish its relevance, it can often be enough to establish irrelevance. I found 90 potentially relevant items. I then looked through these more closely, applying more stringent exclusion criteria, which resulted in 48 relevant items. Interestingly, 22 of these were articles from the journal “Body, Movement and Dance in Psychotherapy”, which I had already identified as an important source to search. Thus, I only found 26 items which I would not have accessed through this journal, and these were of varying degrees of relevance.

I conducted several searches on PEP (Psychoanalytic Electronic Publishing), the digital archive of psychoanalytic literature.

Table 1: PEP Searches

Search terms	Results	Relevant articles
“body psychotherapy”	31	12
“body awareness”	118	11
“somatic countertransference” or “body countertransference”	44	12

Interestingly, many of the relevant articles on PEP were very recent ones. This seems consistent with the recent surge of interest in the body within psychoanalysis. As PEP only shows abstracts for articles published within the last 3 years, I needed to search for these recent articles in other databases. I also came across a number of articles which I already had.

I also conducted a number of searches in EBSCO Health: Psychology and Behavioural Sciences Collection, a collection of databases held by the AUT library which includes full text coverage for nearly 400 psychology journals. None of my searches yielded many results, thus I used a range of different search terms to ensure that I would find

any relevant articles. Again, I found a number of articles which I already had, suggesting that my search was nearing saturation point.

Table 2: EBSCO Health- Psychology and Behavioural Sciences Collection searches

Search terms	Results	Relevant articles
“body awareness” AND psychotherapy	20	2
“body psychotherapy”	14	2
“somatic psychotherapy”	0	0
"somatic countertransference" OR "body countertransference"	3	2
Body AND "psychodynamic psychotherapy" OR "psychoanalytic psychotherapy"	26	2
Bioenergetic* AND psychotherapy	3	1

My exclusion criteria developed over time, becoming more stringent as I realised that I needed to refine my search in order to isolate a manageable quantity of literature appropriate to the limitations of a 60 point Masters dissertation. Aveyard (2010, pp. 72-73) points out that inclusion and exclusion criteria are necessarily “a combination of limits that are necessary to focus your search, and pragmatic limitations that are required due to the resources available to you”. Since my focus was on psychodynamic psychotherapy and body psychotherapy, I regretfully excluded numerous other modalities of therapy, despite their relevance to my research question: dance movement therapy, authentic movement, art therapy, play therapy, EMDR, hypnosis, chiropractic, and sex therapy. I excluded group psychotherapy and couples therapy, as well as therapy with children and adolescents. I also made the decision to exclude unpublished dissertations for practical reasons.

Within the field of body psychotherapy, exclusion criteria were more complex to apply. My primary focus was on bioenergetics and psychodynamic forms of body psychotherapy, however many of the writers in this field bring an integrative approach to their work, combining elements of Reichian, psychodynamic, and humanistic theory, thus much of the relevant material was from an integrative perspective. However, I did exclude articles and books which were predominantly written from a different

theoretical perspective, such as transactional analysis, (W. F. Cornell, 2003) and Jungian analysis (Greene, 2001).

Terminology

I will briefly comment on some of the terms I use regularly, and what I intend by these terms. As I describe in the above paragraph, my use of the term “body psychotherapy” is necessarily somewhat vague and general. Although I wished to focus specifically on bioenergetics, as it is the modality I have trained in, I did not want to limit my inquiry to bioenergetics as this seemed overly narrow. Moreover, the term “body psychotherapy” is often used in a general way in much of the literature.

My use of the terms “psychoanalysis”/ “psychoanalytic”, and “psychodynamic psychotherapy” is similarly fraught. Although I recognise that psychoanalysis, psychoanalytic psychotherapy, and psychodynamic psychotherapy are different approaches, it is beyond the scope of my dissertation to engage significantly with these differences. Thus, I endeavour to be historically accurate in describing, for example, Freud’s approach as “psychoanalysis”. I also endeavour to be accurate in naming whichever approach is described in any given piece of literature. Beyond this, I use these terms interchangeably, along with the more generic term “psychotherapy”. The same applies to my use of the terms “patient”/ “client”, and “analyst”/ “therapist”.

In writing about different modalities it has proved difficult to be completely consistent in my use of capitalization. I decided not to capitalize the main schools and approaches of psychotherapy which I refer to throughout the dissertation: psychoanalysis, psychoanalytic psychotherapy, psychodynamic psychotherapy, body psychotherapy and bioenergetics, as well as different psychodynamic approaches such as intersubjectivity and self-psychology. However, for the sake of clarity I have capitalized modalities which I mention very briefly, as well as the schools of trauma therapy which I discuss in some detail in Chapter 8. It seemed necessary to capitalize the latter, because the nature of their names could lead to confusion otherwise. Somatic Experiencing, in particular, I felt would not be clearly apparent as the name of a specific approach unless capitalized. My choices also reflect the conventions within these approaches. Lowen (1975, 1958/2006) writes about bioenergetics using lower case. Levine (1997) and P. Ogden and Minton (2000) use capitals throughout in writing about their respective modalities: Somatic Experiencing and Sensorimotor Psychotherapy.

Selection of literature.

As I described above, my literature search proceeded in a systematic way. However, the choice of literature which I focus on in the body of my dissertation was determined more hermeneutically. I was aware of inclining towards certain articles, and particular writers. On an intellectual level these choices were determined by factors such as quality of writing and reasoning, and depth and breadth of thesis and of sources. However, on an emotional and energetic level I was drawn to literature which engaged, stimulated and energised me. This literature tended to resonate with my own thinking and feeling, but also extended this in new ways. Most of the writers I was drawn to in this way have written more than one item of literature in the field, thus they have developed their ideas in a number of directions, while aligning their thinking to a particular orientation. This breadth made such writers enriching “conversational partners”. I will include ongoing, specific reflection on this as I discuss this literature in the body of the dissertation.

In contrast, I read many articles which at first glance seemed enticing, but left me feeling to a greater or lesser degree energetically and emotionally flat, and intellectually unstimulated. There was a fair amount of repetition in content, argument and themes in the literature I surveyed, thus there were many articles I read which did not seem to offer anything very new to the conversation. Therefore I tended not to engage with such articles beyond a first reading, other than to note their congruence with other literature.

The nature of my topic meant that divergent views among writers tended to be along the lines of theoretical orientation. Most if not all of the literature about the body in psychotherapy is written by clinicians who are advocating the importance of including the body in psychotherapy, although the ways they envision this vary according to their theoretical orientation, as I will describe.

Dissertation structure.

As I read, certain themes appeared again and again. The structure of my dissertation gradually took shape in my mind in response to these themes. Chapters 3 and 4, in which I look at the historical context of the body in psychotherapy, and outline a developmental view of the body as a resource, respectively, are in a sense an extended introduction or foundation for the material I go on to explore in subsequent chapters. In Chapters 5 to 9, I examine ways in which the body is used and experienced as a

resource in psychotherapy, in relation to the three main themes I identified: awareness, communication and shifting states. Finally, in the discussion section I summarise my findings, discuss gaps in the literature and directions for future research, and reflect on my process

Chapter 3: Historical Overview of the Body in Psychotherapy

“the ego is first and foremost a body ego” (Freud, 1923/1961)

Introduction

Since my inquiry into the experience of the body as a resource is informed by hermeneutics, with its emphasis on historical context, it seems particularly important to locate this inquiry within the context of the history and traditions of psychotherapy. As I have outlined in my methodology section, Cartesian dualism is seen as the basis for the historical split between mind and body within the western cultures where psychotherapy has developed (Ben-Shahar, 2012; Leder, 1992; S. Shapiro, 1996; Soth, 2006; Young, 2006). This split has also been expressed within the culture of psychotherapy in various ways, a key theme in much of the literature I have reviewed.

Young (2006) explores the disavowal of the body in psychotherapy as part of a wider cultural phenomenon. He names numerous distorted, objectifying ways of relating to the body which have become normalised within our culture. For example, the body is often seen as “something to be medicated or fixed by the medical profession...*(or)* something to be perfected and controlled through diet and exercise” (Young, 2006, p. 87). Orbach (2004) proposes that our cultural preoccupation with body image, with all its dysfunctional sequelae, is so powerfully destructive because for many of us “an interior sense of vitality and aliveness has failed to be established” in our early development (Orbach, 2004, p. 40). This idea resonates with me, as I have often wondered about this link in our culture between an excessive focus on body image, and a lack of connection with the aliveness of the experiential body. I also notice within myself that the more fully embodied I feel, the freer I am from concerns about my body image.

Freud and psychoanalysis

It is generally agreed that psychoanalysis began with a strong focus on the body, but subsequently moved away from this, privileging “language over body, insight over direct experience, mind over matter” (Klopstech, 2009, pp. 15-16). Young (2006) points out that the work of Janet, which can be seen as a precursor to body psychotherapy, preceded Freud’s development of psychoanalysis by several years, and believes that

Janet influenced Freud. Freud's earlier work was more somatically based, anchored in drive theory and utilised treatment approaches such as hypnosis, catharsis and touch. Over time the focus became predominantly psychic, as his structural theory of the unconscious took centre stage, and free association and dream interpretation became the primary treatment approaches (Klopstech, 2009). However, S. Shapiro (1996, p. 298) argues that the focus on the body in classical psychoanalysis is "a pseudobiological theory" which offers a very limited understanding of bodily experience, restricted to "sex, aggression, and to a lesser extent hunger and thirst". Similarly Kimble Wrye (1998, p. 103) writes that "though a transcendent genius interested in bridging soma and psyche, Freud was also Victorian, Cartesian, Newtonian, patriarchal, drive oriented and oedipal" all of which limited his capacity to attend to "the body of sensorially lived experience". Thus, while the body was a focus in early Freudian psychoanalysis, only limited aspects of bodily experience were attended to.

Ferenczi and Reich

Other members of Freud's inner analytic circle contributed greatly to the early development of psychoanalysis. According to W. F. Cornell (2009, p. 79) Sandor Ferenczi and Wilhelm Reich were "perhaps the two most prominent and ultimately most reviled apostates". They each engaged with the body in psychoanalysis, in different ways, and they each "challenged Freud on a number of key issues that were so emotionally charged that both... (*of their*) names ultimately came to be associated with unacceptable, repellent practices" (W. F. Cornell, 2009, p. 79). Reich's expulsion from the International Psychoanalytic Association in 1934 can be seen as a painful, pivotal moment in the "disownment of the body" (Young, 2006, p. 86) in psychoanalysis. It also marks the beginning of body psychotherapy as a separate discipline.

The central focus of Reich's work was on "freeing our involuntary life from the controls imposed by society and consciousness" (Totton, 2003, p. 90). Like Freud, he saw sexuality as a core issue. Reich emphasised the need to work to dissolve muscular and psychological blocks, which he described as "armouring", in order to facilitate surrender to the organismic energy of the body, and to achieve full orgasm, which he saw as synonymous with psychological and somatic health (Totton, 2003). By grounding psychotherapy in precognitive neural and somatic processes, Reich "opened a new realm of understanding and technique to the therapeutic process centred in careful

attention to shifts in bodily aliveness and movement within the therapeutic hour” (W. F. Cornell, 2009, p. 80).

Ferenczi’s contributions to psychoanalysis included reintroducing Freud’s seduction theory, and assuming that his patients’ traumatic experiences were real, rather than fantasised. He explored the role of bodily expressions of emotion and experimented with both touch and relaxation techniques. He also attended increasingly to his own somatic countertransference (Klopstech, 2000b).

While Reich’s work led to the development of several schools of body psychotherapy, outside the mainstream of psychoanalysis, Ferenczi’s work remained obscure until recently attracting interest from within psychoanalysis due to the reawakened interest in somatic transference and countertransference, and in working analytically with abuse trauma (Klopstech, 2000b).

Body Psychotherapy after Reich

Reich’s work has directly or indirectly influenced most schools of body psychotherapy. Totton (2003) points out that the focus of Reich’s work changed over the course of his career, and that different body psychotherapy approaches stem from different phases of his work. Bioenergetics is the largest single school which developed out of Reich’s work. It was founded by Alexander Lowen and John Pierrakos, who were pupils and patients of Reich, in the early 1950s. Pierrakos subsequently moved on to create Core Energetics. Totton (2003) contrasts Reich’s focus on surrender with Lowen’s emphasis on grounding, autonomy and agency. This shift was embodied in clinical practice by Lowen’s tendency to have clients work standing, rather than lying down. Likewise, at the somatic level Lowen focused more on the musculature and central nervous system, in contrast to Reich’s focus on the viscera and autonomic nervous system.

There are innumerable other schools of body psychotherapy that trace their lineage to Reich’s work. I will briefly enumerate some of these, to give a glimpse of the diversity of approaches that exist, although it is beyond the scope of my dissertation to go into any detail. Biosynthesis, which was developed by David Boadella, focuses on the three embryological layers on which the body is structured, and relates these to three core principles of centring, grounding and facing (Totton, 2003). Biodynamic therapy was developed by Gerda Boyeson, a Norwegian physiotherapist who developed the notion

of “psycho-peristalsis”, looking at the role of the intestines in digesting emotional stress (Boyesen, 2006). Bodydynamics was developed by Lisbeth Marcher , who connected patterns of muscular development with Reichian characterological development (Bernhardt, 1992). Other modalities include the Chiron approach, taught by the Chiron Centre in London, a humanistic, integrative approach; Embodied-Relational therapy, developed by Em Edmondson and Nick Totton; Hakomi, developed by Ron Kurtz, which centres on mindfulness. Gestalt therapy as developed by Fritz Perls, was also strongly influenced by Reich’s work (Totton, 2003).

Somatic Practitioners

There are also parallel disciplines of embodiment which have developed in the western world throughout the last century, through the work of practitioners such as Gindler, Selver, Speads, Alexander, Feldenkrais, Bainbridge-Cohen, Conrad Da’Oud and numerous others. It feels important to me to acknowledge these disciplines, and honour their contribution to fostering the wisdom of the experiential body, although they are outside of the field of psychotherapy. Johnson (1995, p. ix) describes such practitioners as “innovators who have devoted their lives to developing strategies for recovering the wisdom and creativity present in breathing, sensing, moving and touching. They worked quietly, wrote very little”. The practices which these somatic practitioners developed tend to approach the psyche-soma from the opposite direction to psychoanalysis, such that increased awareness of somatic experience in body work may evoke emotions and memories, and over time generate psychological as well as somatic change. S. Shapiro (1996, p. 299) states that the body work of these practitioners “parallels but rarely touches psychoanalytic theorizing and is largely unknown by psychoanalysts”. However, Geuter, Heller, and Weaver (2010) describe a strong, formative, albeit indirect influence of the bodywork of Elsa Gindler on Reich’s development of body psychotherapy in Berlin in the early 1930s. They also note the influence of Gindler’s work on the psychoanalyst Otto Fenichel. Thus, it seems that there was originally more connection and mutual influence between somatic practitioners and psychoanalysts than there is now.

Like Shapiro (1996, 2009), I believe that somatic practices can be an invaluable complement to psychotherapy, for both client and therapist. However, while Shapiro also advocates including the experiential body in psychoanalytic treatment, she gives few suggestions for how this may be achieved. The split that she writes about between

psychoanalysis and the body also seems manifest in her suggestion to refer clients for bodywork. I believe that a body psychotherapy approach can offer a framework that integrates psychological and somatic work, and I will elaborate on this throughout my dissertation.

The Body in Post-Freudian Psychotherapy

The schools of “mainstream” (as opposed to body-oriented) psychotherapy which developed in the decades after Freud mostly trace their roots back to psychoanalysis, and, with the exception of humanistic psychotherapies, most of them “give little room to the body in their theories or clinical practice” (Klopstech, 2009, p. 17). Stepansky (2008) suggests that from the mid 1930’s analysts may have distanced themselves further from the body in order to differentiate their practice from the invasive procedures of the new somatic psychiatry, such as electroshock therapy and prefrontal lobotomy, which many analysts were uncomfortable with. Likewise, “psychoanalytic distance from body-based therapies has been reinforced by ongoing concern with the discomfiting reality of boundary violations” (Stepansky, 2008, p. x), a frequent feature in the history of analysis.

Nonetheless, the body has certainly featured increasingly in psychoanalytic writing. Some key contributions have been McDougall’s (1989) work on the subject of somatising, and Anzieu’s (1989) articulation of the concept of “skin ego”, the idea that “sensations connected to the material skin are the basis on which the psychic apparatus (the bodily ego, sense of self) is formed” (Cavanagh, Failler, & Johnston Hurst, 2013, p. 3).

Integration

There is consensus in much of the literature I have reviewed, that the tide is turning regarding the integration of the body in psychoanalytic and psychodynamic psychotherapy (W. F. Cornell, 2009; Kimble Wrye, 1998; Klopstech, 2000a, 2000b, 2009; S. Shapiro, 1996; Stepansky, 2008; Young, 2006). There is a growing interest in this area, which stems from a number of different factors. Firstly, the shift within psychoanalysis towards a relational or intersubjective perspective has brought the body into the foreground, as

subjectivity focuses on feeling and subjective experience and therefore, necessarily, on the body....Intersubjectivity is not only about two minds intertwined but about two bodies intersubjectively intertwined, therefore both the patient's body and the therapist's body contribute to the relational body. (Klopstech, 2009, p. 20)

Secondly, the emergence of affective or interpersonal neuroscience has brought a new, research based understanding of the centrality of somatic affective communication in human development, fundamentally changing “the view of what matters in psychotherapy...breaking up the long standing privilege of language process over body process” (Klopstech, 2009, p. 19). Thirdly, knowledge from the discipline of traumatology compels psychotherapists to consider the profound impact of trauma on brain and nervous system development and functioning, and the fact that “traumatically experienced material is not encoded in a symbolic, but in a procedural way” (Eldredge & Cole, 2008, p. 80). This highlights the need for a focus on somatically based “bottom-up” processing, rather than the “top-down” narrative based processing which is predominant in verbal psychotherapies (P. Ogden & Minton, 2000; P. Ogden et al., 2006). I will discuss each of these developments in more detail in subsequent chapters of this dissertation.

Body psychotherapy is also being shaped by these paradigm shifts. Klopstech (2009, p. 18) states that “the relational paradigm changed the clinical practice and the view of the body within bioenergetic analysis in major ways”, effectively shifting it from a predominantly one-person psychology as developed by Lowen, influenced by Reich, towards a one-and-a-half and two-person psychology (Klopstech, 2000a). Akhtar (2009, p. 197) describes one person versus two person psychology as “a current North American psychoanalytic euphemism” differentiating classical ego psychology from relational and intersubjective approaches. Stark (1999), in describing three modes of therapeutic action, also includes one-and-a-half person psychology. This relates to approaches that posit the need for corrective emotional experience; such as self-psychology. Soth (2006) writes about the inevitability of objectification and re-enactment at the relational level in traditional one-person body psychotherapy. He describes a case example from his early work where he, the therapist, re-enacted his client's father's lack of acceptance of his body self, while also enacting the client's internal split between body and mind. Soth thus advocates integrating a relational or intersubjective view into body psychotherapy.

Body psychotherapists such as Soth (2006), Klopstech (2000b), W. F. Cornell (2009), Ben-Shahar (2012), and others are engaging with psychoanalytic thinking, promoting “cross-fertilisation” between these historically separate disciplines. Ben-Shahar bemoans the loss of “psychoanalytic thinking, and particularly... psychoanalytic rigour” (2013, p. 11), which resulted from the historically separate development of body psychotherapy, and from its subsequent involvement with the human potential movement.

Reflections

I am particularly inspired by the writing of Cornell and Ben-Shahar, as they both grapple creatively with the tensions and potential in integrating body psychotherapy with a psychoanalytic approach. Both are very erudite in giving voice to the value of body psychotherapy, while also acknowledging its flaws and weaknesses. And, perhaps most inspiringly, both write about their clinical work with a depth of honesty, courage and vulnerability which I find very moving. At the somatic level I tend to feel energised, and to feel a natural sense of integration between my body, heart and intellect as I read their work.

I feel that writers such as these are working to “mend the split” between psychoanalysis and body psychotherapy, and to reclaim the unity of mind and body. I notice my own pain and sadness as I recount the history of the fractures and disconnection between body and psyche in the history of psychotherapy. I am aware of how this pain is connected with my own long struggle to heal this split within myself. It is also connected with the pain I felt at times around the absence of the body in my psychodynamic training, and my own ongoing difficulty in bringing this aspect of experience into the culture of psychodynamic psychotherapy. This struggle seems to be both uniquely personal to me, and at the same time part of a collective cultural struggle.

I am also very mindful that this is a uniquely “western” pain and struggle². Cultures that have been less influenced by Cartesian thinking do not share the same split between body and mind, and tend to have a more holistic worldview (Johnson, 2000). This potentially opens up vast realms of enquiry which stretch far beyond my dissertation, which is largely confined to the western fields of psychotherapy and body

²Although we are located in the Southern hemisphere where notions of “east” and “west” are imported, and have no bearing on our immediate geography, I use the term “western” as a convenient shorthand, since almost all of my subject matter and sources are also imported from Europe or North America.

psychotherapy. Although this is not something which I dwell on throughout the dissertation, it nonetheless seems vitally important to hold in mind that I am writing about a specific, limited area of human understanding. This is something that I will reflect more on in my discussion section, as I consider body psychotherapy in the context of Aotearoa New Zealand.

Conclusion

I have given an overview of some key events in the history of the body in psychoanalysis, and the development of body psychotherapy. I have described how the initial bodily focus of Freud's early work gave way to a predominantly psychic focus within psychoanalysis. This was partly connected with the expulsion of Reich and Ferenczi, who both promoted engagement with the body, from Freud's inner circle. Reich went on to develop his own "school" of body psychotherapy, which has influenced the development of most subsequent body psychotherapies, including bioenergetics. In recent decades some reconciliation seems to be happening between these historically separate approaches due to a combination of the influences of intersubjectivity, neuroscience and trauma therapy. This stands to benefit both psychoanalysis and body psychotherapy as each learns from the strengths of the other.

Chapter 4: Developmental Context of the Body as a Resource

You do not have to be good.

You do not have to walk on your knees

for a hundred miles through the desert, repenting.

You only have to let the soft animal of your body

love what it loves.

(Oliver, 1992, p. 110)

Development of the Body as a Resource

To be well-resourced, in a somatopsychic sense, seems to be a natural consequence of healthy development and attuned parenting, especially in the early months and years of life. The apparent simplicity of Mary Oliver's dictate to "let the soft animal of your body love what it loves" speaks to me of a healthy state of being where we can trust the wisdom of our bodies to guide us in life. The foundation for this connection with our instinctual somatic wisdom is ideally laid in early infancy. The last thirty years have brought a wealth of understanding about early infant development to the field of psychotherapy through developments in neurobiology and the work of researchers such as Stern (1998) and Schore (2012). It is now recognised that brain development is an intersubjective process, initially occurring through somatic, non-verbal affective communication between babies and their primary attachment figures. Babies are born with a very limited capacity for self-regulation, and thus depend on their caregivers to help them to regulate arousal and affect. This requires that caregivers are psychologically attuned to shifts in infants' states in order to regulate them, and also aware of their own misattunements, in order to repair inevitable failures. This dyadic regulation gradually facilitates the development of the infant's own capacity to self-regulate (Schore, 2012). Schore proposes that such "attachment transactions" are critical to the development of early maturing right brain systems which are "involved in the nonconscious processing of emotion, modulation of stress, self-regulation and thereby the functional origins of the bodily based affective core of the implicit self" (2012, p. 30).

As P. Ogden et al. (2006) state:

the primary sensations at the very beginning of life are physiological and tactile, and the primary form of communication immediately after birth between parent and newborn is through touch.The sense of self is first and foremost a bodily sense, experienced not through language but through the sensations and movements of the body. (p. 42)

D.W Winnicott (1954) recognised the unity of psyche and soma in early infancy, and emphasised the importance of handling and physical holding of the baby in facilitating “integration” and “personalisation” in the infant (1945). He describes healthy development, where the environment/parent actively adapts to the baby’s needs, allowing the baby to remain in the unintegrated state where “its *continuity of being is not disturbed*” thus allowing psyche and soma over time to “become involved in a process of mutual interrelation”. Then, “at a later stage the live body, with its limits and with an inside and an outside, is *felt by the individual* to form the core for the imaginative self” (D.W Winnicott, 1954). Thus the sense of self is deeply grounded in early somatic experience.

Tonella (2011, pp. 2-3) builds on Winnicott’s work, delineating a bioenergetic model of somatopsychic development during early childhood where the self develops, in relationship with his/her attachment figures, through successive phases, focused on “energy, sensations, muscular tone, emotions and representations”. Attuned, embodied parenting throughout these stages supports the development of a solid “bodyself” (Tonella, 2011, p. 1). Tonella uses the metaphor of a house to elucidate his model, thus each phase represents the floor of a house, which needs the foundation of the previous level in order to be solid and functional. Thus early sensorial and muscular development is fundamental to balanced emotional and cognitive development in subsequent phases. Tonella (2011) also points to the importance of “building stairs” within the house: that is, to develop the capacity to link each of these aspects, and to move between them at will.

Similarly, Stern (2008, p. 183) acknowledges the “importance of nonverbal concepts in providing a base for linguistic concepts and meanings” as language is acquired in subsequent development. He points out that the implicit knowledge that is nonverbal, nonsymbolic and nonconscious “does not disappear when we learn language, its repertoire simply becomes larger”. However in his description of the developing

infant's "senses of self", Stern (1998, p. 162), highlights the enormity of the transition to "the sense of a verbal self", describing the acquisition of language, often seen as a purely positive developmental step, as a "double-edged sword". Language "drives a wedge between two simultaneous forms of interpersonal experience: as it is lived and as it is verbally represented (Stern, 1998, p. 162), splitting the experience of the self. This is the point in development where the sensory experience of the body may begin to take a back seat to verbally based cognitive development.

Tuccillo (2006) reflects on the somatopsychic and relational elements which support healthy sexual development. She sees sexuality as "the core of the life force" (Tuccillo, 2006, p. 64), and believes that it is organised by early relational experiences, which provide the foundation for our relationship to our sexuality in adulthood. She proposes that the key elements of a positive early relational matrix, with respect to sexuality, are "safety, love, acceptance and nurturance of the life force, admiration and adoration, pleasure cathexis, and the model set in the relationship of the parents to each other" (Tuccillo, 2006, p. 65). I think it is important to acknowledge that a positive, healthy relationship to our sexuality is a fundamental part of experiencing our bodies as a resource.

Developmental Difficulties and Disconnection from the Body as a Resource

So far I have described some ways of understanding healthy development from a somatopsychic perspective. However, in psychotherapy we are also concerned with understanding what inhibits healthy development, and how deficits, wounds and trauma manifest in the psyche and body. Perhaps, to return to Mary Oliver, how we may metaphorically spend a lifetime walking on our knees through the desert, because that is the only way we know how to live. This image of self-inflicted physical pain and strain is particularly apt to a body psychotherapy perspective, which assumes that the form and motility of the body are affected by developmental trauma. This manifests as "body armour", a term coined by Reich to describe systematic patterns of chronic muscular tension which develop "through habitually inhibiting our impulses of emotional expression" by holding the breath and contracting the musculature (Totton, 2003, p. 72). Reich conceptualised character structure from a somatic and energetic perspective, seeing this as "the *embodiment* of trauma and defence" (Totton, 2003, p. 73), manifesting in different forms at different developmental stages.

We now know that the structure of the brain is affected by early relational trauma: “during early critical periods organised and disorganised insecure attachment histories are ‘affectively burnt in’ the infant’s rapidly developing right brain. These stressful relational experiences are encoded in unconscious internal working models” (Schoore, 2012, p. 35).

According to Winnicott, if the early environment does not actively adapt to the baby’s needs, the baby must react to the corresponding impingement. This “disturbs the continuity of the going-on-being of the new individual” (1954, p. 202). Certain kinds of environmental failure create overly active mental functioning, whereby “the thinking of the individual begins to take over and organise the caring for the psyche-soma, whereas in health it is the function of the environment to do this” (D.W Winnicott, 1954, p. 203). Winnicott describes this split-off aspect of mental functioning as a “mind-psyche, which is pathological” (1954, p. 203). Lewis (2011a), a bioenergetic therapist, has articulated the concept of “cephalic shock” (p. 113) which he describes as the psychosomatic basis for premature ego development and the “mind-psyche”, which is often localised in the head. He also links this with Winnicott’s concept of the “false self” (D.W Winnicott, 1960). Lewis describes the infant as “bracing” against unempathic, dissonant handling and holding, pointing out that “in the first weeks of life, the neuromuscular system of the head and neck is the most developed...and therefore must take the brunt of the shock...since the voluntary muscular response possible at this time is quite limited, the infant’s autonomic nervous system must become involved in this holding against the shock to its ongoing being” (Lewis, 2011a, p. 114).

Lewis describes a very early form of somatopsychic response to relational trauma. A bioenergetic understanding of character structure illuminates the ways that body and psyche are shaped by difficulties at different developmental stages. Lowen (1958/2006) developed Reich’s (1933/1972) understanding of character structure, and this is a significant aspect of bioenergetic theory, and an underpinning of clinical practice.

Conclusion

In summary, healthy development and attuned parenting support an individual to grow up with a solid sense of self, anchored in a relational matrix and grounded in a state of natural unity of mind and body. Such individuals are well resourced in a somatopsychic sense. Developmental difficulties and trauma lead to myriad forms of disconnection

between body and mind, which nonetheless manifest somatically as well as psychically. Of course to distinguish between healthy and unhealthy development is to create an artificial duality. Most human beings experience a complex mix of both healthy and unhealthy dynamics in their formative years. Clearly developmental difficulties of one kind or another tend to underpin the psychological and interpersonal difficulties that lead people into psychotherapy. Using the body as a resource in psychotherapy in a wide range of ways, as I will describe in subsequent chapters, can support clients in reconnecting mind and body.

Reflections

I notice that my own response to reading and writing about the work of clinicians, theorists and researchers such as Winnicott, Stern and Schore is a sense of tenderness, gratitude and humility. I feel as though I am in the presence of intellectual giants, who seem to delicately hold the embodied reality of the human infant in mind, at every turn, a powerful juxtaposition. I am reminded of a bioenergetic training I did with Guy Tonella³, on attachment, where I frequently had the sense that he was holding a baby as he taught. Perhaps the baby that is present is the baby-self within me, who feels seen and affirmed by these writers who eloquently acknowledge the fundamental unity of mind and body from our earliest beginnings.

³NZ Bioenergetic training group, 5-9 May 2010

Chapter 5: Awareness

Enough

Enough. These few words are enough.

If not these words, this breath.

If not this breath, this sitting here.

This opening to the life

we have refused

again and again

until now.

Until now.

(Whyte, 1990)

Introduction to Body Awareness

A central aspect of including the body in psychotherapy is the use of body awareness. For therapist and client alike, deliberately focusing one's awareness on body sensations is a gateway into a vast realm of experience and intelligence which can inform and guide psychotherapy in numerous ways. This realm is always with us, as near as the breath, and yet, as David Whyte points out, this simple life of the body may be something which we, and our clients "have refused again and again" to open our awareness to.

S. Shapiro (1996, p. 298) writes about the virtual absence of the "experiential body" in psychoanalytic theory and practice⁴. She describes this as a "complex experience which includes the whole range of somatosensory phenomena: our breath, pulse, posture, muscle strength, fatigue, clarity and speed of thought, sense of boundedness; our skin, mucous membranes, bodily tension, facial expression, taste, smell, pulse, vitality."

⁴ Far more has been written about the body by psychoanalytic practitioners since 1996. Nonetheless, I agree with Shapiro that often the ways in which the body is written about fail to include the experiential body.

Fogel (2011, p. 183) defines embodied self-awareness (ESA) as “the ability to sense, in the present moment and without mediating thought... sensorimotor feelings along with the motivational and emotional feelings that accompany them.” He outlines the neurophysiology of implicit embodiment, which is comprised of interoception, which is anatomically linked to motivation and emotion; and the body schema, which includes proprioceptive functioning. These networks can then link to an additional network which includes the anterior insula and parts of the prefrontal cortex, which brings this implicit body-related information into an embodied awareness. Fogel goes on to state that:

ESA is an essential component of all forms of human development and well-being. Its absence at any age is a form of dissociation from the lived body and is often accompanied by symptoms of depressed moods, feelings of stress and lack of control, attachment insecurity, and chronic physical disease. (2011, p. 183)

In my next chapter I will explore more relational forms of body awareness, such as somatic countertransference, however, in this chapter I suggest that there is an important place in psychotherapy for embodied self-awareness in its own right. W. F. Cornell (2008) gives a clinical vignette describing work with body awareness and movement that supports his client to explore her own self-organisation. In this piece of work, he is largely a witness as his client attends deeply to her own “process of somatic inquiry and gradual reorganisation” (2008, p. 40). Cornell suggests that

what the relational perspective too often overlooks is the fact that we as infants, children, and adults spend significant amounts of time *alone*, in a solitary relation to our own thoughts, affect states, reveries, and bodies. And when alone, we are not simply waiting desperately for someone else to show up so that we can be engaged in some sort of dyadic completion. An enormous amount of learning, of psychic growth, of self-organisation and disorganisation happen through our bodily experience when alone, engaged with one’s self in the tasks of psychomotor mastery and in interaction with the physical environment. (2008, p. 32)

While embracing the wisdom of the relational perspective, I resonate deeply with Cornell’s statement, largely through my own experience of such states, as well as my own deep appreciation for solitude. In my own process, such solitary somatic explorations (whether they be alone, in therapy, around others such as in my dance practice, or in nature) have been vitally important. Winnicott (1958) proposes that the capacity to be alone is a hallmark of emotional maturity, and that this capacity develops through “the experience of being alone in the presence of someone” (p. 418), generally

the mother, in early infancy. This unintegrated state allows the infant, in time, to experience “a sensation or an impulse” which “will feel real and be truly a personal experience” (D.W Winnicott, 1958, p. 418). This experience seems to me to be part of what this aspect of therapy may provide. Body awareness seems to be especially fundamental to this kind of internal work of self-organisation. I see this as one form of somatic resourcing.

Klopstech (2000a) outlines ways that an integrative model of therapeutic action can be applied to bioenergetic therapy, whereby the therapeutic mode shifts between one-person psychotherapy, one-and-a-half person psychotherapy, and two-person psychotherapy, according to the particular client’s needs at any given time. She suggests that

there are patients who need to spend considerable time in model 1, (*one-person psychotherapy*), becoming more directly acquainted with the life forces residing within their bodies and ‘re-establishing the body’s relationship to itself’, before any physical engagement in relationship, corrective or mutual, would be meaningful to them. And vice versa, there are patients, who first need the experience of being held in the relationship by an empathic other, before they can dare to enter their inner lives, body and soul. (Klopstech, 2000a, p. 63)

S. Shapiro (2009) who, ironically, critiques what she perceives as Cornell’s (2009) emphasis on relational body work, also advocates the use of body awareness techniques with patients, and encourages analysts to engage in their own somatic awareness work in order to deepen their capacity to work with this dimension in analysis (S. Shapiro, 1996, 2009).

Body awareness is a theme throughout much of the literature I have surveyed, both psychodynamic and body oriented. It is also a key component of the somatic approaches to trauma therapy which I will review in Chapter 8. Two significant ways that body awareness is framed and utilised are mindfulness (Sills, 2006; Weiss, 2009), and Focusing (Gendlin, 1981), although it is also frequently described in the literature without reference to these terms. Mindfulness and Focusing are comprehensive, rich practices in their own right, and extremely helpful tools for developing and deepening body awareness in psychotherapy. I will now give an overview of these two concepts.

Mindfulness

Mindfulness is an ancient Buddhist concept and practice, which has become very popular in recent years within the fields of Western psychotherapy and psychology, and indeed the wider culture. The Buddha presented the teachings of mindfulness, or “sati”, in Pali, in the satipatthana sutra, as “the very heart of the path towards liberation from suffering” (Weiss, 2009, p. 6). Weiss (2009, p. 6) defines mindfulness as a “state of consciousness that can passively observe the present moment, pleasant or unpleasant, just as it is, neither clinging to it, nor rejecting it. Typically, it is focused inward, on internal experience in general, or on specific features of its landscape”. Weiss compares the Buddhist notion of an internal compassionate observer self, with psychodynamic concepts such as the “reflexive ego”.

The work of Kabat-Zinn, Siegel and others has demonstrated the benefits of mindfulness to the Western public (Kabat-Zinn, 2005, 2009; Siegel, 2010). Linehan’s development of Dialectical Behavioural Therapy has been instrumental in bringing mindfulness practice into mental health settings (Linehan, 1993). These developments have largely removed mindfulness from its spiritual and cultural origins in Buddhism. I have mixed feelings about this. On the one hand I celebrate the fact that mindfulness is becoming increasingly integrated into mainstream western society, and the mental health system. On the other hand, it also feels disrespectful to me to appropriate what has historically been a spiritual practice, in myriad culturally specific forms around the world, for secular psychological ends. Buddhist teachers and psychotherapists such as Jack Kornfield, Tara Brach and Mark Epstein have written extensively about the relationship between Buddhist psychology and spiritual practice and Western psychotherapy (Brach, 2003; Epstein, 1995; Kornfield, 1994, 2008). I see these writers as bringing Buddhism and psychotherapy together in a way that is deeply respectful of the wisdom of both, and have found Kornfield’s teachings particularly valuable for my own practice and life.

Fronsdal (2001) points out that the body is often ignored in Western Buddhist teaching and writing, whereas he understands mindfulness practice as taught by the Buddha to be “an invitation to experience our bodies and to embody our experience” (p. 48). The Buddha was primarily “interested in understanding how we experience and perceive directly through our psycho-physical senses” (Fronsdal, 2001, p. 48). Fronsdal cites the Buddha, who said

There is one thing that when cultivated and regularly practiced leads to deep spiritual intention, to peace, to mindfulness and clear comprehension, to vision and knowledge, to a happy life here and now, and to the culmination of wisdom and awakening. And what is that one thing? Mindfulness centered on the body. (2001, pp. 47-48)

Jeremy Logan, an Insight meditation teacher, suggests that we might well use the term “bodyfulness” to talk about meditation practice, since body awareness is such a fundamental aspect of practice (J. Logan, personal communication, May 12, 2014). Kornfield (1994) writes about the tendency to use spiritual practice as a way to transcend and avoid emotional pain, and the attraction of “out-of-the-body” experiences. He states that “a true spiritual path demands something more challenging, what could be called an ‘in-the-body-experience.’ We must connect to our body, to our feelings, to our life just now, if we are to awaken” (p. 27).

Weiss (2009, p. 13) suggests that mindfulness sits naturally alongside body psychotherapy, with its emphasis on “sensing, feeling and observing the inner world”. He describes the use of mindfulness within body psychotherapy as a means of working directly with implicit memory as it emerges, privileging observation of present moment experience rather than reflection or analysis. This seems consistent with Stern’s (2004) ideas about the need to bring the present moment into central focus in psychodynamic psychotherapy rather than leaving it behind in the rush towards meaning that occurs in most psychodynamic treatment.

Focusing

“Focusing” is a specific approach to body awareness, discovered and developed by Gendlin (1981). Gendlin, in collaboration with Rogers, at the University of Chicago, conducted research into which elements in the therapy process correlated with therapeutic change. The research showed that “clients who ‘freshly referred to ongoing felt experiencing’ during the therapy sessions tended to have significantly more positive therapy outcomes than clients who merely talked about their problems or their emotions” (A. W. Cornell, 2013). Moreover, the success or failure of the therapy could be predicted from the first session, as therapy did not appear to change clients’ ability to freshly contact immediate experience. This led Gendlin to develop ways to teach this ability, which he named Focusing, which seemed so integral to effective therapy.

Focusing centres on a type of experience which Gendlin named the “felt sense” (Gendlin, 1981). “A felt sense is a freshly forming, whole, bodily sense of some life situation” (A. W. Cornell, 2013, p. xviii). It is more than an emotion or an interoceptive body sensation, although it includes aspects of these. It has “intricate, implicit meaning” (A. W. Cornell, 2013, p. xviii). Typically, when a felt sense emerges there is a pause, the person shifts their attention to their inner experience, and initially discerns something vague, murky, and difficult to put into words, before gradually identifying some words, possibly metaphorical, that fit their felt sense. When Focusing works, there is a change in the body state, a “felt shift” (Gendlin, 1981, p. 11), which in turn facilitates change in the person’s perspective on their life situation. A. W. Cornell (2013) points out that the ability to hold a compassionate, curious attitude to whatever is emerging, is crucial to successful Focusing, and that in clinical practice, the therapist models this and supports the client in developing it.

Movement

I would also like to reflect briefly on the role of movement in body awareness. In psychodynamic psychotherapy physical stillness on the part of both therapist and client generally seems to be an implicit aspect of the therapeutic frame. A still body is regarded as the optimal therapeutic presence (S. Shapiro, 1996). Certainly physical stillness has an important place in supporting and facilitating internal self-awareness, which is no doubt why it is also cultivated in most formal meditation practices. However, I believe that movement, in myriad forms, can also be an important catalyst for, as well as a means to deepen embodied self-awareness. As embodied beings, movement is our natural state. Lowen and Lowen (1977) point out that

a living body is in constant motion; only in death is it truly still. This inherent motility of a living body, which is the basis of its spontaneous activity, results from a state of inner excitement that is continually erupting on the surface in movement. (p.5)

Thus, to remain constantly still requires effort and strain. S. Shapiro (1996, p. 317) writes about this, suggesting that “we are all prisoners of this cultural preference for stillness”. It is also a feature of academic culture, as Johnson (2000) calls attention to. In my three years of formal study for my Masters in Psychotherapy I can think of only a few occasions where movement and embodied self-awareness were actively encouraged. As I work on this dissertation I struggle ongoingly with the irony of writing about the body in a cerebral, sedentary way. As I sit and write I tend to become

disconnected from my sensorial experience. Parts of my body become numb and tense, I am inclined to breathe in a shallow way. Like S. Shapiro (1996), I do not have a solution to this, only ways of managing and moderating it.

Body psychotherapy uses a wide range of active interventions including guided or free movement, for a wide range of therapeutic purposes. I will discuss some of these in Chapter 7. An important purpose of such interventions is to increase clients' embodied self-awareness. Movement is particularly central to some other forms of therapy such as dance movement therapy, however, it is unfortunately beyond the scope of my dissertation to explore this.

Conclusion

Both mindfulness and Focusing are practices that support present moment body awareness. Both emphasise the importance of cultivating an accepting, compassionate attitude towards whatever is observed, while acknowledging that this is not easy for many of us. I also suggest that movement can facilitate an additional dimension of embodied self-awareness. It seems to me that developing the capacity to compassionately observe the subtleties of our sensorial experience, is the foundation for the experience of the body as a resource.

Reflections

In revising this chapter I feel a familiar sense of flatness, dullness and boredom that seems to have dogged my writing of this chapter from the beginning. I am puzzled by this response to a topic that I have a passionate interest in. Nothing I try seems to shake it, and I wonder if it relates to the disjunction of writing about internal awareness from the outside, which feels so eternally far away from my inner experience. I decide to try to write a little about awareness, from the inside, from my body:

Dropping down, following the breath in and down to a place of stillness that is in perpetual movement. Feeling the solidity of my body holding me, earth supporting me, that I may let myself soften, become more fluid. Heart opening, sadness at how far I drift from this home that is my body. The insistent tightness in my neck, embodiment of this struggle. Movement impulse to let my head, neck, sway and release, stretching back shoulders, arms, opening chest, yawning expansion, connection from the mouth down into chest, belly, coughing as I land more deeply in visceral stuck-releasing centre,

emotion-sensation all one. Finding feet, legs, pelvis, freedom to move what is stuck, kindness for what is stuck, feeling the ground I've gained, and so many miles to go. Movement releasing and energising, bringing something new into being that would stay forever unborn in the muted, frozen, rigidity that my body has learned, is unlearning, one breath at a time.

This simple act of tuning into my body awareness, allowing and following it, describing and free associating to what I experience as I have just done has a profound effect on my energetic state. I feel more alert, alive, relaxed and grounded. This demonstrates to me once again, the importance and power of embodied self-awareness; this time from the inside. I see this as part of the conversation that is happening within me, between my mind and body, as I work on this dissertation.

Chapter 6: Communication

“There is no such thing as a body”

(Orbach, 2003, p. 11)

The Relational Body

Susie Orbach playfully paraphrases Winnicott’s famous statement “there is no such thing as a baby”, to emphasise the relational nature of our body selves. She suggests that there is “no such thing as a body, there is only a body in relationship with another body” (Orbach, 2003, p. 11). The body is slowly becoming more fully included within psychoanalysis with the development of relational and intersubjective perspectives, and the increasing awareness of somatic countertransference, which I will discuss below (Anderson, 2008; Aron & Anderson, 1998; White, 2014). At the same time, body psychotherapy approaches have been enriched and deepened by a relational focus (Ben-Shahar, 2014b; Klopstech, 2000a, 2000b, 2009). An embodied relational perspective sees therapist and client as necessarily relating and communicating somatically. Thus, in this section I will examine relational perspectives on the body⁵, and explore the somatic communication that is present in the therapeutic dyad.

From the moment of conception we develop as body selves within an intersubjective matrix, which is shaped by wider cultural constructions of embodiment and of gender. Our bodies have their own psychological and developmental histories. Our embodiment or lack thereof is directly related to early experiences of handling and holding. Our relationship to our bodies is shaped by the way our parents related to our bodies, as well as their relationships with their own bodies (Orbach, 2003, 2006). As I explored in Chapter 4, communication in the infant-mother dyad is an entirely somatic phenomenon. Orbach (2003) notes the irony that while attachment theory is an inherently physical theory, it tends to be translated into psychic terms within the field of psychotherapy.

⁵ For the purposes of this dissertation, I will tend to use the terms “relational” and “intersubjective” interchangeably and in a general way, although I recognise that proponents of these schools see significant differences between them (Ringstrom, 2010). However, in the body oriented literature I have reviewed they are generally not differentiated, and are used interchangeably. Elucidating and reflecting on the differences is beyond the scope of this dissertation, so I will follow suit.

Orbach critiques the “mentalist preoccupations” (2003, p. 6) of psychoanalysis, whereby the body is seen as an adjunct to the psyche, rather than being seen and related to in its own right. She believes that “by mentalising physical experiences we are missing crucial dimensions in our patients’ experience... (*and*) perpetuating a kind of hyper-psychism” (Orbach, 2003, p. 12). Over an extensive clinical career with a focus on body and gender related issues, Orbach slowly began to see body symptoms and bodily countertransference “less as symbolising the state of the mind, as much as representing the struggle of the body to come to therapy and to come into being” (2003, pp. 7-8). She articulates an embodied relational perspective. She suggests that clients with troubled relationships to their bodies need to use the therapist’s body as a temporary external body as they work through their body distress, and eventually become able to internalise the therapist’s body. This is similar to the notion of the therapist providing an external auxiliary ego when the client’s own ego capacity is limited or temporarily disabled (Orbach, 2003, 2006).

I see Orbach’s conceptualisation of this process as a way in which the therapist’s body may be used as a resource by the client. The solidity of the therapist’s own relationship to her body is drawn on by the client as a holding, containing force as the client allows her brittle, adaptive “false body” (Orbach, 2006, p. 99) relationship to disintegrate, in a potentially lengthy process of mourning and loss. Then, over time, the client becomes able to take in the sense of the therapist’s body, and to use it to slowly develop “an internal body that is alive and of use to herself” (Orbach, 2006, p. 101). I will write more about this aspect of Orbach’s work below, as I discuss somatic countertransference.

To my mind Orbach describes and seems to work with an intangible energy of embodiment, a deliberate stance of holding the body in mind. She writes about the need for the therapist to make her body available for the client to use, however, she does not generally seem to mean this in a physically active sense⁶. It is interesting to compare her approach with a body psychotherapy approach where the therapist may also make her physical body available for the client to use. W. F. Cornell writes of offering his clients a “somatic dyad” and “a space within which one can *act* as well as *think*, to experiment with movement, aggression, tenderness and physical contact” (2009, p. 76). He goes on

⁶ Orbach’s (2004) article, “When touch comes to therapy”, where she reflects on the use of touch, suggests that there are, however, exceptions to this.

to say that he wants his clients “to have the opportunity to affect and be affected by the actual body of another” (W. F. Cornell, 2009, p. 79), and gives an extensive case example of this type of work.

Ben-Shahar describes working with a third, intersubjective, shared body, co-created by therapist and client (Ben-Shahar, 2014a; Ben-Shahar & MacDonald, 2011). Essentially, he works in an intersubjective way that includes the body, via touch and other somatic interventions, as well as strong awareness of his somatic countertransference. Ben-Shahar and MacDonald (2011) co-write a rich, deeply honest account of MacDonald’s therapy with Ben-Shahar. I find this article inspiring, but also disturbing. It conveys the content and feeling tone of many of MacDonald’s abuse memories. Ben-Shahar describes his powerful affective and somatic responses to MacDonald. For example, he describes a strong physical nausea, which is present for him throughout much of the therapy, until the point where MacDonald’s dissociated memories begin to emerge. He also describes needing to face into his own terror, self-hate and bodily shame in the course of the work. Ben-Shahar describes a depth of “surrender to an intersubjective third, which threatens to touch and change both parties deeper than they intended to” (Ben-Shahar & MacDonald, 2011, p. 45). I feel a visceral fear as I engage with the energy of their work, via this article, which I see as connected both with the disturbing content, and my own responses to this, as well as my fear of the level of intimacy and vulnerability which such work requires of a therapist. At the same time, I am inspired and awed by the possibility of this depth of engagement and its transformative power.

Touch

The issue of touch has been a significant area of contention between the disciplines of psychoanalysis and body psychotherapy, historically, and to this day. I will digress by very briefly summarising this history, and some recent developments. Reich and Ferenczi both used touch with patients, and as I discussed in Chapter 3, both were ultimately expelled far from Freud’s psychoanalytic inner circle. Therapeutic touch remained a key component of Reichian and subsequent body psychotherapy practice, and became taboo within psychoanalysis. The main theoretical rationale for not touching patients centres on not gratifying the patient’s desires, and thereby enabling her/him to work through the painful feelings which this generates (Totton, 2003). The linking of touch with potential boundary violations seems to have cemented this position. A few clinicians, such as Winnicott, wrote about touching disturbed patients,

but it seems that “reports of unusual interventions with very primitive patients...*(were)* taken lightly as colourful exceptions” (Maroda, 2002, p. 145) by the psychoanalytic community.

In recent years, some brave psychoanalytic writers have begun to thoughtfully question the taboo on touch, the concomitant certainty that physical touch is necessarily an acting out, and the notion that all patients would always be better served by verbally working through the issues connected with the desire for touch (Maroda, 2002; McLaughlin, 2005; Orbach, 2004). I felt touched reading the reflections of these very experienced clinicians who grapple with their own vulnerabilities in addressing this issue, in service of offering the most therapeutic interventions for their patients. Maroda (2002, p. 159), in reviewing the literature and her own clinical experience, concludes that “utilising limited, nonsexual touching...can be very appropriate and therapeutic”. Reading the writing of these clinicians I am reminded of Scott Baum’s assertion during a bioenergetic training that therapists who are not trained in touch have forsaken their ethical responsibilities to their patients (S. Baum, personal communication, February 20, 2011). Indeed, writers in the field of body psychotherapy underline the importance of good training, personal therapy and supervision in using touch as a therapeutic intervention (Ben-Shahar, 2012; Ben-Shahar & MacDonald, 2011; W. F. Cornell, 2009; Totton, 2003). Halsen (1995, p. 103) states that “knowing when to touch and when not to, and how to touch, needs just as much insight and training as knowing when and how to interpret”. The use of touch clearly has the potential to intensify regressive and erotic feelings, thus the therapist has a heightened responsibility to reflect on the therapeutic purpose of the touch and its potential meaning to the client, keeping historical, interpersonal, and transference implications in mind (W. F. Cornell, 2009). It seems to me that wherever we position ourselves as therapists regarding the use of touch it is something that it is fundamentally important to think about deeply and ongoingly. For me as a new therapist, grappling with the process of integrating two theoretical paradigms, it is a challenging area, yet one which is invigorating and growth provoking to reflect on. Of course this is also connected with my own issues around touch, which it seems vital to remain conscious of and keep exploring. It is beyond the scope of my dissertation to examine the issues surrounding touch more fully, however, I will consider the use of touch again in the next chapter, as I look at its different uses in body psychotherapy.

The therapist's body

With or without physical movement and touch, deliberately bringing one's body into the therapeutic relationship implies a deeper level of involvement and exposure for the therapist which can be both challenging and enlivening. Ben-Shahar (2013, p. 9) suggests that Freud's decision to sit out of sight behind his patients may have been partly due to his own body-shame, and "apprehension about his embodied presence". Orbach (2003, p. 13) states that "it can be extremely discomforting to recognise that our bodies are being scrutinised by our patients not just for how we look but for how we are in them". However, she reframes this challenge, suggesting that "having nowhere to hide is one of the wonderful opportunities that working psychotherapeutically offers us as therapists", providing us with the necessity and impetus to reflect deeply on our own processes and to grow and expand by doing so. Moreover, it seems to me that to offer our bodies for our clients to use, to provide our bodies as resources for another, also offers us a concurrent necessity to do our own somatic work in order to maintain a grounded, embodied, vital presence. This is something that is a focus in body psychotherapy, but is seldom explicitly acknowledged in psychodynamic work. I will explore this in more depth later in this dissertation, when I discuss therapist self-resourcing, in Chapter 9.

I believe that the more we are able to be present in this way, the more capacity we have to attune to our clients' somatic communication, and also to communicate directly with them at a somatic, energetic level in therapeutic ways. Thus our conscious embodiment can in itself assist our clients to connect with their bodies. Westland (2009) gives a clinical example of how deepening her own body awareness during an assessment with a client, which was initially cognitive and superficial, supported the client in contacting a deeper level of her own being. Westland describes her own presence as becoming "more spacious and less cognitively insistent. Gradually the client *drops down into herself* (i.e. her breathing has deepened and fills more of her whole body, she looks more relaxed across her chest and arms). She slowly comes to what feel like central life statements with feeling tones attached to the words" (Westland, 2009, p. 124). This could also be understood as a process of dyadic regulation (Ben-Shahar, 2014a), wherein the therapist's self-regulation affects the client. Tonella (G. Tonella, personal communication, May 6 2010) talks about the importance of breathing consciously as a means of self-regulation and regulating countertransference, maintaining an optimal

level of vitality and the capacity to respond to the client's moment to moment experience.

Somatic Countertransference

In recent years there has been an increasing focus within psychoanalysis, on somatic communication and somatic countertransference (Bady, 1984; Balamuth, 1998; Jacobs, 1973; Kimble Wrye, 1998; Orbach, 2003; Ross, 2000). The term "somatic countertransference" (or "body countertransference" or "bodily countertransference") is used to refer to bodily sensations in the therapist that relate either to the therapist's unresolved issues, or to the client's experience (Jacobs, 1973; Kimble Wrye, 1998; Ross, 2000). I will focus primarily on the latter: somatic communication from the client to the therapist. However, from an intersubjective perspective this is a somewhat artificial distinction, since the subjectivities of both client and therapist are seen as co-creating the relational matrix within which therapy takes place (Stolorow & Atwood, 1996). Somatic phenomena and countertransference are considered to be particularly linked with early pre-verbal, affective communication between mother and baby (Jacobs, 1973; Kimble Wrye, 1998; Ross, 2000). Jacobs (1973) suggests that the regression involved in analytic listening makes the analyst particularly susceptible to such somatic communication.

Somatic countertransference is understood in different ways by different writers. It is linked with empathy (Jacobs, 1973), and the "ability to put ourselves in the skin of another person and to hear, smell, see, taste, and touch the roses and the weeds of another" (Bady, 1984, p. 530). Ross (2000) sees it as a form of projective identification (T. H. Ogden, 1979) which may be either defensive or developmental (Hinshelwood, 1991). She gives case examples of both types. In instances of defensive projective identification she describes feeling sudden, violent, powerfully visceral sensations, with an accompanying sense of being controlled. She sees this as a situation where the client is forcibly evacuating their feeling experience and violently projecting it into her. In developmental projective identification there is a more gentle form of communication of the client's early experience which she is able to receive, metabolise and then give back to the client.

Balamuth (1998) links somatic phenomena to the emerging awareness of enactments, and unlike other writers, does not seem to specifically use the term "somatic

countertransference” to describe these. Maroda (2002, p. 124) describes enactment as an “affectively driven, unconscious, mutually acted-on set of behaviours”, which she also believes is a “repetition of converging emotional scenarios from the patient’s and the analyst’s lives”. Balamuth believes that vivid body sensations are often present at the point where the analyst begins to become aware of being involved in an enactment. He suggests that awareness of the body may be key at this point since it is often awareness of a level of bodily tension and suppression of breathing that allows the analyst to become conscious of “repetitious rigidification and falsification of the authenticity of the analytic encounter - which is the stance that characterises enactments” (Balamuth, 1998, p. 280). He emphasises the importance of the analyst free associating to his own bodily experience. Balamuth notes that T. H. Ogden’s (1994) clinical descriptions of working with the intersubjective analytic third, (the dynamic interplay of analyst and patient’s subjectivities), encompass this type of attention to bodily sensations which “are experienced as significant clues to unconscious and split-off parts projected into him by the patient” (Balamuth, 1998, p. 279).

Orbach writes engagingly about a range of dramatic somatic countertransference experiences in her clinical work (Orbach, 1999, 2003, 2006). These seem to encompass different types of countertransference. She describes a number of cases where she experiences a concordant countertransference (Racker, 1957), that is, she has a somatic experience that seems to be similar to her patient’s experience of their own body, and is indicative of the early object relations that shaped their relationship to their body. For example, Orbach (2006) describes a concordant countertransference with her client Colette, where she finds herself feeling dowdy, unattractive and negative towards her own body in relation to Colette. This constellation begins to shift after Orbach has a dramatic experience of feeling an intense burning sensation across her skin, while writing her notes after a session with Colette. At the next session, Colette tells her, for the first time, that she had a brother who burned to death as an infant, before she was born. Orbach comes to understand this unusual bodily countertransference as encoding “a sense of grief, horror, agony, shame, fear and hesitation that may have lain inside her mother’s body and that her mother brought to her physical mothering of Colette” (Orbach, 2006, p. 103). Thus we can perhaps understand this as a complementary countertransference (Racker, 1957) of Colette’s experience of her mother, albeit a complex and unusual one. The awareness that Orbach gains through this somatic

countertransference seems to be instrumental in deepening the affective work of Colette's therapy. Orbach says that:

working through these emotional cadences in my body and finding words to speak of bodies that were desolate, bleak, and sorrowful we began to break up the viscera of Colette's monolithically false body and to enliven it, albeit with painful affective states of sorrow and sadness. (2006, p. 104)

Thus Colette moves into a period of mourning, in her therapy. As she begins to claim her desire to have "her body and not her mother's" (Orbach, 2006, p. 104), Orbach begins to feel less dowdy, and to have a sense that Colette is starting to be able to absorb and make use of her body.

Orbach also describes some somatic experiences she has which she understands as becoming, transferentially, what her patients need her to be. For example, she has an intense, visceral fear of being violently raped by her client, Rob, which she comes to understand as "a corporeal translation of a famous Winnicottian paradoxical formulation: the patient needs to destroy the object and the analyst needs to survive the destruction" (Orbach, 2003, p. 6). She feels that she needs to receive Rob's hatred and aggression at a bodily level, and to manage her fear, allowing herself to be disturbed, but not to collapse. She feels that she is required to "remain stable, rooted in my own body in order for there to be a body in the room for him. He could only put together a body for himself via a violent encounter with another" (Orbach, 2003, p. 6).

She also describes a more pleasant experience where she has a sense of deep physical contentment and wellbeing such that she feels like a purring cat, with a client who has a troubled body. She understands that:

with Herta, my purring body became the means by which she could relinquish her hated, diseased body. She needed a body in the room that was wonderfully at peace and bountiful, and she had conjured one up for me to hold and inhabit since she was not yet able to do this for herself. (Orbach, 2006, p. 102)

I wonder if this can also be understood as a form of complementary countertransference, where the patient invokes the good object, or self-object they require, in the therapist? This seems different from the usual understandings of countertransference, where the therapist experiences feeling like one of the client's objects may have actually felt. In this case, it seems that Orbach feels something that, as far as we know, the client has

never experienced herself or with another. I find this a delightfully hopeful and creative possibility, that a client could generate in the therapist the qualities that they most need, that they can then slowly internalise.

Orbach's descriptions of her work with somatic countertransference demonstrate how integral this can be to the therapy process. Orbach seems to imply that body countertransference often expresses something that the patient is not able to acknowledge/feel or work through. By receiving and metabolising this form of communication, she is able to use it to follow the patient's innate bodily wisdom, in whatever creative form it expresses itself. The different articles I have reviewed have described such communication as somatic countertransference, "body empathy" (Jacobs, 1973, p. 87), projective identification and enactment. It seems to me that different theoretical concepts are used to understand very similar phenomena: communication from the client to the therapist at a somatic level. I see this as a way that the therapist can, in a sense, draw on the client's somatic communication, via their own bodily experience, as a resource to inform the therapy.

This is something that has become more widely understood and accepted within psychoanalysis over the last thirty years. I had a strong visceral response of sadness and anger to Ross's opening statement in her article on somatic countertransference: "It is difficult to write with any erudition about something that feels strange, bizarre, and downright shameful" (2000, p. 451). Although she describes her subsequent reading as helping to rescue her from her "quagmire of negative associations to somatising" (Ross, 2000, p. 456); her initial statement does seem to capture something painfully apt about some of the negative attitudes within psychoanalysis towards somatic phenomena, and how these attitudes become internalised. Nonetheless, this is slowly changing as "erudite" voices within and beyond psychoanalysis reclaim somatic communication as a highly organised, sophisticated phenomenon that operates throughout the human lifespan (Schoore, 2012; Stern, 2008).

Conclusion

I have described the intersubjective perspective as a basis for understanding the phenomenon of somatic communication. I have detailed some ways in which the therapist's body may be drawn on as a resource by the client, particularly via the therapist's communication of their own felt sense of embodiment. I have then described

the concept of somatic countertransference, as a means by which the therapist may receive somatic information about their client's experience. This may inform the therapy in significant ways.

Reflections

In rereading this section my appreciation for Orbach's writing is very apparent. I admire her insistence on speaking on behalf of the body in a field where the body has traditionally been seen "only metaphorically" (Orbach, 2006, p. 96). I find her writing powerfully engaging, inspiring and enlivening. Her case examples of her somatic countertransference provide me with ways to describe this, as for ethical reasons I am unable to write about my own experiences. Moreover, Orbach's experiences are infinitely more colourful than anything I have experienced thus far. I will, however, conclude this section with some of my own musings on hypothetical somatic countertransference states, as a way of exploring how my body may respond to different clients.

Listening to my own body in the presence of another, how does my immersion into being with, receiving the other, shape my very breath...?

Noticing...where I am not breathing, where I feel pulled up, out of my body into a shared trance of verbal virtuosity. Feeling like only the mind exists, all of my energy spinning busily in my head. Bringing myself back down into my heart, my belly, my feet. Speaking simply from this place, breaking the spell for a moment.....

Feeling a heaviness in my limbs, a stupor, like an anaesthetic seeping into my bloodstream. A powerful struggle to keep my eyes open and stay with this one, who speaks robotically, hypnotically. A strong pull to check out, to not be here, to give up.....

Feeling my heart, ache in my chest, longing to wrap this vulnerable little one in a blanket, ever so delicately, and sing her to sleep, protecting her from the endless intrusions of harsh reality. My body feeling her raw fragility as my own, as though my skin is so thin that the world floods in.....

My body as receiver, resonant, open to what passes between us yet grounded enough to orient us both in the here and now, sooner or later, to find words for the wordless and offer them.

Chapter 7: Shifting States - Somatic Interventions

“Put the psyche in motion and it will heal itself”

(Roth, 1989)

General Introduction to “Shifting States”

The theme of “shifting states” has, for me, unified the material I will discuss in the next three chapters. “Shifting states” is an expression I learned from Michael Maley (M. Maley, personal communication, December 5, 2012)⁷, in relation to helping clients to develop skills, in the stabilisation phase of trauma therapy. He describes the ability to shift states as an essential capacity for clients to develop in order to work with trauma. Essentially this means that they are able to alter their level of arousal, and to be in present time.

I will write about trauma therapy in Chapter 8, however, I am also extending the meaning of this phrase, “shifting states”, to encompass broader dimensions of therapeutic change connected with somatic, energetic and emotional shifts. I see the capacity to shift states as connected with self-regulation at each of these levels: somatic, energetic and emotional. Somehow for me this phrase captures a sense of movement, fluidity, and ultimately freedom. The quote from Gabrielle Roth, which I begin this section with, likewise encapsulates the healing power of movement, and the body-mind’s innate healing capacities. Working directly with the body can facilitate changes of state in a very immediate way. Consistent, ongoing, mindful work with the body can, I believe, create lasting, integrated change in the body-mind⁸. Thus, I see the notion of shifting states as integral to experiencing and using the body as a resource. This is a vast subject, which I will explore, necessarily to a limited extent, through the lens of several different topics. Firstly, in this chapter, I look at how body psychotherapy may use somatic interventions to facilitate shifting states. Secondly, in Chapter 8 I review

⁷ Bioenergetic training module on “Trauma and shame”, with Michael Maley, Wellington, December 5-9 2012.

⁸ This is a good rationale for giving somatic exercises as “homework” for clients, and for clients and therapists alike to engage in regular somatic practices, as Lowen and Lowen (1977) and S. Shapiro (1996) suggest.

somatic approaches to trauma therapy. Finally, in Chapter 9, I consider how therapists may resource themselves at a somatic level.

Somatic interventions

Introduction

Body psychotherapy utilises a vast range of physical interventions⁹, for myriad therapeutic purposes. In this section I will describe and reflect on some of these, with a particular focus on the bioenergetic approach. It feels somewhat artificial and unnatural to write about such interventions outside the context of the therapeutic process which they are usually embedded in, so clearly this chapter presents an incomplete picture of bioenergetics as a psychotherapy. However, it is my conviction that the somatic techniques that differentiate the practice of body psychotherapy from other forms of therapy are important resources, which deserve specific attention. Moreover, this chapter feels like another attempt on the part of the experiential body, the actual body, to assert its presence in this conversation, to summon attention to its solidity, fluidity, simplicity and mystery. With the use of somatic techniques in therapy, the body is present in a very immediate, concrete way, literally bringing another dimension into the therapeutic process.

The notion of “shifting states” seems to me to capture an essential quality of the many different purposes a therapist may use somatic interventions for. One technique may have many different purposes. For example, I think about my own use of grounding techniques (which I will describe shortly) in different clinical situations. I have used these exercises at various times with clients who are dissociating, to help them come back to their bodies and to the present moment. I have used them with clients who are in an anxious state, clients who are generally disconnected from their somatic experience or emotions, and clients who are hyperaroused and distressed. In each case, the exercises seem to have facilitated an energetic shift, to a greater or lesser degree, from one state to another, in a way that seems to have been therapeutically helpful in that moment. This can also be understood as a means of helping clients to regulate their arousal and affect, and learning to use the body as a resource.

⁹ I notice my ambivalence about the use of the word “intervention”, which for me conveys the idea of an “expert” therapist doing something to a passive client. Perhaps the notion of a somatic “exploration” or “experiment” is closer to the spirit of inquiry that I see as fundamental to psychotherapy. Nonetheless, the notion of intervening does suggest doing something that causes change, so in that sense it seems apt.

Lowen defines therapeutic growth as “an increasing ability to integrate more excitation and more feeling into one’s life and actions” (Lowen, 2011, p. 46), an integration which requires “expanding or changing the body so it can tolerate more excitation and aliveness” (Lowen, 2011, p. 46). This kind of work with the body to expand its capacity for aliveness and the flow of energy is a fundamental aspect of “shifting states” within bioenergetic therapy.

Of course, somatic techniques are only tools, and psychotherapy involves using such techniques judiciously, with awareness of the therapeutic relationship, of the client’s specific issues and process, as well as transference and countertransference. Klopstech comments on the enormous, potentially bewildering complexity of integrating psychoanalytic awareness with body psychotherapy work, saying “and you thought psychoanalysis was the impossible profession!” (Klopstech, 2000a, p. 64). Her comments certainly resonate with my feelings of overwhelm at times as I contemplate this task of integration.

Grounding

I will begin by discussing grounding, a foundational concept within bioenergetics, articulated and developed by Alexander Lowen. As Judith (2004) notes, grounding is also a developmental foundation, and is thus a primary task in a somatic psychotherapy for anyone who is insufficiently grounded. In practice, grounding generally consists of simple exercises centred on movements with the feet and legs, which the therapist demonstrates and guides the client through, encouraging them to be mindful of body sensations and feelings, as they practice. For example, one of my favourite grounding exercises involves standing on both feet, and shifting all of one’s body weight onto one foot at a time, with the knee bent, for a minute or two. This exercise mobilises sensation in the legs and feet (Lowen & Lowen 1977).

The underlying purpose of grounding is to facilitate somatic, energetic and emotional connection with the earth, and with a deeper centre of gravity within one’s body, thereby increasing one’s sense of security (Lowen & Lowen 1977). Lowen (1975) sees grounding as synonymous with being in touch with reality. Being grounded enables a person to tolerate greater levels of affect and charge, and to discharge excess excitation (Lowen, 1975). Grounding manifests differently at different somatopsychic developmental stages; for example in infancy it is connected with being held, with the

mother's body experienced as "ground", and with a more "horizontal" alignment, whereas in adulthood it is more connected with standing in a "vertical" alignment and connected with self-possession and autonomy, (Conger, 1994; Maley, 2002; Totton, 2003). At any stage of life it is a deeply relational concept whereby "you are literally exchanging energy with the planet under your feet and you are both nourishing and being nourished through that connection" (Maley, 2002, p. 19).

Breathing and movement

I will now look briefly at the importance of breathing in body psychotherapy, and how the breath may be worked with. Clearly, breathing is fundamental to life, and attention to the breath is central in body psychotherapy since constricting the breath is one of the fundamental ways we learn, as young children, to inhibit our feelings (Lowen, 2004; Totton, 2003). Thus, "restoring the client's capacity to breathe fully and freely" is a central goal of body psychotherapies in the Reichian tradition. "It is not a matter of willed, deliberate deep-breathing, but of surrender to our spontaneous breath" (Totton, 2003, p. 83).

In bioenergetics, breathing, movement and feeling are seen as profoundly interconnected. Holding the breath reduces the motility of the body and cuts off feeling. Chronic muscular tension and constrictions in breathing patterns are mutually reinforcing, and support the suppression of feelings. Thus bioenergetics works with each of these elements, often in conjunction (Lowen, 2004; Maley, 2002). The breath may be worked with through awareness and encouragement to breathe deeply and naturally, through exercises that open up the chest and diaphragm, such as stretching back over a Swiss ball or bioenergetic stool¹⁰, and through exercises that induce involuntary vibratory movements, by placing the body in a stressed position (the grounding exercise I mentioned above could be one example). Bioenergetics also uses conscious expressive movements as part of the organic flow of therapeutic work. For example, these might include movements such as hitting a pile of mattresses with a tennis racket, developing the capacity to express negativity, hostility and anger in an embodied, grounded way; or reaching out with the arms, expressing tenderness and desire. These exercises can release muscular tension and allow the breath to deepen, enabling a fuller connection with embodied feelings.

¹⁰ A bioenergetic stool is a padded wooden stool, about 80cm high, which one stretches back over, resting the back of the chest on the stool. This stretches the back muscles, and spontaneously deepens the breathing.

Lowen and Lowen (1977) stress that doing exercises mechanically or compulsively will provide little benefit. However, there can also be great value in doing certain exercises as a regular practice in order to strengthen underdeveloped somatopsychic capacities, which Lowen advocated (Lowen & Lowen 1977).

Such bioenergetic exercises work with the underlying principles of energetic charge and discharge, which are worked with together “to raise a person’s energy level, to open up his self-expression and to restore the flow of feeling in his body” (Lowen, 1975, p. 50). Including somatic work with powerful forces such as aggression and sexuality as part of the therapeutic process can gradually enable a more integrated, clear, embodied relationship with these aspects of one’s being. Thus the full life-force energy of the body becomes more available as a resource.

Moss (1996) critiques the fact that the classical bioenergetic approach frequently uses exercises which impose physical stress and strain on the body, and are often experienced as painful. She describes developing her own modality, Feminist Body Psychotherapy, in response to both her discomfort with this aspect of traditional body psychotherapy, and with the sexism and homophobia she experienced in psychoanalysis and body psychotherapy in the 1960s and 70s. She was strongly influenced by body therapy approaches originating from the work of Elsa Gindler. This led her to develop gentler exercises working with breathing, awareness, movement and touch, which “create the space to open” (Moss, 1996, p. 66). In some respects I share Moss’s views in that at times I question the value of techniques which cause pain, and which foster an attitude of “pushing through”(Moss, 1996, p. 67) defenses. She and numerous others both within bioenergetics and in the wider body psychotherapy community have contributed to the development of subtler (and more relational) ways of working over the last thirty years or more.

I see classical bioenergetics as developed by Lowen, informed by psychoanalytic drive theory and Freudian ego psychology, as both a response to the deeper needs of its time, and in some ways as a product of its time. The conservative, repressed cultural climate of 1950’s America was ripe for a therapeutic approach emphasising emotional expression and catharsis. By contrast, in the current era there may be more need to work

somatically with containment than with active expression (G. Tonella, personal communication, May 7 2010).

Nonetheless, as I have described I think there is great value in expressive techniques, which it would be unfortunate to lose sight of. Exercises which stress the body, and those that promote more vigorous movement and expression may often be helpful and necessary in restoring connection with the embodied life-force energy. I also resonate with Klopstech's (2011) reflections on the current backlash within body psychotherapy against catharsis and cathartic techniques: a counterreaction against the overuse of catharsis in previous eras. She suggests that some possible factors in this counterreaction are the attempted rapprochement with mainstream therapy schools, as well as political correctness and the "feminisation" of the profession of psychotherapy. She proposes that cathartic experiences and interventions which promote catharsis can be an important part of body psychotherapy if they "become integrated within the patient's self and are transitioned and extended into her everyday life - with its lower levels of intensity" (Klopstech, 2011, p. 442).

Touch

Another important intervention in many body psychotherapies is touch¹¹. Touch is seen as an important medium of communication. Davis (2012) lists some specific reasons for the use of touch in bioenergetics, such as releasing tension or energetic blocks, assisting with grounding, providing containment or offering boundaries, providing protection and safety, providing support, working with resistance, and providing nonverbal contact when working with nonverbal or preverbal material. Westland (2011) reviews the literature on touch in psychotherapy and summarises the many different reasons that touch may be used. Some additional reasons to use touch that she names are: to dissipate transference and to make the symbolic concrete (for example, in trauma work), to provoke catharsis and emotional expression in emotionally defended clients, to increase energy flow and allow breathing to deepen.

In traditional bioenergetics, touch, as well as the other interventions described above, tended to be used within a one-person model of psychotherapy. As contemporary bioenergetic therapists and theorists have integrated more relational approaches and

¹¹ Not all body psychotherapists use touch, and those that do may not use it with all clients. Babette Rothschild is a notable example of a body psychotherapist who does not use touch.

theories, this model has become less prevalent, while still being an important aspect of the bioenergetic approach. Klopstech (2000a), follows Stark (1999) in proposing that body psychotherapists need to become conversant with all three modes of therapeutic action; that is, to be able to move between a one-person, one-and-a-half-person, and two-person therapeutic stance. She suggests that therapists need to be able to move between these models according to different clients' needs in the moment, perhaps many times in one session, although she also believes we will tend to use one model as our "home base". Klopstech (2000a) uses hypothetical clinical examples to illustrate how a similar somatic intervention may be used with a different emphasis or focus in each different therapeutic mode.

In a similar vein, Asheri (2009), describes the approach to relational body psychotherapy which developed at the Chiron Centre¹². She advocates holding the possibility of touch as an intervention that can be appropriate or inappropriate in any given moment, depending on the developmental state that the client is in, and in relation to the intersubjective space. She proposes that the use of touch needs to be "a living, creative, dialectic process of constant negotiation...according to the shifting sand of the intersubjective meeting" (Asheri, 2009, p. 111). She gives an extensive case example of her work which illustrates the subtlety, complexity and richness of this approach. She points out that this approach challenges the therapist as well as the client, to "walk to the edge of (*their*) safety zone and flirt with possibilities which are less familiar and less settled within habitual patterns of predictable therapeutic interventions" (Asheri, 2009, p. 119), and that, if this is done consciously, skilfully and ethically, it can be powerfully transformative.

Conclusion

I have described a range of ways that the physical body may be worked with as part of a bioenergetic psychotherapy. I see grounding, breathing, movement and touch as resources that may all be incorporated into the therapy at different times, for myriad therapeutic purposes, enabling somatic, energetic and emotional shifts. They may support the development of self-regulation and expand the body-mind's capacity to tolerate excitation and aliveness. Such somatic interventions and practices can enable

¹² The Chiron Centre in London provided body psychotherapy training for over 20 years, and developed an embodied, integral and relational approach to psychotherapy.

clients to cultivate somatic resources that may have been lacking in their early development, and to come into a relationship with the body as a resource.

Chapter 8: Shifting States - Trauma

Introduction

Developments in the last twenty years in the field of trauma therapy have brought the body to centre stage in this area of psychotherapy. The connection between mind and body in the psychophysiology of trauma is hard to ignore. The characteristics of posttraumatic stress disorder (PTSD) include an array of interconnected somatic, affective and cognitive symptoms. These include chronic alterations in the physiological stress response, hyperarousal, amnesia, hypermnesia, anxiety and panic, nightmares and flashbacks. Trauma can interfere with declarative memory¹³, thus trauma memories are frequently stored in a somatosensory form (Van der Kolk, 1994). Hence, trauma survivors may be plagued by disturbing somatic symptoms, and it may be difficult and frightening for them to be present in their bodies.

There is a growing body of literature written by somatic psychotherapists who have developed approaches to trauma therapy that work directly with the body. I will describe, compare, and reflect on these approaches: Somatic Experiencing, developed by Peter Levine (Levine, 1997, 2010), Sensorimotor Psychotherapy, developed by Pat Ogden and colleagues, (P. Ogden & Minton, 2000; P. Ogden et al., 2006), and Babette Rothschild's (2000), approach to trauma therapy. All of these approaches help clients to shift states, or modulate their arousal using the body, as a foundation for trauma work. Somatic Experiencing and Sensorimotor Psychotherapy also articulate specifically somatic approaches to processing trauma. Eye Movement Desensitisation and Reprocessing (EMDR) (F. Shapiro, 2001) is another approach to trauma therapy which also considers the somatic level, however, it is beyond the scope of my dissertation to explore this.

Somatic Experiencing - Peter Levine

Levine (1997, 2010) draws on the study of the behaviour of animals in the wild to reflect on both the development and the healing of trauma in humans. He views PTSD as the consequence of a natural process gone awry, and emphasises our innate, organismic capacity to heal from trauma. Describing the body as a resource for healing,

¹³ The term "declarative memory" relates to long term memories that can be consciously recalled in words. In contrast, procedural memory describes unconscious memories such as skills.

Levine writes: “held within the symptoms of trauma are the very energies, potentials and resources necessary for their constructive transformation” (1997, p. 37).

Levine (1997) points out that the human nervous system is essentially the same as that of animals, and that it responds in the same way to life-threatening situations. However, animals in the wild do not develop chronic trauma. Levine (1997) suggests that, unlike animals, humans tend to override their instinctual responses, which may predispose us to developing traumatic symptoms. In the wild, when an animal is threatened, the organismic response is one of intense arousal, priming the animal to fight or flee. Where neither of these solutions is effective, the third option of freezing/immobility comes into play, an adaptive response to attack by a predator. In animals, the transition from this state of immobility or from other hyperaroused states, back to a normal homeostasis, is accompanied by a physical discharge of energy involving vibrating and trembling. This is the organism’s way of regulating very different states of nervous system activation. Levine (1997) notes that there is an enormous amount of energy mobilised in the fight/flight response. In moving into the freeze response, an intensely forceful turbulence is created. Levine (1997) likens this to driving and simultaneously accelerating and slamming on the brakes. He essentially states that traumatic symptoms are caused by the frozen residue of energy that has not been resolved through an active response, or discharged. He sees this physiological discharge, and the completion of instinctive responses, as the key to healing (as well as preventing) trauma.

Levine (1997) states that in human beings the neo-cortex may, through fear, override the instinctual need to discharge energy. He emphasises that “if we are highly activated and terrified upon entering the immobility state, we will move out of it in a similar manner” (Levine, 1997, p. 102). This is biologically appropriate, as survival may depend on mobilising violent aggression, or making a frantic escape. However, in chronically traumatised humans, the fear of this intense energy, and the overpowering surges of emotion that may accompany it, tend to “reactivate the immobility, extending it, often indefinitely, in the form of frozen terror. This is the vicious circle of trauma” (Levine, 1997, p. 109).

Levine (1997) argues that in healing trauma there is a need to access and integrate these biological energies, and to actively complete the freezing response. He proposes that developing facility with the “felt sense” (Gendlin, 1981) (as described in Chapter 5 of

this dissertation) is a foundational requirement for this work. This is a way to listen to and track somatic and emotional experience, by following the stream of our body sensations in their totality, and their rhythmic variations. Levine (2010, p. 137) notes that “helping clients cultivate and regulate the capacity for tolerating extreme sensations, through reflective self-awareness, while supporting self-acceptance, allows them to modulate their uncomfortable sensations and feelings”. Other key Somatic Experiencing processes include supporting clients to develop active, empowered defensive responses in place of the passive responses of collapse and helplessness; uncoupling the conditioned associations of fear and helplessness from the biological immobility response; and supporting the discharge of energy mobilised for life-preserving action, to resolve states of hyperarousal (Levine, 2010). Levine (2010) also emphasises the need to move through these processes in a gradual, gentle way, utilising pendulation and titration: moving in and out of hyperaroused states, and touching into small amounts of difficult sensations at a time, to keep clients within the “therapeutic window”, defined by Briere and Scott (2006) as “a psychological midpoint between inadequate and overwhelming activation of trauma-related emotion during treatment” (p. 125).

Levine (2010) outlines some case examples, describing the strong focus on body sensations that is a hallmark of his work. The interventions described above are worked with at a bodily level. The therapist supports the client in noticing and tracking their body sensations in working with traumatic memories, and guides or encourages them to allow the body’s instinctive responses to complete themselves. A common example of this is working with the instinctual flight response by encouraging a client to physically feel the urge to run in their legs and to allow the legs to move while connecting with the physical sense of strength, power and agency in this part of the body. Levine (2010) warns that premature cognition, and attempts to make sense of one’s experience before allowing the body to complete such inhibited actions only interferes with trauma resolution. Likewise he critiques the emphasis on memory retrieval and emotional abreaction in some forms of trauma therapy, which he believes can be retraumatising, reinforcing the sensations of collapse and feelings of helplessness.

I feel very inspired by Levine’s deep faith in the body’s instinctual healing capacity, born of decades of experience working with traumatised clients. He sees the body as a resource for healing and transformation, and articulates a theoretical framework for this

vision. I find the tone of his writing immensely, overtly hopeful, a quality that seems profoundly needed in working with trauma. Levine (1997) also writes in an accessible way, bringing his understandings about trauma to a wide, non-clinical audience, and encouraging people to work with his techniques for themselves, while repeatedly emphasising the importance of accessing the help of a therapist in working with complex or overwhelming issues. Thus he contributes to a valuable democratisation of the process of healing from trauma. However, as P. Ogden and Minton (2000, pp. 150-151) point out, Somatic Experiencing “does not specifically include therapeutic maps to address cognitive or emotional processing”. Moreover, while acknowledging the importance of safety, Levine does not specifically work with the therapeutic relationship or transference and countertransference. He proposes a “discharge” model of therapeutic change, which I think has value, but is oversimplistic in regards to working with complex trauma, as I will describe below. Thus, it seems to me that his approach is best suited to working with shock trauma: one off life-threatening incidents, rather than ongoing historical trauma, or developmental trauma.

Lewis (2011b) critiques Levine’s approach as regards working with developmental trauma. He proposes that the application of an ethological model to human beings must also consider attachment theory and research. He suggests that Levine’s ethological theory does not pay enough attention to the differences between species, such as the prolonged helplessness of human infants compared to other animals. In early developmental trauma the “perpetrator” is generally also the attachment figure. In a dangerous situation, human infants are hardwired to engage in “proximity seeking behaviour” (Ainsworth & Bell, 1970; Bowlby, 1982) towards their attachment figure. An infant’s cries of distress in an abusive situation can thus be seen as both an organismic “fight” response, at the level the infant is capable of, and also as proximity seeking behaviour. If the infant’s attachment figure has no capacity to attune to their distress over a prolonged period, this may result in cephalic shock (Lewis, 2011a), which I discussed in Chapter 4. In working with adult clients with such chronic developmental trauma, Lewis proposes that Levine’s model is inadequate. He compares it to traditional bioenergetic/Reichian models wherein the body’s spontaneous motility is seen as the essential curative agent, and there is little focus on the therapeutic relationship. Lewis emphasises the vital importance of the therapeutic relationship, in supporting clients to slowly internalise emotional self-regulation, when this has not developed in childhood. However, he also suggests that Levine himself, may in fact be

doing this in his clinical work, as he attunes to his client's felt sense, without explicitly considering this as part of the therapy.

Sensorimotor Psychotherapy - Pat Ogden

Sensorimotor Psychotherapy (P. Ogden & Minton, 2000; P. Ogden et al., 2006) is another significant somatic approach to trauma therapy. Like Levine's approach, it focuses on sensorimotor processing, while also integrating this with emotional and cognitive processing. This model also includes a strong focus on the therapeutic relationship, as well as attention to transference dynamics. Thus I find Sensorimotor Psychotherapy more comprehensive than Somatic Experiencing, and more compatible with a psychodynamic approach. P. Ogden and Minton (2000, p. 149) define Sensorimotor Psychotherapy as "a method for facilitating the processing of unassimilated sensorimotor reactions to trauma and for resolving the destructive effects of these reactions on cognitive and emotional experience". Sensorimotor Psychotherapy uses the body "as a primary entry point in processing trauma" (P. Ogden & Minton, 2000, p. 149), which then, in turn, facilitates emotional and cognitive processing.

Mindful tracking of body sensations is at the heart of Sensorimotor Psychotherapy. Unlike Levine, P. Ogden and Minton (2000) differentiate this from the "felt sense" (Gendlin, 1981), which can include emotional and cognitive elements. They emphasise the importance of clients learning to distinguish between physical sensations and trauma based emotions. By focusing solely on physical sensations, in the early stages of trauma stabilisation, clients limit the amount of information processing they engage in at any one time, which gradually assists in regulation of arousal. P. Ogden and Minton (2000) propose that the therapist initially acts as an "auxiliary cortex" for the client, observing and contacting sensorimotor states in the client, and regulating their arousal through the therapeutic relationship. There is a focus on right brain to right brain communication, therefore "the therapist pays equal or greater attention to the client's nervous system and bodily communication than to language and meaning-making" (Fisher, 2011, p. 103). P. Ogden and Minton (2000) see this dyadic regulation as engaging the "Social Engagement System" (Porges, 1995, 2011), the ventral vagal branch of the parasympathetic nervous system, which regulates nervous system arousal. At the same time, the client gradually develops their capacity for mindful tracking of body sensations, and for self-regulation. Similarly to Levine, P. Ogden and Minton (2000, p. 164) believe that "*failed active defensive responses* along with the inability to modulate

arousal can be sources of...distressing bodily experiences, and that this distress can be at least somewhat alleviated by helping clients experience the somatic sequence of an active defensive response”.

(P. Ogden & Minton, 2000) describe a hierarchy of levels of information processing: sensorimotor, emotional and cognitive, which largely correlate with the lower, subcortical; middle, limbic; and upper, cortical areas of the brain. They point out that sensorimotor processing is in many ways foundational to the other, higher levels of processing, both developmentally and in general functioning. Much adult functioning is based on top-down processing, whereby the higher, cortical areas control and override the subcortical and limbic activity. The activities of very young children, by contrast, are generally dominated by bottom-up sensorimotor and emotional processes, unregulated by their as-yet undeveloped cognition. Similarly, trauma survivors are frequently overwhelmed by sensorimotor and emotional processes, which they have lost the capacity to regulate.

Traditionally, trauma therapy has utilised top-down techniques to manage sensorimotor and emotional processes. P. Ogden and Minton (2000, p. 154) state that “such top-down processing alone may manage sensorimotor reactions, but may not effectuate their full assimilation”. Thus they advocate utilising the top-down, cognitive function of mindfully tracking body sensations and impulses, “to *support* rather than *manage* sensorimotor processing” (P. Ogden & Minton, 2000, p. 154). They note that clients’ “awareness and processing of sensorimotor reactions exert(s) a positive influence on emotional and cognitive processing, and vice versa” (P. Ogden et al., 2006). Within a therapy session the therapist must evaluate which level of processing to focus on at any given time, sensorimotor, emotional or cognitive.

(Herbert, 2006) outlines an “integrative three systems approach” to complex trauma, also emphasising the need for clients to “experience a balanced flow of communication between all three systems of the brain” (Herbert, 2006 p. 152). She advocates the use of a variety of therapeutic modalities, as she sees any one approach as too limited. She stresses the importance of bottom-up processing, using non-verbal methods of working with sensory material, such as Somatic Experiencing and Rothschild’s (2000)

approaches. However, she does not mention Ogden's work, which seems like a significant oversight¹⁴.

Sensorimotor Psychotherapy is well suited to working with developmental and relational trauma, including early trauma. Janina Fisher (2011) gives a case example of her work with a young woman, Mariela, who experiences intense emotional reactivity to disappointment or misattunement in her relationships with men. She spent the first nine months of her life in a Romanian orphanage, prior to adoption. Although she has no declarative memory of the traumatic neglect that she experienced, Fisher points out that she nonetheless "remembers" this emotionally and behaviourally, since early experiences are stored as "body 'memories', procedurally learnt emotional, autonomic, motoric, visceral and meaning-making states" (Fisher, 2011, p. 99). Therefore, the body can both reveal procedurally learnt tendencies, and can also provide a vehicle for therapeutic intervention. Fisher describes working with Mariela, using movement and physical actions to gradually change her embodied attachment memories. For example, Mariela tends to open too much, too soon, emotionally and somatically, in relationships, causing her to be overly vulnerable to misattunements, and then closes down intensely. Both of these tendencies would have been adaptive in the orphanage situation. Fisher describes working somatically with Mariela to have her use her arms to open and close the chest a little, rather than a lot, as a securely attached child might, to learn to tolerate disruptions. Over time, this type of work can develop new somatic resources, which were not developed in childhood.

Somatic Trauma Therapy - Babette Rothschild

Rothschild (2000)¹⁵ has also made an extensive contribution to somatic trauma therapy. I will refer to some of her ideas in more detail in the next chapter of my dissertation, so I will give a briefer summary of her approach here. Rothschild (2000) also describes the neurophysiology of PTSD, and of somatic memory as a basis for somatic interventions. She places a very strong emphasis on building safety, resourcing, and especially on teaching clients to "put on the brakes" (Rothschild, 2000, p. 79); to regulate their hyperarousal, before proceeding with trauma work. Rothschild (2004a) emphasises the importance of maintaining low enough arousal in therapy, to ensure the effective

¹⁴ Ogden's first book about Sensorimotor psychotherapy, (P. Ogden et al., 2006), was published the same year as Herbert's article. However, Ogden first developed Sensorimotor psychotherapy in the 1980s and had already published a number of articles, for example, P. Ogden and Minton (2000).

¹⁵ Rothschild describes her work as "somatic trauma therapy", however, as far as I can understand this seems to be a description rather than a name for her specific approach.

functioning of the hippocampus. The hippocampus “helps to process information and lends time and spatial context to memories of events” (Rothschild, 2004a, p. 3).

Rothschild (2000, 2004a) describes a range of somatic techniques which can assist clients in “putting on the brakes”: awareness of body sensations, developing “dual awareness”- the capacity to observe the activation of trauma memories and states, while maintaining awareness of safety in the present, working with interpersonal boundaries by ascertaining that the therapist sits far enough away for the client to feel comfortable, and increasing muscle tone in order to feel stronger and more secure somatically and emotionally.

Rothschild (2000) suggests that it is important for therapists to be familiar with a range of theoretical and treatment models, so that they can adapt therapy to the unique needs of each individual client. She acknowledges the importance of the therapeutic relationship in creating safety in trauma therapy, and suggests that with some clients, the experience of misattunement or conflict may, if effectively repaired, lead to greater trust in the therapist.

Conclusion

The development of body centred approaches to trauma therapy represents a major contribution to the dialogue and cross-fertilisation between psychodynamic and body psychotherapies (Eldredge & Cole, 2008). These approaches draw on neuroscience and the burgeoning body of knowledge about the neurophysiology of trauma, which point to a clinical necessity to utilise somatic interventions in therapy with trauma survivors, thus using the body as a resource for psychotherapeutic work. In addition, Sensorimotor Psychotherapy draws on recent research on affect and attachment to underline the importance of the therapeutic relationship for the development of affect regulation and work with attachment difficulties at the procedural, sensorimotor level.

I have critiqued Somatic Experiencing for its lack of consideration of the therapeutic relationship, and the complexities of developmental trauma. However, I believe that knowledge of all these approaches would be very useful for any therapist working with trauma. As with any psychotherapy, the theories and skills which will most benefit one client will be different for another client. Rothschild (2003) in particular, strongly advocates that therapists should be familiar with a range of approaches, and use

“common sense” in deciding how to work with each client. She believes that different modalities can complement each other powerfully within a single course of therapy.

Through somatic forms of trauma therapy, clients who may have only experienced their bodies as sources of pain and disturbing, overwhelming symptoms, slowly develop the capacity to experience and use their bodies as resources. The therapist’s attunement to their own body as well as their client’s body is fundamental to this process. Rothschild (2000) names some specific ways the body can be used as a resource in her approach, which I see as also relevant to the other approaches I have described. She describes “the body as anchor” (Rothschild, 2000, p. 107), where awareness of body sensations can enable clients to anchor themselves in the present, and facilitate the separation of past and present. “The body as gauge” (Rothschild, 2000, p. 109) describes the use of the body to monitor hyperarousal, slowly strengthening clients’ sense of self-knowledge and control. The body can, of course also be used as a brake via body awareness and some of the other techniques I have described above. Rothschild (2000) also suggests that the body can be used as a “diary”- that is, clients can learn to identify trauma triggers through awareness of their body sensations, and awareness of body sensations can help to make sense of, and process somatic memories. Moreover, clients can learn to draw on positive somatic memories as resources to counter trauma states. Levine (1997) also describes using the body as a means of discharging blocked energy which contributes to trauma symptoms. He and P. Ogden et al. (2006) both describe using the body to complete active defensive responses, which may have failed at the time the trauma was experienced. This can generate a new somatic experience of the body as capable, powerful and strong. Thus, the body can be used and experienced as a resource in many important ways in trauma therapy.

Reflections

My own internal response to engaging with these theories and approaches is multi-layered. As a new therapist I feel that I have an enormous amount to learn as I read these writers. I am excited by their wealth of knowledge, and by the possibility of becoming more adept at working with the skills they have developed, with clients in my practice. I feel a thirst for this knowledge and competence on behalf of my clients, whom I see as benefiting enormously from these approaches. At the same time I am sobered by my current limited experience and the tentativeness with which I work somatically with trauma.

Despite its clear links with my clinical work, my engagement with this material has a more cognitive quality than most of the other content of my dissertation. I attribute this partly to its strong emphasis on neuroscience, which I find fascinating, and yet difficult to assimilate. Reading about neuroscience certainly pulls me strongly into my left brain, and cortex. There is also a way that aspects of somatic trauma therapy are more focused on “doing” than “being”. Clearly trauma therapy necessitates a more active and directive stance for a therapist than some other forms of psychotherapy. This also serves to modulate client and therapist anxiety about the overwhelming, terrifying, painful material that clients bring to therapy. Thus I think there is a way that all of this enters into my countertransference to this written material. Somatically and energetically I feel somewhat contracted, though not uncomfortably so, my breath is fairly shallow, I am energised, focused and alert. Clearly my sympathetic nervous system is somewhat aroused. My awareness of my own state in relationship to this material leads naturally into the next chapter, where I will explore the somatic and energetic impact of therapy on the therapist.

Chapter 9: Shifting States - Therapist Self-Resourcing

Introduction

I see therapist self-care and somatic self-resourcing as an important aspect of experiencing the body as a resource in psychotherapy. In examining the literature, it seems that this is also an area in which trauma therapists, especially Babette Rothschild (2006), whose work I will discuss below, are taking a lead. Psychodynamic literature on the subject seems to be scarce, although it should be noted that I have not done a detailed literature search on this specific sub-topic. Similarly, within the body psychotherapy literature I have surveyed I have not found much written on this topic. However, in my personal experience of body psychotherapy, I have found that somatic self-resourcing was a strong focus throughout my bioenergetic training, which was not the case in my psychodynamic training. I also believe that by its very nature, body psychotherapy fosters a greater attention on the part of the therapist to their own somatic experience, as well as bringing physical movement into the sessions which therapists will frequently demonstrate and participate in along with their clients. Both these factors, I suggest, may predispose body psychotherapists to be more conscious of the somatic dimension in their own self-regulation and self-care. In this section I will discuss the literature from each of these “schools”, and reflect on notions of therapist self-care and self-resourcing.

I coined the term “therapist self-resourcing” (to the best of my knowledge), as I feel that this has a slightly different emphasis from the term “therapist self-care”. To me it suggests a more active process of replenishing and developing somatic, emotional and cognitive capacities. Baker (2003) conceptualises therapist self-care as comprising “the processes of self-awareness and self-regulation and the balancing of connections among self..., others..., and the larger community” (Baker, 2003, pp. 13-14). I certainly see self-awareness, self-regulation and balance as key elements in somatic self-resourcing. I believe that the notion of somatic self-resourcing addresses the therapist’s active development of their own somatic resources, both for their own personal benefit *and* for the benefit of their work with clients. Particularly in regards to trauma work, I suggest that this is an ethical responsibility, in light of the potential for vicarious traumatisation.

Rothschild (2006) articulates a rationale for this, as well as describing specific techniques which therapists can use to resource themselves.

Therapist Self-Resourcing in Trauma Therapy

In the last twenty five years it has become increasingly clear that trauma therapy can have a significant negative impact on therapists. Terms such as “compassion fatigue” and “vicarious traumatisation/trauma” (McCann & Pearlman; Pearlman & Mac Ian, 1995), have been used to describe the stress resulting from working with traumatised people. Adams and Riggs (2008, p. 26) describe vicarious trauma as “a process involving a transformation in the inner experience of the therapist resulting from empathic engagement with clients’ traumatic material”. They emphasise that unlike countertransference, which is present in all therapeutic relationships, and unique to each therapeutic dyad, “vicarious traumatisation is a cumulative consequence not specific to any one client, which can be lasting and linked to multiple aspects of the therapist’s personal and professional life” (Adams & Riggs, 2008, p. 26). Vicarious trauma can generate somatic and psychological symptoms of PTSD in people who work with trauma survivors (Adams & Riggs, 2008).

Rothschild (2002, 2004b, 2006) draws on neuroscience to explore the dangers of empathy, and to provide guidelines for therapists to protect themselves from vicarious traumatisation via somatic awareness and techniques. The discovery of mirror neurons (Gallese, 2009; Rizzolatti & Craighero, 2004) establishes a biological, neurological basis for empathy and indeed for intersubjectivity. Mirror neurons fire in the brain when one witnesses another’s action, as though one was performing the action oneself. Gallese (2003, p. 171) hypothesises that emotions displayed by others can be implicitly understood via “mirror matching mechanisms” in the brain. Rothschild (2004b, 2006) explains that mirroring or mimicking another person’s facial expression and body posture enables us to feel what they are feeling emotionally and sensorially, via “somatic empathy”. This frequently happens unconsciously, including in the therapy room. Forester (2007) describes this phenomenon as kinesthetic empathy, or mimesis. Rothschild (2004b, 2006) emphasises the importance of therapists becoming *conscious* of how they physically mirror their clients, in order to both harness the power of this intervention to increase their empathic understanding, as well as to guard against vicarious trauma which may ensue from empathising too acutely with traumatised clients. She gives a range of case examples which illustrate these concepts.

Rothschild's main thesis is simple: becoming aware of our mimicry gives us a vital freedom of choice. She suggests that in instances when we find ourselves absorbing too much of our clients' feelings we need to become aware of our mimicry and consciously return to the sensations of our own body and out of synchronisation with the client, in order to "apply the 'empathy brakes'" (Rothschild, 2004b). Rothschild (2006) describes body awareness, and especially awareness of one's autonomic nervous system arousal as a crucial tool in managing the demands of trauma therapy. She suggests using similar tools as those she advocates for trauma clients (Rothschild, 2000), in order for the therapist to "put on the brakes" of their own autonomic arousal; essentially to regulate themselves. She suggests using techniques to develop strength in specific muscles which correspond to specific psychological attributes, according to Bodydynamic therapy¹⁶. For example, developing strength in the arms may help to develop self-assertion. Increasing muscular tone in the face of immediate stress may also help to regulate arousal. Rothschild also suggests developing "sensory anchors" (Rothschild, 2006, p. 120), a technique of invoking safe, pleasurable associations to, for example, a particular place or person, using sensory memory. Other techniques include working with physical boundaries and physical space; cultivating body armour in specific, vulnerable areas; "pushing away with the eyes" (Rothschild, 2006, p. 142); and maintaining an awareness of one's body "edges", through feeling sensations on the skin.

Rothschild challenges the common notion that projective identification is "an active process on the part of the client and a passive one on the part of the therapist" (Rothschild, 2006, p. 198). She suggests that this notion can lead to therapists blaming their clients, and feeling like helpless victims. Moreover, she infers that the notion of somatic empathy locates the active mechanism of projective identification within the therapist. She refutes the idea that clients can "induce" emotions in their therapist. I appreciate Rothschild's promotion of therapist empowerment and self-responsibility regarding taking on clients' feelings. She conveys the very important message that therapists have the power to "control how much, how often, how intensely,...(they)will resonate with...(their)clients' feelings" (Rothschild, 2006, p. 199). Nonetheless, I think there is value in maintaining the notion of projection as an intentional, active (albeit

¹⁶As noted in my introduction, Lisbeth Marcher developed Bodydynamic therapy, and a detailed map of the patterns of muscle development, linking this with Reichian characterological development (Bernhardt, 1992; Totton, 2003). She helps clients to develop "body resources", by focusing on specific muscles connected with their developmental deficits or trauma. Rothschild trained in this approach, and her work is strongly influenced by it.

unconscious) force, and to remain open to the subtle dimensions of unconscious communication, regardless of whether one languages these as countertransference or somatic empathy.

For example, Davies and Frawley (1994) describe specific countertransference constellations that they believe need to be worked through in the treatment of sexual abuse survivors. This type of psychodynamic therapy necessitates the therapist being involved in relational enactments, where they may alternately experience themselves as, for example, victim, perpetrator or rescuer. Their framework seems at odds with Rothschild's, as she seems to suggest that enactments are neither desirable nor inevitable. However I think each stance could augment the other. Rothschild's approach could help therapists to be more conscious of their emotional and somatic responses as they are involved in enactments, enabling them to work with them more effectively. Nonetheless, it seems that there is necessarily an unconscious aspect to the therapist's initial involvement in a situation of projective identification or enactment. Such phenomena require that "we surrender ourselves and our bodies to be shaken by the mutually weaved (*sic*) transference fields" (Hadad & Ben-Shahar, 2012, p. 54).

Hadad and Ben-Shahar (2012) write about projective identification as a somatic phenomenon, illustrated by a vignette from Ben-Shahar's work, which I think conveys the potential for combining Rothschild's ideas with a psychodynamic understanding of projective identification and enactments. Ben-Shahar describes his disturbing, somatically based countertransference feelings at a particular point in his work with a traumatised client, which included a powerful dissociative pull, sadistic sexual arousal, and deep shame. He slowly comes to understand these as a somatic and emotional enactment of a predator-prey dynamic. This understanding seems to have informed and deepened the therapy in crucial ways.

Just as the notion of projective identification can be misused to blame clients, I think that Rothschild's ideas have the potential to be distorted and used by therapists to blame themselves when they do not succeed in regulating their feelings effectively or quickly. It seems to me that the middle ground is an intersubjective understanding of these dynamics, where we understand that together we create our shared experience. It is neither our client's "fault" nor our own that we experience disturbing somatic states. These represent a fundamental resource for understanding our clients' experiences.

However, it is also vitally important that we regulate ourselves by maintaining our own body awareness and using somatic tools to modulate our own autonomic arousal.

Although I am focusing on somatic resourcing in this section I certainly see other ways of working with our disturbing somatic countertransference and hyperarousal as equally important. These include supervision, personal therapy and peer support. The relational aspect of all of these is probably as important as the emotional and cognitive insight that they may generate. This could also be understood as dyadic regulation, engaging the “Social Engagement System” (Porges, 2011) to modulate autonomic arousal.

Psychodynamic Perspectives on Therapist Self-Resourcing

As previously mentioned, very little seems to have been written about therapist self-care/self-resourcing from a somatic perspective, within the psychodynamic literature. McWilliams (2004), in a chapter on self-care, writes a section playfully titled “care of the id” (p. 286). She addresses physical self-care in terms of health, including adequate sleep and countering the sedentary nature of the profession via exercise. Similarly, Baker (2003), in her book on therapist self-care, writes about tending the physical self in regards to health, rest, exercise and sexuality. Certainly these are vital considerations, however, there is a lack of attention to subtler aspects of somatic experience, either within or beyond the therapy room.

Harris and Sinsheimer (2008), are the only psychoanalytic writers I came across who reflect on this. They engage specifically with the notion of “analytic vulnerability”, suggesting that the analyst’s body is “both crucial to analytic functioning and insufficiently cared for, at a theoretical as well as a practical level” (Harris & Sinsheimer, 2008, p. 255), which is certainly consistent with my experience and reading. They reflect on the powerful emotional and somatic demands of analytic work, in terms of the need to metabolize vast quantities of clients’ conscious and unconscious emotional material. They suggest that the profession generally holds “a powerful imago of the good analyst: invulnerable, all giving, maternal, containing, being of heroic service” (Harris & Sinsheimer, 2008, p. 259), which we are all influenced by, especially if we have a personal history of being parentified as a child, as many analysts do. Harris writes of feeling shame on a psychoanalytic panel, in speaking about self-care and vulnerability, and seeks to “address and diminish the presence of shame” regarding these issues by “calling for theorization” (Harris & Sinsheimer, 2008, p. 259) about

them. Harris and Sinsheimer note that self-care, in terms of supervision and personal analysis, is an integral part of analytic training, however “it seems that conventional support and care is directed at the mind” (2008, p. 262).

Harris and Sinsheimer give the lovely analogy of a “sick cello” Harris knew of, that was cured (of a “misjudged coat of varnish”), by having Bach’s music electronically piped into it for hundreds of hours, “until the varnish cracked and eased” (Harris & Sinsheimer, 2008, p. 256). They infer a comparison with the analyst’s body as the analytic “instrument”, however, they do not provide suggestions of how a similar healing may be achieved by analysts. This analogy brings to my mind the notion of vibration in body psychotherapy. Lowen and Lowen (1977, p. 5) propose that “vibration is the key to aliveness”, and that by increasing the vibratory state of the body through bioenergetic exercises, a state of vitality can be achieved and maintained. Similarly, as discussed in the previous section, Levine (1997) proposes that involuntary shaking and trembling are the key to resolution of trauma, and that animals in the wild do this instinctively. Thus, body psychotherapy offers both a theoretical rationale, and tools for maintaining vitality and discharging excess charge via somatic exercises (Lowen & Lowen 1977). Personally, in addition to bioenergetic exercises, I find that my own practice of 5Rhythms dance (Roth, 1989), is a powerful and pleasurable way of working with the innate somatic impulses of vibration and discharge. These impulses tend to be organically evoked in the third of the 5Rhythms, “chaos”. Juhan, a senior 5Rhythms teacher and psychotherapist, describes this rhythm as an opportunity to soothe the nervous system via gentle shaking and releasing, for which she gives the analogy of “bouncing the baby”, (not “shaking the baby”!) (A. Juhan, personal communication, February 2, 2013)¹⁷. To return to the impaired cello: I have the impression that it lacks the capacity to resonate in a harmonious way, since its varnish has a constricting effect. My own experience is that the more I am able to release somatic blocks and soften into natural motility and vibration, the more capacity I have both to receive others’ somatic communication and to metabolise disturbing somatic states. I experience both these capacities as drawing on my own body as a resource.

I felt excited and affirmed reading Harris and Sinsheimer’s article, as it is a rare expression of what I consider to be important issues, in a psychoanalytic context.

¹⁷ Exploring the 5Rhythms in any detail is sadly beyond the scope of my dissertation. Juhan (2003) notes the surprising commonalities between the elements of the 5Rhythms practice and forms of psychotherapy which she examines in her research, something which resonates with my experience.

However, they raise awareness of the issue, rather than providing many practical suggestions as to how therapists may work with this at a personal, somatic level. The exceptions to this are Sinsheimer's description of using a yoga headstand after a difficult morning of work, an inversion which she calls her "favourite move for shedding projections" (Harris & Sinsheimer, 2008, p. 261); as well as her description of developing a type of visualisation, where she imagines herself surrounded by a soft substance like cotton batting, to protect herself and remain available, in working with a client who routinely describes horrific, viscerally disturbing scenes and fantasies.

Recommendations for Therapist Self-Resourcing

I suggest that body psychotherapy, including but not limited to Rothschild's (2006) techniques, offers a wealth of techniques, underpinned by theoretical frameworks, which could fill this gap. As Rothschild (2006) emphasises, somatic awareness in and of itself is central to therapist self-regulation. Equally, I see somatic awareness as fundamental to the use of any techniques and exercises. Maley (2002) underlines the importance of developing mindfulness and acceptance as we work with bioenergetic exercises ourselves. With this in mind, as a constant foundation for any somatic practice, I propose that bioenergetic principles such as breathing, grounding, motility, containment, charging and discharging could provide a comprehensive framework for therapist self-regulation and somatic resourcing.

To illustrate this I will once again use the example of grounding, and reflect on how my own practice of grounding techniques supports my self-regulation. As in my clinical examples, I find that grounding exercises have different effects for me at different times. Standing exercises generally help me to feel my feet and legs more fully, and to feel more connection and cohesion between different body parts. This has a subtle but profound energetic effect whereby I feel more solid and robust, and more able to draw on the support of the earth. Sometimes grounding exercises calm me, sometimes they energise me, often both simultaneously. Thus they seem for me to have a naturally regulating effect, supporting both charging and discharging of energy. At times when I feel especially overwhelmed or vulnerable, I find that grounding through lying on the floor is particularly soothing and balancing.

It is always difficult to write about one of these principles in isolation, as they are naturally interconnected. For example, conscious breathing is generally part of any grounding exercise I do, and contributes to its effectiveness.

The notion of therapist self-resourcing mandates reflection as to how and when we incorporate such exercises into our lives and clinical practice. In terms of self-care, deliberate attention to our emotional and somatic state at the end of a working day seems particularly important, so that we can institute practices that help us to soothe our nervous systems and relax. I think somatic practices can also be an important part of preparing for the day, and for our work. I have often used grounding techniques at the start of a day that I anticipate will be challenging, and these can generate a distinct sense of being more energetically resourced to deal with challenges. Using such techniques in free moments throughout the day also seems like an extremely important way to regulate ourselves and remain fully available to our clients. I am often amazed how little time it can take to do a grounding exercise, which can have a big effect on my energy and presence.

Conclusion

As I have described, the area of therapist somatic self-resourcing seems relatively unexplored, especially in psychodynamic psychotherapy. Rothschild (2006) has made a unique contribution in proposing somatic tools for managing the pitfalls of somatic empathy in trauma therapy. Body psychotherapy has a lot to offer in this area, in terms of both theory and practice. I have made some suggestions and recommendations regarding the use of somatic techniques for self-regulation. I concur with Harris and Sinsheimer (2008) that this area would benefit from further theorisation and exploration.

Reflections

I notice a sense of warmth and comfort as I engage with this subject, as though reflecting about self-care and self-resourcing is in itself a form of self-resourcing and nurturing. I am also aware of my passion for this subject. I feel a kind of fierce protectiveness on behalf of the tender, all too human soma whose needs are so easily overlooked, overridden, or put on hold. I see this as a regrettable tendency in the culture of psychotherapy when it comes to therapists' own self-resourcing; as well as a tendency that is increasingly prevalent in our wider culture. Within the culture of

psychodynamic psychotherapy, I see the emphasis on emotional and cognitive processing as so often missing out the body's needs, which I experience as lopsided and incomplete. Moreover I have a passionate conviction that only through resourcing ourselves well somatically (as well as emotionally and relationally) can we be optimally present for our clients. Certainly my heartfelt engagement with this subject is connected with my own journey. I would like to close this chapter with a piece I wrote some time ago as part of a process in my bioenergetic training, which encompasses both my sense of the body being "missed", and my awareness of my need to claim space for it.

My body won't say 'YES!' until.....

she's welcome, welcomed into presence,

until there's a place laid for her at the table,

a mihi, a karanga calling her here,

into incarnation on this earth, earth body walking on the earth.

....until she is seen, recognised, honoured, blessed.

....until I can extend this welcome home to my body into every realm I find myself in,

welcome home to my soul.... into the paradoxical safety of this vulnerable earth body.

.....until I can exhale into peace.

Chapter 10: Missing Voices- Discussion

Introduction

In this section, I will make some brief suggestions for further research. I will also reflect on what I see as some significant gaps in the literature, particularly in regards to the absence of voices from different cultural perspectives. I will go on to suggest some ways in which Maori models of healing, and bioenergetics might begin a conversation, wherein the embodied life force energy is seen as a resource.

Gaps in the Literature and Directions for Further Research

As I have described in Chapter 9, I found the literature on therapist self-resourcing from a somatic perspective to be scarce, particularly within psychoanalysis. I see this as an area that would benefit from further investigation, reflection and theorising. As I have indicated, I see body psychotherapy as having particular strengths and resources in this area, which could well benefit clinicians of other theoretical persuasions.

I am aware that the topic of “the body as a resource” would be a fruitful topic for a more phenomenological inquiry. Interviews with therapists and/or clients would be one way of exploring this, within a qualitative methodology. My literature review could provide a foundation for this form of research in future. Had my project been larger than a Master’s dissertation, I would have considered this, however, it seemed clear that reviewing the literature was a large enough task in its own right in this instance.

Cultural Perspectives

I am painfully aware that most of the literature I have reviewed is written from a white, western perspective. I have found very little written about the body in psychotherapy from different cultural perspectives, or engaging with cultural issues. This strikes me as a significant gap in the literature. I will discuss the two articles which I did find and offer some beginning reflections around body psychotherapy and the body as a resource in the context of Aotearoa New Zealand.

Ablack (2009) writes about working with diversity in body psychotherapy from her perspective as a black therapist in England. I appreciate her discussion of the need to

bring “the complexity and richness of our own multiple heritage and identity states...to the centre of our thinking, being and doing” (Ablack, 2009, p. 131), in order to foster true relationality in our work. This strikes me as a hermeneutic sensibility, in terms of being acutely aware of how we are shaped by the many traditions we are part of, and how this shapes the intersubjective dynamic with our clients. Ablack (2000) also writes about working with traumatised black women clients, and the value of the safety and mirroring that clients can experience in working with a black therapist. This safety can create a space where clients can more readily work with the internalised hatred, fear and racism that may accrue from the experience of being black within a dominant white culture. Ablack raises important issues which I see as fundamental to all psychotherapy, and as easily sidelined. The fact that I am only writing about cultural issues in my final chapter is no doubt a case in point, as is the lack of engagement with these issues in the literature. However, I do not see Ablack’s ideas as particularly specific to a body psychotherapy approach, rather she is writing about culture and she is a body psychotherapist. She does not seem to me to comment particularly on the interface between culture and body psychotherapy.

Towards a Maori Body Psychotherapy

As a beginning body psychotherapist in Aotearoa New Zealand, of English and Maori descent (Ngati Toa, Ngati Mutunga and Te Ati Awa), it seems particularly important to me to reflect on body psychotherapy from a Maori/indigenous perspective. I have not found any literature on Maori or indigenous body psychotherapy, and this is not something that has been written about from a bioenergetic perspective¹⁸. Of course, this absence is also reflective of the narrow focus of my topic, which is confined to the western discipline of psychotherapy. This means that traditional Maori healing methods have not been part of my literature search, despite their potential relevance to the topic of “the body as a resource”. However, it seems to me that body psychotherapy is aligned with a Maori view of health and wellbeing in some key ways, as I will discuss.

I am aware that this is a complex, multi-layered conversation to begin. It seems important to acknowledge the work of Waka Oranga (Hall, Poutu, & Wilson, 2012) in grappling with the complex notion of Maori psychotherapy, articulating the values that underlie this, and striving to promote and honour Maori wisdom in the wider

¹⁸ The other body psychotherapy modality that is taught and practiced in NZ is Hakomi. I understand that there are Maori Hakomi practitioners, and that this approach has engaged with a Maori worldview, however, it is beyond the scope of my dissertation to explore this.

psychotherapy community. It also seems important to acknowledge that this is necessarily a political act. Woodard (2014) suggests that “psychotherapy in Aotearoa has flourished in a supposedly apolitical space”, which has in fact been created and maintained by political ideologies and policies which “reflect the needs and values of the *dominant* group which, being the norm, are invisible - and, hence, “apolitical” (Woodard, 2014). Woodard focuses on the 1907 Tohunga Suppression Act, as a defining moment, politically and symbolically, in the suppression of traditional Maori systems of healing, and the growing dominance of a western biomedical model of health. Clearly this model of health, and the process of colonisation, has failed Maori at a systemic level in devastating ways, as evidenced by innumerable negative statistics (Durie, 2003; Woodard, 2014).

Psychodynamic psychotherapy can be critiqued for its narrow focus on the intrapsychic and individual dimensions, and lack of consideration of broader social and cultural aspects. I suggest that some aspects of body psychotherapy make it more readily compatible with Maori models of health than psychodynamic psychotherapy. Essentially, both matakauranga Maori and body psychotherapy offer a holistic understanding of what it means to be human. Thus, Maori models of health tend to see the body as a resource, inextricably interconnected with a range of other spiritual, relational and natural resources.

Two widely used Maori models of health are Te Whare Tapawha, and Te Wheke, articulated by Mason Durie, and Rangimarie Rose Pere, respectively (Durie, 1998). Durie (1999) has also described a Maori approach to counselling: Paiheretia. McNeill (2009) notes that in comparison to the simplicity of Te Whare Tapawha, Te Wheke is a more complex model that is grounded in matakauranga Maori, which has made it more difficult to fully apply in mainstream health settings. I am struck by what I see as some commonalities between Te Wheke, and bioenergetics. I would like to reflect on these, in a spirit of wanting to add my voice and encouragement to the korero between bioenergetics and te ao Maori. I acknowledge the risk, and perhaps inevitability of my brief reflections being overly reductive, however, I offer them in humility:
Ahakoā he iti, he pounamu.

Te Wheke translates as the octopus, and Pere (n.d.) describes its eight, interconnected tentacles as comprising the following eight dimensions of wellbeing:

Wairua - spiritual dimension

Taha tinana - the physical body

Ha a koro ma, a kui ma - breath of life from forebears

Mana ake - uniqueness of the individual, divine vested authority

Whanaungatanga - kinship

Hinengaro - the mind and brain

Whatumanawa - relating to the emotions and senses

Mauri - life principle, ethos

Firstly, I trust that it is self-evident at this stage in my dissertation, that body, mind and emotions are seen as functionally unified, and that all of these aspects are considered and worked with in a body psychotherapy approach. Similarly, Te Wheke gives each of these equal importance and sees them as interconnected.

I suggest that the central bioenergetic concepts of energy and life force have some similarities with the concepts of wairua, mauri and mana ake. Lowen (1975, p. 65) proposes that a person's spirit is "determined by how alive and vibrant he is, literally by how much energy he has". He goes on to define spirit as "the life force within an organism manifested in the self-expression of the individual" (Lowen, 1975, p. 65). Pere (n.d.) states that "at conception the 'mauri ora' comes in as absolutely unique to the individual". Barlow (1991, p. 83) describes mauri as the "power which permits...living things to exist within their own realm and sphere". He states that "no one can control their own mauri" (Barlow, 1991, p. 83). However, Pere (n.d.) writes about the importance of safeguarding and nurturing one's mauri.

Similarly the "ha", or breath is associated with the mauri, and Lowen (1975) acknowledges that many different cultures have linked the breath with the life force or spirit, stating that breathing is central in bioenergetics since "only through breathing deeply and fully can one summon the energy for a more spirited and spiritual life" (Lowen, 1975, p. 66).

Pere (n.d.) describes whanaungatanga by saying "every living thing that seeks for sustenance from our Earth Mother, is family". This interconnectedness, and interdependence, so crucial to a Maori worldview, is also echoed by Lowen (1975), who

describes soul as an experiential sense of being connected with the world around us, sensing one's "belonging to the great natural order of the earth" (Lowen, 1975, p. 68).

I do not intend by any means to imply that these aspects of matauranga Maori are understood in identical ways within bioenergetics, nor to suggest that bioenergetics encompasses all aspects of a Maori worldview. I am aware that there is a risk of cultural appropriation in making such comparisons. However, I do feel that there is some common ground, and ways in which the philosophies and practice of bioenergetics might inform and enrich understandings of Maori psychotherapy. I see the focus on the embodied life force energy as a particular strength of bioenergetics, and a powerful means of drawing on the body as a resource. I see this as having some affinities with Maori concepts and experiences.

Like other forms of psychotherapy, bioenergetics can still be critiqued from an indigenous perspective for focusing primarily on individual dysfunction. Although body psychotherapy has since its inception, "often been explicitly counter-cultural in tone and content" (Totton, 2003, p. 136), it has nonetheless also reinforced the dominant culture's norms in a range of ways. For example, as Totton (2003, p. 145) points out, "body psychotherapists tend to make generalisations - about character types, patterns of armouring and the value of emotional expressiveness - which may well not be of universal application".

I believe that any Maori psychotherapy (or psychotherapy with Maori) needs to hold in mind the impact of the cultural trauma of colonisation and subsequent political oppression. Likewise, issues of alienation and cultural identity may be central, and need to be acknowledged. Durie (1999) emphasises the importance of connection with whanau, whakapapa, marae, and whenua in fostering a secure Maori identity. Ablack (2000, p. 149) echoes the centrality of ancestry in her work with black clients, who have told her "they feel as if formerly empty parts of themselves have substance and meaning when they start to be open to the sense of ancestry in themselves." It seems to me that these issues of cultural identity are of universal importance, yet indigenous and minority cultures tend to lead the way in highlighting this.

I also see potential for the bioenergetic concept of grounding to be extended to more overtly encompass cultural identity. I see this as being encapsulated in te reo in the

word “turangawaewae”, with its literal translation of “a standing place for the feet”, and its connection with ancestral whenua and marae.

Tūrangawaewae are places where we feel especially empowered and connected. They are our foundation, our place in the world, our home....In the concept of tūrangawaewae, the external world is a reflection of an inner sense of security and foundation. The mountains, rivers and waterways to which one can claim a relationship also express this internal sense of foundation. (Royal, 2012)

Thus I propose that a Maori perspective on grounding needs to consider the breadth of such indigenous relationships of belonging.

Calling in Spirit

This discussion also highlights for me my discomfort with the body-mind binary I have largely focused on in this dissertation. It has seemed necessary to narrow my focus in this way, however, at times this view has felt very limited. For me, a holistic approach to life, and psychotherapy, also includes the spiritual dimension, something that is clearly fundamental to indigenous worldviews. Western cultures have, of course, a long history of seeing body and spirit as being in opposition to one another. Totton (2003, p. 144) points to the fact that body psychotherapy can potentially focus on the body as “something without spirit, something distinct from spirit rather than the immanent expression of spirit”. However, he also emphasises that many people who experience body psychotherapy find that “the more deeply one goes into the experience of embodiment, the more strongly one becomes aware of the spiritual and subtle aspects of reality” (Totton, 2003, p. 144). This is certainly consistent with my experience, however, I have also at times found the absence of overt spirituality to be painful, in both my psychodynamic and bioenergetic trainings. This absence may partly be attributed to another famous schism in the history of psychoanalysis, that between Freud and Jung.

I have found Judith’s (2004) work to be a rich contribution to a more fully holistic body psychotherapy. She articulates a developmental progression which encompasses both Reichian characterological understandings and yogic understandings of somatic, psychological and spiritual development in relation to the chakras. She also draws on Jungian concepts, as well as Erikson’s developmental stages. For me, her work puts my bioenergetic understanding of character structure into a larger, deeper container of spiritual wisdom, in a thoughtful, grounded way.

Conclusion

I have discussed gaps in the literature, and possible directions for future research and exploration. I have then reflected on some possible commonalities between Te Wheke, a Maori model of wellbeing, and bioenergetic ideas. I have also briefly discussed the separation between body and spirit that is prevalent in western cultures, and which has shaped the cultures of psychotherapy. In discussing these “missing voices” I wish to at least allude to a vaster spiritual context of interconnectedness which I see “the body as a resource” as a part of.

Chapter 11: Discussion and Conclusion

Reflections

As I begin this final discussion chapter of my dissertation, I would like to return to some of the hermeneutic understandings I laid out in the beginning. The notion of the literature review as a conversation with the work of others within the tradition of one's subject has been central to my process. The inevitability and indeed necessity of bringing my own subjectivity, fore-understanding and prejudices to this conversation have shaped it in a unique way. Thus, a hermeneutic literature review is always one of a kind. To me this seems akin to the intersubjective encounter in psychotherapy, where the "mutual interplay between the subjective worlds of patient and analyst" (Stolorow & Atwood, 1996, p. 182) continually shapes each therapeutic dyad in unique forms.

As I have noted, I have been strongly drawn to the work of a number of writers who have inspired and engaged me at an intellectual, emotional and somatic level. This is akin to the hermeneutic idea of "inclining" towards particular texts (Smythe & Spence, 2012). My engagement with these writers often seems to include an idealising transference (Kohut & Wolf, 1978) which feels developmentally appropriate to my status as a new therapist grappling with the issues they are exploring. Brightman (1985) writes about narcissistic vulnerabilities during psychotherapy training, suggesting that trainee therapists benefit from a supervisory relationship "in which the supervisor may come to serve as a professional analog to the idealised parent", by virtue of both their empathic mirroring, "admiration of the self's capabilities", and their functioning as a "figure for idealisation and eventual identification-internalisation" (Brightman, 1985, p. 307). I see something of this process at play in my engagement with the work of writers I admire. Thus, much of my dissertation feels like a conversation with wise mentors and elders, where I am largely receptive, yet actively metabolising their words and connecting them with my own ideas, intuitions and wonderings; perhaps identifying with and slowly internalising what I admire and respect in them.

At the same time working on this dissertation has also been a sometimes painful process of trying to find my voice.....or perhaps "my voices" expresses the challenge more accurately? I am aware of this dissertation as one of the first expressions of my voice as a psychotherapist. It is also a significant step up in honing my academic voice.

There has been an ever-present tension regarding how to enable my “body voice”, which I see as intimately connected with my emotional experience, to speak in this conversation. I have also felt a struggle around how to bring my Maori voice into a dissertation that is based on a western healing paradigm; which culminated in writing the previous chapter. This process of finding my voice/s has included some painful interactions with mentors, which have nonetheless catalysed and crystallised my emerging expression.

Summary and Discussion

I will now briefly summarise the findings of my research, in relation to two overarching themes which have emerged during the writing of my dissertation. In doing so, I will reflect on some implications for practice.

Qualities of attention: “seeing” through multiple lenses

This dissertation highlights the importance of body awareness in experiencing and using the body as a resource. I will discuss this, and also reflect on the value of the forms of awareness which psychodynamic psychotherapy generally privileges, proposing that a quality of attention that includes attunement to somatic, energetic, emotional and unconscious processes offers the optimal therapeutic presence.

I see body awareness as one theme or thread which connects all the aspects I have explored in this dissertation. As I have described, compassionate awareness of one’s internal somatic experience seems to be both a fundamental starting point, and often an end in itself in terms of somatic resourcing. This deceptively simple capacity underpins every aspect of experiencing the body as a resource, for both clients and therapists. Helping clients to develop somatic awareness is a key aspect of body psychotherapy, and is seen as a particularly vital skill in somatic trauma therapy, as it allows clients to learn to regulate their affect and autonomic arousal (Levine, 1997; P. Ogden & Minton, 2000; Rothschild, 2004a). While the need to develop this capacity is most dramatically apparent for dysregulated, traumatised clients, I believe it is an important resource for all of us, and one that requires regular practice of some kind to maintain and deepen. Therapists need to cultivate embodied self-awareness as a resource for their own self-regulation and self-care, in order to be optimally present to their clients, and as a means of enhancing and refining their attunement to somatic communication from their clients.

Psychodynamic psychotherapy places a strong emphasis on insight and emotional awareness, but does not tend to focus overtly on somatic awareness (S. Shapiro, 1996). I believe that attending to the body in the ways I have described may deepen the scope of psychodynamic work, bringing a fuller dimension of awareness to bear on our human experience. In contrast, refined attention to unconscious communication and to the intersubjective field, are strengths of the contemporary psychodynamic approach, which have contributed to the development of a more fluid, relational stance in body psychotherapy over the last three decades (Ben-Shahar, 2012; Klopstech, 2000a). I believe that both body psychotherapy and psychodynamic psychotherapy foster important qualities of attention for clinicians, both of which should ideally be at play in therapy. Essentially I propose that our attunement to our patients, and our states of reverie should actively include embodied self-awareness and awareness of our patients' somatic states.

Cockburn (2013) delineates seven “lenses” through which we may endeavour to “see” our patients, in learning the practice of bioenergetic therapy. These lenses include faculties such as listening and sensing, as well as looking. Together, they comprise a kind of perception that is rooted in the fullness of our own sensory awareness, encompasses receptivity to unconscious communication, as well as lightly holding theoretical knowledge such as awareness of character structure and body reading. To extend Cockburn’s metaphor a little, it seems to me that body psychotherapy and psychoanalysis have traditionally “looked” through rather different lenses. The more of these lenses we are able to incorporate into our practice, the fuller our “vision” will be. The more embodied our vision is, the more we can access our own bodies as a resource, and help our clients to do the same.

The body in solitude and the relational body: Resourcing through self-regulation and dyadic regulation

Another key theme that has emerged in various ways throughout this dissertation is the contrast between the body in solitude, and the relational body. I see both of these as important aspects of using and experiencing the body as a resource. This can be understood via the concepts of self-regulation, and dyadic regulation, as I will summarise below.

“Solitary” experiences of embodiment may be an important part of therapy (and possibly an adjunct to therapy), for many clients, enabling them to access and develop somatic resources (W. F. Cornell, 2008). These experiences might take the form of a one-person psychotherapeutic mode, where the therapist may direct, suggest, or simply witness the client’s somatic experience. This type of somatic work is also a very important aspect of somatic trauma therapies, particularly in the stabilisation phase, where there is a focus on helping clients to learn to regulate their autonomic arousal, as I have described in Chapter 8 (P. Ogden & Minton, 2000; Rothschild, 2000). Solitary somatic practices may also form an important part of therapists’ own self-resourcing.

Relational work with the body may take many forms. It may occur via the types of processes which Orbach (2003, 2006) describes, as I have outlined in Chapter 6; where therapeutic change occurs through the therapist receiving and metabolising the client’s somatic communication, and making her own body available, in an energetic sense, for the client to slowly internalise and thereby build his own sense of a solid body-self. In a body psychotherapy approach it may also include active physical engagement (Ben-Shahar & MacDonald, 2011; W. F. Cornell, 2009). If the word “relational” is used in a broad sense, this type of work could include both one-and-a half-person and two-person psychotherapeutic modes; that is both a “holding” therapeutic stance where a corrective emotional experience is provided, and/or an intersubjective way of being that involves mutuality and reciprocity (Klopstech, 2000a).

I propose that all of these modes of therapy include the potential for the body to be experienced as a resource. This could also be framed in terms of somatic and affective regulation. Ideally, therapists can connect with their own bodies as a resource, and maintain “good enough” self-regulation. They can then also support their clients to develop this internal capacity for self-regulation, via dyadic regulation. In this way, the therapist’s body becomes a resource for the client to draw on, and supports the client to experience their own body as a resource. Schore (2011) underlines the role that right brain, implicit communication in the therapeutic dyad plays in developing the capacity for affect regulation in dysregulated, traumatised clients. He also emphasises the psychobiological, embodied nature of implicit communication.

Ben-Shahar (2014a) describes two different forms of dyadic regulation, firstly, “self-object” or “regressive dyadic regulation”, where the therapist functions as a self-object,

essentially regulating the client on her behalf. In this instance the therapist needs to focus on her inner work “strengthening her embodied presence, centering and grounding” (Ben-Shahar, 2014a, p. 22), resourcing herself in order to resource and regulate her client. Ben Shahar then goes on to describe a more sophisticated form of dyadic regulation which he describes as “generative dyadic”, or “mutual regulation”, which involves “working directly with the shared field - with the intersubjective body: surrendering to a shared field of self and then retrieving the balance of the system” (Ben-Shahar, 2014a, p. 23). He proposes that “the shared body-mind is frequently more resourceful and contains greater possibilities and flexibilities than the individual selves of which it emerged” (Ben-Shahar, 2014a, p. 23). This implies drawing on the shared, intersubjective body as a resource.

Ben-Shahar uses an extended example from his own life, to explore these different modes of regulation. He writes about a difficult time when he and his two young daughters all became very sick with whooping cough. He and his wife attempted to support their healing by regulating the girls in myriad ways. However, Ben-Shahar found that this was only fully successful when he was able to surrender to the larger, intersubjective body which they all co-created, and allow it to regulate them. He states that:

when we are able to surrender to connection, to open to a wider mind - the resources that are available for us are richer and wider... According to this view, the major therapeutic act is not helping the other to regulate but to become part of the system: an act of positioning and surrender and not one of skilful doing... Through these lenses, the self has lost its individual skin-bound definitions: it is no longer the client or the therapist, it is the dyadic dance, but this novel autonomous dance can self-regulate. (Ben-Shahar, 2014a, p. 26)

Ben-Shahar’s ideas help me to crystallise some of my thinking on the body as a resource into a simple framework. Essentially I see four main ways of relating to the body as a resource in psychotherapy:

1. ***Therapist self-resourcing***: The therapist uses their own body as a resource for their self-regulation (which also indirectly benefits their clients in significant ways).
2. ***The therapist’s body as a resource for the client***: The client draws on the therapist’s body as a resource. They may use the therapist’s body as an “auxiliary body”, or as part

of a corrective emotional experience. This can be understood as regressive dyadic regulation.

3. ***The client's own body as a resource:*** The client is able to use their own body as a resource and self-regulate.

4. ***The shared, intersubjective body as a resource:*** Therapist and client draw on the intersubjective body as a resource, in a bi-directional, mutual yet asymmetrical way. This can be seen as generative dyadic regulation.

I do not see these states as a linear progression, rather I see them as interweaving in different ways. However, I do think that to a certain extent therapist self-resourcing is an important foundation for all the other states. By the same token, an intersubjective stance suggests that the shared body of the therapy dyad may also resource the therapist in ways that she may not achieve alone. I see the client's capacity to experience their body as a resource as something that can develop and be strengthened by both forms of dyadic regulation. I also believe that immersion in the intersubjective body may require that the client has good ego-strength, a good enough capacity for self-regulation, and for relating to their body as a resource.

I see the concept of regulation as capturing an essential part of how the body may be used and experienced as a resource in psychotherapy. At the same time, I see "the body as a resource" as encompassing the potential for much more than regulation. Perhaps the capacity to self-regulate, and to use others for self and mutual regulation via dyadic regulation and the social engagement system (Porges, 2011), is a *foundation* that can be built in psychotherapy, when it has been lacking in early development. This foundation may then support the development of other ways of experiencing the body as a resource for pleasure, creativity, sexuality, expression and expansion. I return to Johnson's (1995) definition of "soma" which I included in my introduction, which describes the body as a source of wisdom and creativity. I see the capacity for self-regulation as the foundation for grounded experience of the fuller dimensions of embodied self-expression, creativity and pleasure; which an embodied approach to psychotherapy can support and deepen. Moreover, Johnson follows the apostle, Paul in describing the soma as "the luminous body transformed by faith" (Johnson, 1995, p. xv), a beautiful, evocative depiction of the body's potential to be a vessel for spirit. Judith (2004) articulates the ways in which comprehensive psychotherapeutic work with our somatic and psychological issues can pave the way for a grounded opening to our spiritual

nature. While I recognise that this may be well beyond the scope of most psychotherapies, I nonetheless see this as the ultimate potential for the experience of the body as a resource.

Conclusion

My research suggests that an embodied, relational approach to psychotherapy is the optimal kind of approach to develop the capacity to use and experience the body as a resource in the fullest sense. Body psychotherapy and psychodynamic psychotherapy both have specific strengths regarding the use and experience of the body as a resource, as I have described throughout this dissertation. Body psychotherapy brings a depth of embodied awareness to the therapy process, a theory base which includes a wealth of understanding of the somatic dimensions of character structure, and an array of somatic interventions which enable a holistic psychotherapeutic approach. Contemporary psychodynamic psychotherapy offers a depth and breadth of theoretical approaches. Relational and intersubjective perspectives have changed the face of psychoanalysis, and have also become important influences on body psychotherapy in recent decades. The understanding that psychoanalytic theory provides regarding unconscious communication seems vital to work with somatic communication and countertransference. Finally, somatic trauma therapies and affective neuroscience seem to in some ways provide a bridge between these historically separate approaches, giving a neurobiological rationale for including the body in psychotherapy.

I have summarised my findings with reference to two main, overarching themes relating to awareness, and regulation. I argue that using the body as a resource in psychotherapy requires a quality of therapeutic attention which includes both somatic awareness and awareness of unconscious communication and the intersubjective space. I go on to propose four main ways in which the body can be used as a resource in psychotherapy, with reference to notions of self-regulation and dyadic regulation.

My process in writing this dissertation has also led me to conclude that experiencing the body as a resource is a relational phenomenon. That is, it is founded on a respectful, compassionate, kind relationship to our own bodily self, which in turn extends into our practice with clients, where we may gradually support them to come into this kind of relationship with their own bodies. I have not found it easy to practice what I am preaching throughout the writing of this dissertation. The difficulty which I outlined in

my introduction regarding staying connected to my embodied experience while writing in an academic manner has certainly not been resolved. However, I see navigating this tension between embodiment and intellect as an ongoing part of my life journey. I would like to honour the simplicity and power of embodiment in closing with a blessing by John O'Donohue which for me captures something of the relationship with the body as a resource:

To learn from animal being

*Nearer to the earth's heart,
Deeper within its silence:
Animals know this world
In a way we never will.*

*We who are ever
Distanced and distracted
By the parade of bright
Windows thought opens:
Their seamless presence
Is not fractured thus.*

*Stranded between time
Gone and time emerging,
We manage seldom
To be where we are:
Whereas they are always
Looking out from
The here and now.*

*May we learn to return
And rest in the beauty
Of animal being,
Learn to lean low,
Leave our locked minds,
And with freed senses*

*Feel the earth
Breathing with us.*

*May we enter
Into lightness of spirit,
And slip frequently into
The feel of the wild.*

*Let the clear silence
Of our animal being
Cleanse our hearts
Of corrosive words.*

*May we learn to walk
Upon the earth
With all their confidence
And clear-eyed stillness
So that our minds
Might be baptized
In the name of the wind
And the light and the rain.*

(O'Donohue, 2008)

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