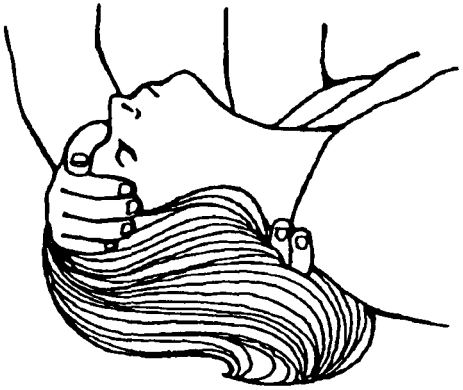
THE BODY IN PSYCHOTHERAPY

PART II



Analytical Body Psychotherapy

Guy Gladstone

Round about fifteen years ago I recall being warned off what I now do by an accomplished Gestaltist who was switching tracks to train as a psychoanalyst. He was of the view that I would have to choose between humanistic psychotherapy and a psychodynamic perspective; no integration was possible. He looked sagely at me, but his voice was bitter and I suspected he was wrong, though at the time I couldn't have said why and how.

An emerging modality

Analytical Body Psychotherapy (ABP) is not proposed here as an original modality. Virtually all its features will be found in other therapies. However, its particular synthesis of theoretical perspectives and technical procedures is distinctive enough to warrant writing about it. I can count on one hand the therapists in Britain who avowedly work in this way. But then what are practitioners doing out there? Actually very little is known about this. Many therapists, perhaps fearful for their professional image or even identity, not to mention the flow of referrals, will hesitate to expose where their practice diverges from their formal affiliation. It was precisely through such a process of going public that ABP itself originated.

Two of Alexander Lowen's international trainers based in Belgium, Sander Kirsch and Jacques Berliner, had begun to resituate their bioenergetic training within a psychoanalytical frame. ABP's development was accelerated when about eight years ago they went public on their differences with the International Institute for Bioenergetic Analysis, and Lowen,

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rather than engage in debate, compelled their resignation. They had realised that the 'analysis' in bioenergetic analysis was restricted to Lowen's developments of Reich's character analysis and was strictly speaking only an analysis of the form and movement of the body in the singular, a body viewed as largely outside the dyadic relational process crucial to psychoanalysis. Put another way, unconscious fantasy and object-relatedness in all its many representations were replaced by the Reichian emphasis on energy and armouring against its free flow. For Berliner and Kirsch 'bioenergetic analysis' had become a serious misnomer.

Centrality of transference

Thus ABP harks back to that pivotal point in the history of body psychotherapy roughly denoted by the publication in 1933 of *Character Analysis*, when Reich moved away from psychoanalysis into the development of character analytic vegetotherapy. With benefit of hindsight one can see that there were other potential departure points from the theory and technique of classical psychoanalysis. Sixty-five years later ABP is one of these. For Kirsch and Berliner the transference relationship had begun to be conceived as a long-term continuous process in which the client manifests deeply unconscious attitudes, expectations and desires (as in psychoanalysis); as opposed to isolated moments of intense and obviously illusory projection or displacement (the view of transference often taken from a humanistic or body psychotherapy standpoint). It followed from this distinction that for Kirsch and Berliner active body interventions had to take their place within a consideration of how a particular intervention would hinder or further the working through of the transference relationship, whether at a part- or whole-object level. Thus whether it is a 'hard' mobilising approach as typified by the bioenergetic, or a 'soft' melting contact as typified by the biodynamic — and ABP can use either — the question that faces the practitioner is 'Who do I become for the client when I propose and implement such interventions?'

Focus and safeguards

The working through of unconscious expectations, illusions and resistances emerging within the security and regularity of a longer-term therapeutic process, individual or group (often of three years' or more duration) is from an ABP perspective of more central importance than moments of emotional catharsis or the attainment of deep and easy breathing with a balanced muscular tonus, to select some examples of what is typically valorised in body psychotherapy. It is not what the therapist sees to be the client's character structure so much as what for a long time is invisible to both therapist and client (the lower right-hand square of the Johari window), the unconscious, that is the focus of ABP. ABP has an uncovering assignment. For this to happen an ABP practitioner will maintain a minimal distance from the client to ensure a separation of roles, avoiding dual roles such as client–therapist and trainee–trainer and also any undue intrusion of the therapist's reality either within or around the edges of sessions. Clients in ABP must have an unprejudiced freedom to fall into and elaborate whatever variety or intensity of negative transference their history disposes them to. Likewise ABP practitio-

ners maintain a dialogue with themselves about the nature of their unfolding countertransference, both to pre-empt impulsive interventions and in the knowledge that here they may often find more reliable indications of the client's past than the story the client can for a while put into words. The working through and interpretation of the negative transference is the most central and indispensable assignment of ABP.

As an ABP practitioner I therefore endeavour to avoid deflection of negative transference on to figures outside the room or objects such as cushions within the room. Unless the issue is an actual trauma when the client's need for a long period will be to feel the therapist beside them rather than opposite them (until ready one day to live the therapist as 'the enemy', as Sander Kirsch puts it) then I will try not to disturb any build-up of bad feeling in my direction. I strongly believe that intense disappointment or hostile feelings need to be lived and resolved dyadically; not, as in much humanistic work, triadically, with the therapist comfortably out of the firing line as the caring ally of the client versus some nasty 'back there' (in time) or 'out there' (in space) who together they defeat — a Pyrrhic victory, I might add. (I am exaggerating somewhat, in order to make a point about an ABP bugbear.)

Therapeutic space

Where, a reader might well ask, does this differ from psychoanalysis or psychodynamic psychotherapy? Firstly, the ABP practitioner faces the client, who may be lying down, seated, standing or moving in the space of the room, with the therapist adjusting their own position intuitively to remain more or less in contact. The space of the session is elastic. Clients are not immobilised either on a couch or in an armchair. The changes in spatial placement will often be initiated by the client who at the outset of the therapy has usually (but not always) been given such permission. On occasions it is the therapist who moves into a new alignment with the client. My chair allows me to lean back, tilt forward, swivel towards or away, even rise up over (a gesture with ironic value), not to mention move in close or further away, using its castors.

Non-verbal expressions

Secondly, the analysis in ABP is both of verbal and non-verbal elements of the client–therapist relationship. Body language, body image (the mental picture of the body) and body structure are included in the therapeutic discourse. With clients who are sufficiently secure in themselves the ABP practitioner can undertake a body reading during the initial interview process. When words are lacking or the client's words seem to contradict what their body expresses, the ABP practitioner will tend to focus on enhancing body awareness, either overall or in a specific region of the body. Structures such as a guided visualisation can be used to facilitate this. A client's relationship with their own body may be evidenced through a drawing or equally through the way they talk about and relate nonverbally to the therapist's body. The body in ABP is understood as having a concrete presence, an imaginary presence and a symbolic presence.

Catharsis reconsidered

Thirdly, ABP practitioners avoid imposing

constraints on noisy non-verbal expressions, constraints that are invariably present in psychoanalytic and conventional psychodynamic psychotherapies from at least three sources (modelling by the therapist of subdued presence; situational inhibitors such as lack of adequate soundproofing; and the often unconscious reproduction by the therapist of the surrounding culture's modes of body–mind splitting). In ABP, emotional self- expression is actively supported so long as it serves to deepen a client's enquiry. However, when cathartic expression is functioning to unawarely discharge and distract from a relationship tension between the therapist and client, or to avoid the uncovering of unconscious intra-psychic conflict, the ABP practitioner is likely to interpret this and ultimately interrupt it.

The place of touch

Fourthly, touch has a place in ABP practice, always within a consideration of its transferential and countertransferential significance. Touch may be used to intentionally activate transference (in due course the better to analyse it). Touch can be used to clarify the nature of an existing transference. Additionally touch has some specific applications that are essential for certain clients. Some people need to establish better contact with their surface, that is to say their skin (where they end and world begins); others need to contact their deep insides (their bones, their small muscles, their internal organs). Touch may help more regressed clients who have confused physical and mental processes to differentiate these and thereafter progress. In ABP touch is not deployed (as it is in forms of massage) to cultivate functional capacities, attainment of which is deemed healing. Rather its value lies in enhancing self-perception through contact with sensations and providing 'bridging' experiences, which transitionally lead into advances in verbal or other symbolic articulation. Working through in ABP is understood to include a progression from sensations, to emotions, to images, to words, to a symbolic understanding.

Limitations of free association

Fifthly, ABP jettisons the sacred cow of the invariable sufficiency of free association (the only technical directive formally given to analysands in psychoanalysis). This is a rule posed to be broken, in so far as analysands will be unable to observe it; that such lapses provide opportunities for interpretation is an insufficient guarantor that analysands will productively research their lives. The divergence here is so fundamental that I will quote from Rycroft's *Critical Dictionary of Psychoanalysis* to clarify the assumptive nature of free association:

> Free association technique relies on three assumptions:
>
> (a) that all lines of thought tend to lead to what is significant;
>
> (b) that the patient's therapeutic needs and knowledge that he is in treatment will lead his associations towards what is significant except in so far as resistance operates; and
>
> (c) that resistance is minimised by relaxation and maximised by concentration.

Many people who gravitate to body psychotherapies intuit that they cannot rely on the traditional psychodynamic pathway of 'talking about it'. In ABP a

wide-ranging interview procedure is usually followed, comprising one, two, or sometimes three preliminary sessions of information gathering. Out of this the ABP practitioner formulates an initial working hypothesis about the client, the kind of working alliance needed, and interventions that could be appropriate to this particular person. A loose form of differential diagnosis is regarded as necessary, so that the client who has sufficient psychic structure can be helped to regress and the client with insufficient internal structure can be helped with structuring questions and experiences. This preliminary interview and the practitioner's reflection upon it serves to identify the proportions and degree of presence of the two dimensions of experience that free association (and its subsequent interpretation) commonly fail to reach: one is the whole area of pre-verbal experience, the other is what in ABP is termed a 'chronic unresolved shock state' and in more orthodox psychospeak 'post traumatic stress disorder'.

Reaching the pre-verbal

With regard to pre-verbal experience the ABP practitioner introduces transitional structures that assist both client and therapist in first contacting and later naming crucial formative processes. Such structures are especially necessary where clients lacked an early experience of someone who cared for them in a good enough way, this lack rendering the formation of a working alliance more problematic. Much more knowledge is now available from studies in perinatal and infant development than was available when the classical procedures of psychoanalysis were developed. But the relatively new knowledge has mostly yet to percolate through to the level of therapeutic technique. Meanwhile the client who cannot free-associate cries out for alternative approaches. With such a client either there is no spontaneous flow of thoughts, or else the apparently spontaneous flow of words bypasses whatever 'it' is. In other instances the client 'knows' what 'it' is yet has no words with which to address it. People with nothing to say may turn out to have been terrorised or humiliated at a very early age and in the absence of a capacity to free-associate they desperately need a way through which they can reveal themselves.

Shock states

The events giving rise to these are actual trauma, where the intensity of the event is outside the range of normal human experience. Events such as repeated childhood sexual abuse, the sudden death of a parent or involvement with a plane crash give rise to primitive forms of physiological defence such as dissociation from the body or hypervigilance, either instead of or in addition to the normal psychological defences of projection, denial or repression. The ABP practitioner inherits the bioenergetic understanding of the intense emotional states behind the defence and the correspondingly intense physical interventions that may be necessary at certain points to help people clear themselves of the chronic unresolved shock state and come alive again, often only after a careful preparatory process of rebuilding the bodily capacity for containment. At the same time the ABP practitioner remains psychodynamically alert to the pull of the repetition compulsion, which in the case of a person in shock may appear as an

antitherapeutic demand to be overwhelmed by the power of bodywork — hence the high percentage of clients in shock who gravitate to body psychotherapy.

Acting in

A sixth divergence from psychoanalytical orthodoxy concerns the procedure of 'acting in'. In ABP, as in psychodrama, the therapeutic space is viewed as a theatre in which the sensations, images and impulses of the client will at times through their enactment within the session become the key to the recovery of significant memories, to the deepening of insight and the development of new capacities for relating. I would contend that much 'acting out' as opposed to remembering (meant here as outside the time and the space of the session) occurs precisely for want of a therapeutic preparedness to facilitate 'acting in'. The counterpart to the immobilised client is the immobilised therapist, perhaps deprived by dogma of readily available resources from other therapeutic traditions. On some occasions 'acting in' is carefully delineated. For example a client speaking of parental coldness and lack of experience of physical affection could be helped through an articulated and negotiated demonstration by the therapist or group members of what the client now perceives would have made a difference then. The new representation here is not suggested as a way to rewrite history (as some NLP appears to veer towards) — what happened can't be changed. Rather the aim is to give the slip to the repeating pattern through a progressive experience, where the analysis is embodied precisely in what is counterposed to a regressive transference of attraction, both in and out of the session, to unsupportive and depriving figures. Whereas humanistic therapy can too readily lapse into concrete substitutions, psychoanalytical psychotherapy can too readily hover endlessly in symbolic abstractions that never touch the client. Here ABP occupies middle ground.

Whereas in the example of 'acting in' just given the issue is a deficit at the level of early object relations, 'acting in' is also used where the issue is a block to the expression of a drive, typically an over-inhibition of angry feeling with a knock-on reduction of self-assertiveness. Here 'acting in' would tend to unfold within the transference, perhaps in response to a remark by the therapist , rather than in a negotiated exercise, assuming the client to have a sufficiently well-structured identity. This might be a client who feared that were they to show rage they would be harshly punished, an experience-based anxiety. Less well-structured clients might present with fear that the expression of rage would be uncontainable, so that the therapist would be experienced in the transference as too fragile to withstand the clients' true feelings, thus carrying the clients' own projected fragility. Analysis here is accomplished by a controlled disposal of catastrophic fantasies, a careful disruption of the spell which the client labours under. Modelling an availability for the expression of difference, perhaps consciously acting into an emergent dispute, the therapist becomes available to the client to have a fight with. (Fancy a pillow fight with your therapist?) In general, 'acting in' functions to allow words to be found for emotional processes that took place before words were available to denote specific

feelings. The shared experience of 'acting in' permits either therapist or client to find the necessary words.

For the more psychodynamically minded reader I would make the point that 'acting in' is not to be confused with Ferenczi's experiments in 'active technique', which included the analyst forbidding the discharge of sexual and emotional feelings outside the analytic sessions and/or the analyst's warmth and continuing accompaniment of the client, sometimes as an active participant in their life outside the therapeutic hour; nor with Alexanders' 'corrective experience', where the therapist deliberately adopted a sustained position with the client which was opposite to what the latter had lived as a child. In these two often cited and often slated episodes in the history of psychoanalysis, curative value was attributed to such manoeuvres *per se*. No such claim is made for 'acting in' as employed within ABP The value of 'acting in' is strictly transitional, mobilising an otherwise stuck process which can then continue to resolve through the evolution of the transference relationship. There is also value in interventions that permit clients to experience themselves as a unity, a body–mind entity. Such satisfactions still take place within a longer-term process with sufficient frustration to ensure the crucial constellation of negative transference on to the therapist's person. 'Why don't you still give me the help you gave me then?!!'

Dreams and sexuality

No account of ABP would be complete without reference to the importance attached to dreams as a regular manifestation of the unconscious within therapy and as a trustworthy indicator of changes in clients' feelings about therapy and the therapist. Arising out of the experience of the sleeping body, dreams are viewed for what they tell of the deeper emotio-somatic changes in the client, such as how the client uses experiences and occupies their bodyspace and how their unconscious body image is represented.

Nor would this account be complete without emphasising the importance in ABP of both the functional and fantasy levels of sexuality. It is my and others' impression that in many therapies these are much neglected and that where a client emphasises sexual issues these may be hived off by referral on to a behaviourally oriented sex therapist. In such instances the therapist's countertransferential unease reinforces widespread despair, confusion and resignation over sexuality in the culture at large. Usually at the interview phase of ABP information is requested which sets an expectation that sexuality is very much on the agenda (questions about active sexual practice, orgasmic capacity and sexual fantasising), as it was with Reich, as it continues to be in Lowenian bioenergetics, and as it always was in classical psychoanalytic drive theory before object relations theory (in its preoccupation with maternal love) eclipsed attention to sexual desire. Through questions that people may never have been asked before they will be encouraged to bring in, discuss and make sense of their sexuality both in childhood and in their teenage and adult life. In body psychotherapy conducted face to face or lying down the level of sexual energy provoked may be difficult to contain for either client or therapist, or both. When sexual

issues foreground in ABP, interventions are mostly confined to the verbal symbolic level, the charge is contained and generally not discharged through bodywork, and working through is focused on the elaboration and resolution of transference feelings.

ABP parts company with Reich and Lowen in theorising problems of identity as preceding and exercising a determination upon problems concerning sexuality, where clients' experience of who they are will decide to a high degree how they live a sexual self. Reich's Garden of Eden of good orgasm before the Fall of sexual repression is an alluring vision that has powered many clients and therapists into much body psychotherapy. Alas the vision hardly corresponds with developmental issues and the variety of internal conflicts that emerge in the uncovering process of therapy in depth, ABP or otherwise.

Psychoanalysis critiqued

It was through both a deep appreciation of psychoanalysis, via personal experience of what it can achieve therapeutically, and an equally personal and painful experience of its limitations, of what it can*not* achieve, that after roughly seven years of practice as a therapist it became imperative for me to attempt the kind of synthesis of traditions (while maintaining distinctions) described here. I was fortunate in having two trainers who were up to the job. Readers may have noticed that I tacitly invoke and then more explicitly repudiate the authority of psychoanalysis over the domain of therapy. This is an old story; maybe I've given it a new twist. Other modalities critical of psychoanalysis (and its offspring, psychodynamic psychotherapy) in terms of its efficacy, accessibility and power relations have moved much further away from the analytic tradition.

From the outside ABP may seem rather old hat. Practising it from the inside is another story. The account given here of ABP will perhaps have made it evident that this is a modality that requires a great deal of both therapist and client. I would surmise that it is therefore unlikely ever to become a popular or prevalent practice in the therapy field. Unlike those body psychotherapists who have responded to Freud by embracing Jung, ABP avoids soul talk in its theorisation. This should not be read as a lack of soul, but could be explained as an indifference to propagation and as a position that where therapy is concerned nothing is sacred. ABP is humanistic in the traditional, philosophical sense of humanism, insisting that therapy not become a new religion. ABP is centauric in its double, hybrid and ambiguous character, a body–mind therapy that places thinking and feeling on a par with each other. The invitation of ABP is to a deep encounter between self and other, the task including the realisation of the dynamics shaping a life, the discovery of a degree of internal unity in spite of fragmentation, and the elaboration of personal meaning through a dialogue between the conscious and the unconscious, the mind and the body.