INTERNATIONAL BODY PSYCHOTHERAPY JOURNAL

THE ART AND SCIENCE OF SOMATIC PRAXIS

INCORPORATING US ASSOCIATION FOR BODY PSYCHOTHERAPY JOURNAL

volume sixteen | number three | fall 2017

EABP

EUROPEAN ASSOCIATION FOR BODY-PSYCHOTHERAPY

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The Hub of Somatic Psychology

International Body Psychotherapy Journal
The Art and Science of Somatic Praxis
incorporating US Association for Body Psychotherapy Journal
volume sixteen · number three · fall 2017

The International Body Psychotherapy Journal (IBPJ) is a peer-reviewed, online journal, published twice a year in spring and fall. It is a collaborative publication of the European Association for Body Psychotherapy (EABP) and the United States Association for Body Psychotherapy (USABP). It is a continuation of the USABP Journal, the first ten volumes of which can be found in the IBPJ archive.
The Journal's mission is to support, promote and stimulate the exchange of ideas, scholarship and research within the field of body psychotherapy as well as to encourage an interdisciplinary exchange with related fields of clinical theory and practice through ongoing discussion.

The IBPJ is available free online.
Print subscriptions: http://www.ibpj.org/subscribe.php
Printed single issue Members €17.50, Non-members €20
Yearly subscription: Members €30, Non-members €35
Two-year subscription: Members €55.00, Non-members €60.
Payment through bank transfer, American Express or PayPal.
Changes of address: secretariat@eabp.org
Advertising: jill.vanderaa@eabp.org

Translation The online Journal is published in the English language. Abstracts of articles are to be found on the IBPJ website in Albanian, French, German, Greek, Hebrew, Italian, Portuguese, Russian, Serbian and Spanish.
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If an article originally written in another language has been accepted for publication in English, the full article may also be found in the original language.

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ISSN 2169-4745 Printing, ISSN 2168-1279 Online

Publishers:
USABP usabp@usabp.org www.usabp.org
EABP secretariat@eabp.org www.eabp.org
IBPJ http://www.ibpj.org

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Cover image: Ineffable by Ofra Sivilya

Fall Issue – Editorial

We are pleased to introduce our Fall 2017 issue. This issue marks a significant transition in our team, Jill van der AA, our managing editor since the journal's inception, will step down and in her place taking the lead for our Spring 2018 issue we welcome Antigone Oreopoulou to our team.

Our articles include an in-depth conversation about self-disclosure from a relational body psychotherapy stance. Danielle Tanner begins her two-part paper entitled, *Therapist Self-Disclosure: The Illusion of the Peek-a-boo Feather Fan Dance and the Art of Becoming Real*, with a portrayal of the historical and theoretical perspectives of self-disclosure and its potential benefits. She then delves in the role of self-disclosure in relational body psychotherapy to explore the intricacies, challenges and risks.

Benedek T. Tihanyi and Ádám Balázs Czinege suggest in their paper entitled, *Integrating Daniel Quinn's Cultural Criticism with Body Psychotherapy Perspectives,* that homeostatic dysregulation together with a pattern of domination might contribute to a damaged body-mind connection in the civilized culture, and interact with personal and family stories of trauma. They propose an affirmative therapeutic approach that includes exploring part of the client's suffering that may originate from civilization to reveal it and empathize with it. They also suggest that the process of helping clients get in touch adaptively with their body resonates with helping society get in touch sustainably with the ecosystem and that the two approaches could fruitfully interact.

In *Learning from Sabina Spielrein: Charting a Path for a Relational Drive Theory,* Esther Rapoport and Asaf Rolef Ben-Shahar write about the pioneering work of Sabina Spielrein, in particular they discuss her seminal paper entitled, Destruction as The Cause of Coming into Being (1912), to provide conceptual tools for reintegrating relationality and drives and charting a path for a relational drive theory. In Spielrein's text, the sexual instinct is conceptualized as a thrust toward interorganismic merger – "transformation from I-ness to We-ness" – a process that intensifies the psychophysiological processes of growth and change. The sex drive for her, then, is fundamentally a relational drive. The authors comment on the phallocentricity and heteronormativity of the drive theory and suggest tools for developing a relational theory that could make room for women's and queer subjectivities.

Case material is used to illuminate the theoretical concepts. Michelle L. McAllister explores the formation and effect of internalized maladaptive messages derived from microaggressions in interpersonal relationships, institutions, and dominant culture in her paper entitled, *The Triphasic Cumulative Microaggression Trauma Processing Model informed by Body Psychotherapy.* She then discusses the Triphasic Cumulative Microaggression Trauma Processing Model, considered a blend of sensorimotor psychotherapy, dialectical behavior therapy's Safe-Place Visualization, Identity theory, traumatology, and processing through cognition, emotion, and body sensation, and offers a case study to demonstrate its use in the therapeutic setting.

The Fall issue also offers book reviews with commentaries for two recently released publications: *The Body Remembers Volume 2: Revolutionizing Trauma Treatment* by Babette Rothschild, and *Character Strengths Interventions: A Field Guide for Practitioners* by Ryan M. Niemiec.

Our Editorial team, our dedicated peer reviewers, and our submitting authors have worked diligently to share these original papers with our readers. We hope the content will engage not only readers' internalized mind/body relationships but also stimulate conversations about the concepts presented on our IBPJ Facebook page, via emails and letters to the Editors and/or the EABP Newsletter. To write in isolation is but the beginning; the depth and reach of each paper comes to the forefront of our work in relationship, and we invite you, our readers, to join us in advancing our field of study and practice by joining conversations, by submitting your research papers, case studies, theoretical advances, academic book reviews, appropriate commentaries and more to the IBPJ.

We also want to congratulate our Editorial Team member Yael Shahar on her recent completion of her Master's Degree in Body Psychotherapy at Anglia Ruskin University.

Sincerely,

The IBPJ Editorial Team

Ineffable

Ofra Sivilya

And old age approaches her, sitting in her lap like a stubborn cat who refuses to move from his seat, until an unfathomable call whispers inside of him, so he raises and leaves elsewhere.

Thus old age sits, determined, before the woman has ripened to receive her, ready to know further, to rest within her complete wisdom.

A woman who leaves not her four cubits, not even to reach out to the outside to retrieve a new memory, and old pain, a familiar grace.

She sits here, like the Buddha, asking for some appeasement she could not find, waiting.

From her window, barren landscapes are seen, monotonous, matching the rhythm of her heart which tendency was to storm yet in her fear she quietened her heart, so much so that sometimes her breath is missing, her soul nearly takes off.

A gloomy cloud, wrapped round her neck and shoulders, concealing a bright blue sky. Her face is worn with sourness, for which a recipe of sweetening has not yet been found. Only her lean body insists of narrow rays of her youth, which she had allowed to pass, with unbearable ease, sounding voices of partial awakening. As she sits, as she waits, she removes and adds, stirring and stirring without tasting, enchanting and whispering words of divination, changing the order of her world, inside.

She loses touch with the outside world, paying no attention to the scribbled notes of dreams which she kept in her pockets, some are so close by already; a mere kiss's distance.

Therapist Self-Disclosure: The Illusion of the Peek-a-boo Feather Fan Dance Part I: The Art of Becoming Real

Danielle Tanner

Received 2nd February 2017, accepted and revised 13th July 2017

Abstract

This article is Part I of a two-part exploration of therapist self-disclosure. These papers view therapist self-disclosure as an integrative concept, in that it can promote a movement toward a deeper, more authentic therapeutic alliance, whilst advancing therapeutic change. The first section is a literature review, it presents the history and theoretical perspectives regarding this intervention. This is followed by a description of the tools and processes employed by relational body psychotherapy in regard to self-disclosure. A clinical case study illustrates the use of self-disclosure by a relational body psychotherapist and the impact on the therapeutic relationship and outcomes. The paper concludes with an exploration of the potential benefits of appropriate self-disclosure.

Part II will explore the intricacies, challenges and risks of self-disclosure.

Keywords: Therapist self-disclosure, therapeutic relationship, relational body psychotherapy

International Body Psychotherapy Journal *The Art and Science of Somatic Praxis*
Volume 16, Number 3, Fall 2017 pp 07 - 20. *ISSN 2169-4745 Printing, ISSN 2168-1279 Online*

Introduction

Self-disclosure, and the Art of becoming Real.

"What is REAL?" asked the Rabbit one day, when they were lying side by side near the nursery fender, before Nana came to tidy the room. "Does it mean having things that buzz inside you and a stick-out handle?"

"Real isn't how you are made," said the Skin Horse. "It's a thing that happens to you. When a child loves you for a long, long time, not just to play with, but REALLY loves you, then you become Real."

"Does it hurt?" asked the Rabbit.

"Sometimes," said the Skin Horse, for he was always truthful. "When you are Real you don't mind being hurt."

"Does it happen all at once, like being wound up," he asked, "or bit by bit?"

"It doesn't happen all at once," said the Skin Horse. "You become. It takes a long time. That's why it doesn't happen often to people who break easily, or have sharp edges, or who have to be

carefully kept. Generally, by the time you are Real, most of your hair has been loved off, and your eyes drop out and you get loose in the joints and very shabby. But these things don't matter at all, because once you are Real you can't be ugly, except to people who don't understand."

From The Velveteen Rabbit, (or How Toys Become Real), M. Williams, 1922.

Definition of Self-disclosure

The psychotherapy room is a place where clients are expected and encouraged to confide their secrets, dreams, fantasies, suppressed memories and immediate somatic and emotional experiences. Clients come to talk about themselves, and therapy is one of those rare moments in life where talking about oneself is not only considered permissible, but necessary. The therapeutic space is also an arena where the therapist must consider what they share with their client, where there is an appropriate balance between the helpfulness of sharing a part of ourselves with another and the recognition of the danger, of perhaps sharing too much too soon. Intentional therapist self-disclosure is the self-revelation of our experiences, of our stress, our anxieties, our resilience and our coping strategies, both successful and not, in the face of human suffering (Farber, 2006). Several authors have attempted to identify deliberate/elective therapist self-disclosure. Hill and Knox (2002) created categories of self-disclosure. They included information ranging from biographical facts (i.e. professional training) to 'strategies', or ideologies that the therapist had found helpful for different life events. In addition, they included the disclosure of feelings, those evoked for a therapist through a past experience, immediate thoughts or feelings regarding the client, as well as those involved in the therapeutic relationship and process. Self-disclosure may also be a means of affirming or reassuring the client, or a way of challenging the client's thought processes or behaviour.

'All disclosures reflect decisions about the boundaries between our private self and the outer world' (Farber, 2006: 1), therefore, conscious self-disclosure and transparency should be appropriate, client-centred, clinically-driven and compassionate. It should be empathetic or 'judicious' (Rachman, 1998). An intervention such as self-disclosure requires a boundary crossing rather than a seduction or transgression (Gutheil & Gabbard, 1993: Gutheil & Brodsky, 2008; Zur, 2004).

What follows is a review of the developing ideas regarding therapist self-disclosure, and a history of the use of self-disclosure in the major schools of psychotherapeutic thought (psychoanalytical, humanistic/ client-centred, behavioural and systemic).

The Historical and Theoretical Positions Regarding Self-disclosure

'The physician should be impenetrable to the patient, and like a mirror, reflect nothing but what is shown to him.' (Freud, 1912: 331)

The theoretical orientation of classical psychoanalysis dictated therapist neutrality, abstinence and anonymity as the axis of psychoanalytical technique, and the foundation for transference analysis (Peterson, 2002, Tubert-Oklander, 2013). The resultant, dual-created, interpersonal void allows for the emergence of the client's unconscious conflicts and desires, which are projected onto the 'blank screen' analyst and the therapeutic relationship (Freud, 1915).

Therapist self-disclosure was regarded as an impediment to this process, in that the client, confronted with the reality of the therapist's self, would halt the possibility of fantasy, and

therefore the transference would be contaminated. The traditional psychoanalytical stance held that by sharing our personal self, rather than simply transitory or situational thoughts and feelings, the known could never be Unknown. It would irrevocably distort the therapeutic alliance, and compromise therapeutic effectiveness (Shill, 2004).

Whether this conservative analytic doctrine was followed in most therapeutic settings is a debatable question, and was certainly not what Freud, the author of these 'rules', tended to abide by in his actual clinical practice (Lynn and Valliant, 1998). This is exemplified by Freud's humanistic and responsive approach to his analysand, in the case of Sergei Pankejeff or The Wolf Man (Freud,1918).

Ferenczi, Freud's contemporary, challenged this standpoint. Ferenczi (1933, 1988) departed from the paradigm of the analyst as a cold, clinical surgeon ensconced within the antiseptic environ of a clinical situation of detachment, clinical expertise, and control (Rachman,1998). Instead, he embraced an ethos of genuine sincerity, honest self-disclosure and warm, empathic attunement. He believed this was essential to reach a traumatised individual and he challenged the nature of clinical interactions between analyst and client. He advocated self-disclosure as an active intervention, and a means to provide reparative emotional experiences, especially in cases of complex trauma (Rachman, 2007) and therapeutic mishap (Ferenczi, 1928). He felt that self-disclosure was essential in redressing power asymmetry (Gaztumbide, 2012) and that to maintain a cold, patriarchic distance was likely to re-enact original childhood traumas, and was indeed counter-effective (Ferenczi, 1933, 1988).

The idea of anonymity began to be questioned. For instance, Ferenczi (1933) noted that clients, who had repeatedly been abused and invalidated in their earlier life, often develop an exquisite perceptiveness of others' internal states -*'they show a remarkable, almost clairvoyant knowledge about the thoughts and emotions that go on in their analyst's mind. To deceive a patient in this respect seems to be hardly possible and if one tries to do so, it leads only to bad consequences'* (p.161). Therefore, he believed that not only was a stringent avoidance of self-disclosure damaging but that a certain degree of self-disclosure was inevitable.

However, the neutral stance, espoused by Freud, continued to be adopted by successors of classical psychoanalysis. Ego psychology perpetuated the axiom of anonymity (Hartmann, 1964). Object relations theory asserted that the therapist could use their countertransference as a tool for identifying unconscious object relations within a client, however, this school continued to discourage the use of non-immediate therapist self-disclosure (Ziv-Beiman, 2013). Even with the event of self-psychology, the emphasis was upon the therapist as a self-object, rather than as a joint participant (Kohut, 1971). It was only within this framework that self-disclosure could be utilised, for the therapist to elucidate their response towards the client in the transferential context.

The paradigm shifted, with the dawning of the intersubjective and relational schools of thought (Mitchell, 1988). However, as Ziv-Beiman (2013) illustrates, there are contemporary strands of psychodynamic and psychoanalytical approaches that encourage some therapist self-disclosure, unaffiliated with the intersubjective or relational movement (Farber, 2006). These proponents believe that self-disclosure should not be unsolicited, but evaluated within the setting of the therapeutic dyad. However, many scholars feel that self-disclosure is inevitable (Farber, 2006) and that change cannot happen without intentional self-disclosure from the therapist as it reveals them to be a 'real person' (Renik, 1995). Nevertheless, there is also the tacit understanding that the intervention should be assessed within the context of the relationship, and at time-appropriate moments in the process (Greenberg, 1995, Mitchell, 1997).

Relational theory and practice highlight the interpersonal aspect of the analytical situations, as well as the role of the therapist's subjectivity in the transference-countertransference dynamic (Aron,1996; Greenberg & Mitchell, 1983; Wachtel, 2008). In contrast to classical psychoanalysis, the interpersonal focus of several modern psychodynamic psychotherapies places importance on self-disclosure in relational and intersubjective perspectives (Aron,1996). The concept of intersubjectivity posits that a client must be deeply met and recognise an 'Other', to identify their commonalities and differences and, thereby, gain ownership of their subjective experience, in relation to 'Other' (Benjamin, 1988).

Along with this perspective change, there has been the development of clinical work within diverse populations, which has fostered a greater awareness of race, gender, and class in the analytical relationship (Moodley & Lijtmaer, 2007; Moodley et.al., 2013). This has led to a movement towards greater efforts for social justice within psychotherapy, and a more egalitarian approach, invested in deconstructing power hierarchies and reducing cultural mistrust within the therapeutic dyad (Aron & Starr, 2012, La Roche, 2013). For many, self-disclosure is a means to this end (, Perez-Foster et al., 1996; Thompson et al.,1994). Additionally, this openness can reduce the transference that can occur in a more analytical, anonymous therapy as it allows for a revealing of the therapist's reality. Inadvertently, it destroys the transferential fantasy; undercutting both idealisation and demonisation of the therapist by presenting a more human face (Waska, 1999).

Humanistic and existential practitioners suggest that therapy necessitates appropriate self-disclosure. Self-disclosure can demystify psychotherapy, challenge the power hierarchies between therapist and client and promote the tenet of therapist authenticity and genuineness (Jourard,1971). In humanistic philosophy, self-disclosure is a means to illustrate the universality of human suffering, limitations, and unresolved issues. Geller (2003), asserts that disclosure plays a role comparable to clarifications, interpretations, and questions in the repertoire of therapeutic tools. Existential therapists share similar views to the humanistic schools, as they are encouraged to share their coping strategies and beliefs in the face of existential issues of meaning and purpose, to enable their clients to find their own (Jourard, 1971; Yalom 2002).

Historically, Cognitive- Behavioural therapy (CBT), has little reference to the practice of self-disclosure, apart from Goldfried et al. in 2003, whom specifically outlines the rationale for using this intervention in CBT. However, Panagiotidou and Zervas' review (2014), acknowledges that social changes and developments in medical science, which empirically support therapists' self-disclosure, have prompted the adoption of new self-disclosure practices. Current approaches, such as Acceptance and Commitment Therapy (ACT), advocates therapist self-disclosure in instances where it enables 'normalization, validation' promotes 'self-acceptance' or enhances the therapeutic relationship (Harris, 2009:235). Nevertheless, this intervention is seen as context dependent, determined by the unique qualities of the participants as well as where they are in the course of treatment.

Other therapeutic approaches, such as social constructionist family therapy (Freedman & Combs, 1996), actively support the use of therapist self-disclosure. 'Reflecting teams' of clinicians are encouraged to make observations within a personal context (i.e. "As an African-Caribbean woman, growing up in a mining town in the East Midlands...."). In associated narrative approaches, for example, 'The Tree of Life' project, there is a radical approach to disclosure in that the facilitators are sharing their life stories (Ncube, 2006).

In feminist approaches to psychotherapy, the therapist is encouraged toward deep self-reflection and critical self-analysis. Greenspan (1995) states, "I am a great believer in the art of

therapist self-disclosure as a way of deconstructing the isolation and shame that people experience in an individualistic and emotion-fearing culture" (p. 53). Considered self-disclosure is valued for its ability to reinforce modelling and foster a more egalitarian, mutualistic relationship between therapist and client, by diminishing asymmetry and power play. Self-disclosure informs the client of the therapist personal opinions and values in political and social arenas. Thus, it enables greater agency for the client. (Greenspan, 1986, 1995; Simi & Mahalik, 1997).

The overall trend in practice shows increased interest in the subject of therapist self-disclosure both in theoretical and research literature. Nevertheless, there remain practitioners who maintain that explicit self-disclosure is unethical or exploitative. They feel that by engaging in this intervention, we are opening ourselves up to the prospect of alienating our client and causing 'alliance ruptures'. These ruptures will then prevent the fantasy of transference and their resolution. Bernstein (1999) severely criticises therapist's disclosure of countertransference as an 'infatuation'; an 'elegant disguise' for a therapist's 'narcissistic gratifications' at the expense of the client's intrapsychic (unconscious) conflicts (p.281). Furthermore, there is the idea that intimate self-disclosure will become exploitative and lead down the slippery slope of either sexual re-enactment or regressive collusion (Gutheil and Gabbard, 1993).

However, the profession-led prohibition on self-disclosure has gradually loosened its iron hold. It is no longer the 'dirty little secret' of the therapeutic world and scholars have begun to expound the positive attributes of therapist self-disclosure, particularly regarding the disclosure of countertransference.

Relational Body Psychotherapy, Resonance and Self-disclosure

Over the last twenty years, relational psychoanalysis has emerged. The philosophy and clinical practice are characterised by a movement from the classical Freudian drive theory (which is impersonal and endogenous) to a developmental model approach (which includes such key concepts as attachment theory, object-relations and self-psychology) (LaPierre, 2015). Therapeutic neutrality and anonymity have been replaced by the therapeutic relationship between client and therapist, as the central locus and primary agent of change. Influenced by this movement, body psychotherapy has begun to incorporate and embrace relational psychoanalytic principles. Relational body psychotherapy (or relational somatic psychotherapy, as it is known in the United States) emerged from this union. This union has been a fertile connection and a greater integration of the two worlds of the psyche and the body (Rolef Ben-Shahar, 2014).

Relational body psychotherapy, underpinned by the humanistic movement and attachment theory, is an embodied clinical approach, which incorporates transference dynamics and therapeutic resonance within a 'relational matrix' (Rolef Ben-Shahar, 2014: 319). Self-disclosure has been an important issue in the world of psychotherapy, and specifically in relational body psychotherapy, where it is joining analytical discourse and contributing somatic skills to the understanding of self-disclosure.

In Davies' (1994) seminal and controversial paper, *Love in the Afternoon, a* clinical vignette is included in which she, the relational analyst, felt it necessary to disclose the presence of her erotic countertransference. Despite Davies being a prolific writer, this piece attracted more attention than any other article she wrote. Twenty years later, in her review of her 'enfant terrible', she examines how it was loved and reviled within the analytical world (Davies, 2013). Davies' original article encourages the appropriate verbalisation of transference and countertransference to untangle and demystify early relationship patterns. This now-classic

paper, further opened up collegial discussion on disclosure of countertransference and, especially erotic countertransference. However, Slavin (2013) suggests that Davis' 'real moment of truth' was 'not a self-disclosure at all', as the thought was not unknown to the client (p.145). She did not say anything that was not known. Instead, she spoke the truth of a poisoning re-enactment. Rolef Ben-Shahar (2014), a relational body psychotherapist, furthers this distinction, by suggesting that sharing resonance material with our clients is not necessarily self-disclosure but a sharing- as Slavin conceptualised - of a 'moment of truth' that 'has the potential for therapeutic transformation' (p. 304).

Going beyond emotional contagion and natural empathy, body psychotherapists develop their capacity to consciously observe and follow changes in 'gut' feelings, the breath, physical tension, heart rate and other bodily sensations, both in their clients and in themselves. In conjunction with supporting their clients' ongoing, and spoken emotions, thoughts and reactions, the relational body psychotherapist is guided by their internal bodily responses.

Relational body psychotherapist will use therapeutic resonance, a 'superb diagnostic tool' (Rolef Ben-Shahar, 2014: p. 298) to bring into awareness non-verbal and unspoken communication in the shared relational field. The body psychotherapist may consciously cultivate this skill, of using their body as an amplifier, into feeling into the intersubjective space and body (themselves and their clients). This process of resonance, of tracking changes through sensory attentiveness, and sharing resonant experiences necessitates a degree of self-disclosure.

Relational body psychotherapists, through the mechanism of resonance, can develop empathy and recognise embodied transference and countertransference. Embodied transference and countertransference refer to the way therapists and clients experience each other's physical states within their own bodies. This mutually-created, bodily (somatic) phenomena (Totton, 2014) is not 'only psychological, but also a bodily process' (Totton & Priestman, 2012: p. 39). Body-centered countertransferential experiences, such as sleepiness, shakiness, muscular tension, sexual excitement, yawning, churning stomachs and nausea (Egan & Carr, 2008), can be vital clues to the intrascape of our client. This bodily conversation is the 'terrain of relational therapy' (Totton & Priestman, 2012: p. 41), a shared attempt to work backwards from transference and projections about each other, which demands an embodied experience and self-disclosure. By disclosing resonant material (or countertransference) with sensitivity, responsiveness and mutual feedback, the therapist can deepen trust, while maintaining focus on therapeutic undercurrents and providing resources to their client.

The profession-led taboo on therapist self-disclosure, orchestrated by classical psychoanalysis, may be an illusion, a misguided belief that we have complete control about what we reveal or keep hidden. In fact, our choice on what we disclose may be inhibited by metaphysical constraints. Intrapsychic and interpersonal interactions are not entirely predictable or controllable. Within the intersubjective space there can develop a rhythmic sense of oneness - like the mother-infant dyad- in which there is a mutual dialogue, and an unspoken, two-way transmission of information. As relational therapists, we should offer containment and holding for intense affective experiences for our clients, but we also recognise mutual influence and our permeability. We may not be able to stringently hold our boundaries in this 'boundless work' (Totton, 2010), and if we followed the process advocated by Gutheil and Gabbard (1993), of avoiding even the appearance of boundary violations, we could also run the risk of becoming ineffectual. The relationship between client and therapist can be a multidimensional, psycho-somatic interaction. With that in mind, we can hold boundaries as an honouring of the client, while with care and attention, and in the interest of trust, authenticity, and therapeutic

transmutation, we can dance outside of this frame.

I will present a vignette of my work with one of my clients, to illustrate self-disclosure.

Vignette

I am sitting with my client Mark, and we are discussing his alcohol addiction. Mark has slowly begun to discuss his familial and personal issues around trauma and addiction over the course of our relationship together. Today, he came into my clinic appearing disheveled, physically and emotionally exhausted and pained in his movements. His eyes are downcast, and when he suddenly and narrowly looks up at me, I notice how red-raw and bright his eyes are. He has arrived at my clinic still within the throes of a significant hangover.

"What about you? Do you drink?" He begins. I falter as I am trying to come up with an appropriate answer- the 'right' answer. I know that I have not, yet, met him fully in our relationship and that this degree of disclosure and intimacy feels too quick. However, there is as much ground to gain or lose, in this tenuous and precarious place, and somehow, I know that I am just not going to get it right. I am already aware that this is how he began his most important personal relationships - in a rush. Significantly, this is also how many of his relationships were quickly crushed and abandoned. I have no wish to be one of his extinguished cigarette butts.

While I am still trying to shape an answer, he is relentless with his questioning. "How much do you drink? How often? What about with a meal? A bottle of wine to finish the day? What about if a mate arrives in town, that you haven't seen for ages, what then? You can't say no, can you?". My heart is racing. I can feel the heat of uncertainty on my back and a rush of adrenaline. "Why does this mean so much to me, to get this answer right?", I ask myself. I can hear my inner critic resounding in my head, "And fools rush in ...". I notice how desperate he is for my answer, and for it to be my truth, not a premeditated, and censored, 'therapeutic' version. I took a breath and chose to disclose my relationship with alcohol.

Then, for the first time, he revealed how much he had drunk the day before, and the impact it was having on his business and his relationships. He spoke of how frightened he had become of the detrimental impact alcohol was having on his body, and of how many times he had blacked out, without even the creation of a memory to attach to. Then, over many sessions, we discussed our experiences and relationship with alcohol and our strategies, successful or otherwise, for coping with trauma. He stopped drinking. He attributes it to one moment in that initial conversation, at the beginning of his self-described 'confession', where I had authentically disclosed my relationship with alcohol. Yet, unacknowledged by him, a catalogue of mutual, deliberated disclosures led us to this place. It was in these moments of transparency, which I felt enabled both the therapeutic alliance to strengthen and where I became - like the velveteen rabbit - 'real' for Mark.

His recognition of his alcoholism opened the floodgates for him, initiating his first step into recovery. He began to tell his significant others that he was engaging in the recovery process from alcohol addiction, which in turn, increased his sense of accountability. He began to reflect on unresolved material from his childhood, such as growing up with a highly functioning, alcoholic father, who was "the life and the soul, but physically trembled before any social event", and was unable to tolerate any emotional turmoil or charge, even positive. The patriarchal model of the 'introverted exhibitionist' had been, unwittingly, adopted by both of his sons.

The therapeutic journey to recovery demands a resilient therapeutic relationship, based on trust, as it is long, difficult, and uncertain, with no guarantee of success. Mark continues to progress on his journey, and after four 'dry' years he is still progressing towards an association

of pleasure with his sobriety ("my body feels great, I can breathe, but it's boring"). He has an ongoing struggle of embodying two world realities. At his core, he knows that he is an addict that cannot choose whether he can drink or not. On another level, he cannot reconcile this with the idea that he is just an ordinary man, who likes to celebrate with his friends and use alcohol as a social lubricant. His self-belief that he is a man of strong character and single mindedness does not sit cogently with his internal perception of a 'weak' addict, and yet these two aspects are both housed in this same animal body.

Later in the therapy, Mark became immersed in the world of international dating agencies and ran up subscription fees of tens of thousands. It was apparent that his addiction had become manifest in another arena. These costly relationships were mediated through emails, translators and telephones. Love letters had to be bought and translators and agencies paid. He never met, touched or sat in the presence of any of his suitors. These relationships expressed his need for connection to another, and the lengths he would go to. Yet, they stopped at the fantasy. As soon as he booked flights to China, prepared his hotel bookings, a woman that he had expressed interest in began to reciprocate his affection. Almost immediately he cancelled all connection. He stopped dead in his tracks and turned away, from China, and from this woman at his office. He reinforced his inner belief that although he had found the 'perfect partner', he did not have time in his busy schedule, and they would only disappoint him anyway. Although professionally successful and able to sustain long term, loyal friendships, he was protecting himself from engaging in a possible, but real intimacy. His overly jocular manner was concealing a restricted expression of emotions, and detachment.

I was aware of Mark's conflictual self-states (Bromberg, 1996) in the transference and projections that were already evident in our relationship. He would veer from a multiplicity of states: from dissociative 'trance' states where he would vividly recount traumatic events in his life but then, like an amnesiac would struggle to recall them in later sessions to intense, heart-breaking, intimacy. He had often been very direct in his questioning of my professional capacity, yet it took him several months to begin asking more personal questions. He was curious about my marital status, and whether I had children, this he initiated by his revelation of how he and his last partner were about to embark upon IVF before he had decided to end their relationship. I answered him, after some consideration. I hesitated as I felt unsure as to whether I wanted to expose so much of myself to him, as well as fearing that it would have a negative impact on our relationship, or take the focus away from him. I wanted to avoid therapy becoming 'too conversational' and therefore cease to provide my client with a clear therapeutic model. I did not want to meander too long, whilst I appreciate that I was providing warmth and empathy, I was also concerned that there was no direction or challenge for the client, and therefore little progress was being made.

When he remarked that I did not look old enough to have three children, it was clear that he did not intend to be flattering, and that he and I are, evidently, both old enough. This self-disclosure opened up the scope for further exploration, about how he felt about his age, what he had achieved, his aims in life, and how he felt about his achievements and creations. It led us to discussions of his feelings regarding his mortality, and how much time he felt he had.

These disclosures and interpretations, then lead us into more contentious ground, one in which I began to question his attraction to younger women, and the dissatisfaction that had manifested in his previous romantic relationships. This opened an exploration of the disquieting sense he embodied; of the unravelling of his dreams and aspirations of having a family life. Upon learning that I had only met my husband after the birth of my second son,

he remarked that he felt that I had overcome significant relationship difficulties and heartbreak and eventually found a way, however unconventional to him, to have the family I had today. He felt re-affirmed by this knowledge, and that my sharing had fostered a feeling that we were "in it together." He felt I was committed to him, his journey and to wherever it was going to lead us.By following a relational approach, and by making my inner experiences accessible, my non-immediate self-disclosures allowed for a deepening intimacy. This was verified by Mark.

His constant preoccupation with finding the 'perfect' romantic partner was masking his terror of a genuine connection. On reflection, he saw how he had suffered his heaviest drinking period during a relationship where he felt unable to escape his partner's sexual advances unless he was in a bar, or too drunk to perform. I felt that his behaviour exemplified how deeply fearful of intimacy he was, and how torn he was between the conflictual needs for both dependency and autonomy. I disclosed my sense of how he, like his father, presented himself as the humorous, playful archetype, yet he sabotaged the connection he yearned, that he was unable to allow existence. Connection was prevented by his exhausting work schedule, and his solitary, often gruelling, physical activities; both precluded him from having a romantic partner.

We came to recognise that his emotional needs were complex. A fear of abandonment drove him, yet he was fiercely loyal and had the ability to hold lifelong friendships. He was not one-dimensional, but intricate, controversial and conflictual. We began a painstaking, long term examination of the factors that prevented him from engaging in a 'real' relationship. A real relationship which is complex, troubling and often frustrating, but can lead to a long term, dependable, reciprocal and loving relationship.

Discussion of Vignette

My disclosures and interpretations were an attempt to address behavioural, cognitive, emotional and interpersonal aspects of his therapeutic growth. At the same time, while we related to the past, present and the here and now experiences, I concurrently demonstrated my commitment to the relationship, which resulted in a deepening of trust. I believe that this active intervention of self-disclosure was a technique that encouraged insight, behavioural and cognitive change, and transformation regarding his experience of self and others.

If we consider the integrative influence of therapist self-disclosure (Ziv-Beiman, 2013), in that it can simultaneously promote different therapeutic goals, and the therapeutic relationship, while providing support and challenge to the client, we can see its powerful role. The clinical implication is that we may consider using self-disclosure when we are seeking to pursue different therapeutic goals and potentially diametric pathways. For example, when we are pursuing a course with our client, and we aim to challenge their perception, thinking or behaviour, we can concurrently strengthen the therapeutic alliance using self-disclosure. The employment of self-disclosure can potentially integrate these two approaches while maintaining homeostasis between challenging and supporting the client in the here and now. Self-disclosure has been a principal element in creating this resilient therapeutic relationship, which although still difficult, is continuing to progress and remain fruitful.

What does it mean to become Real?

As a practitioner of body psychotherapy and Integrative Mindbody Therapy (IMT), I consider my work to be both relational and embodied. In my experience, I have found self-involving disclosure, where the therapist reveals his/her experiences or personal reactions to the client, to be an effective form of communication. I have also found it to be the most challenging

as a practitioner. Self-disclosure demands resilience from the therapist. By allowing ourselves to be seen by our client, we can move from being an object, to becoming 'real'. However, as the Skin Horse explains in the opening gambit it takes time, and we may become 'loose in the joints and very shabby' as we lose the veneer of perfection. However, by instilling a sense of shared intimacy, and deepening the therapeutic relationship through authentic self-disclosure, we open possible doorways of change. Self-disclosure can also challenge the client's perceptions, and create insight into their behaviour. Together with the most fundamental element of love, and more than a little magic, we can form a real relationship with our client.

Self-disclosure creates an environment of congruency and authenticity. As a therapist, I envision my role as one of co-participant and co-creator of the therapeutic relationship. I want a lively engagement with my client, in that I enter the therapy room both with my skills set and theoretical base, at the same time as making myself emotionally and intellectually available. This positioning lends itself to a certain degree of vulnerability and intimate potential behind these closed doors, and the relational therapeutic practice amplifies the complex and nuanced issue of self-disclosure. The intimate nature of the relationship is then further complicated by the close, physical proximity of a body psychotherapist to the client, especially during touch work. Within erotic transference and countertransference, there may be even greater disclosure, as the very conformation of the transference dictates a certain, charged intimacy (Maroda, 2002).

As an advocate of human agency, I am invested in an open and egalitarian relationship which permits mutual self-disclosure. From the theoretical orientation of a relational body psychotherapist, the centre of my therapeutic work is our connection with each other. I choose to bring my subjectivity into my practice, and this, in turn, affects the degree of self-disclosure that is evident in my therapeutic sessions. However, I do not believe that this necessitates unbridled self-disclosure. There can be a 'misperception that to work relationally means to disclose relentlessly' (Watchtel, 2008:245), and we should be 'attentive to the consequences' (Watchel, 2008: p.247).

When I am self-disclosing, I am taking a calculated risk. Each self-disclosure has the potential to become a powerful integrative intervention, that may effectively strengthen the therapeutic relationship, and initiate change in 'emotions, thoughts, motivation, behaviour and interpersonal relationships' (Ziv-Beivman, 2013: p.59) or risk a rupture or even a termination of the therapeutic relationship. There is a need to hold the tension between alliance and challenge.

Why Disclose?

Our self-disclosure intervention can achieve a myriad of therapeutic outcomes: encouraging the development of the therapeutic relationship, correcting misconceptions, and normalising the client's experience (Henretty & Levitt, 2010). Self-disclosure can illustrate the commonality of destructive behaviours or cognitive patterns, and can even mitigate a therapeutic impassé (Maroda,1999) or rupture in the alliance. If we listen and disclose empathically, we can become an empowering agent.

Additionally, self-disclosure is utilised to reinforce desirable client behaviour, to offer alternative ways to think or act, or to help clients recognise boundaries between self and others (Henretty and Levitt, 2010). It can provide an authentic human-to-human interaction, and encourage client autonomy. It validates the person's perception of the world and strengthens the therapeutic relationship/ alliance by creating a deeper sense of intimacy or closeness (Jourard, 1971). Hopefully, the effect will be to form a connection and convey 'presence'

through attentiveness and responsiveness (Audet & Everall, 2010: p. 358). This is of particular importance for clients with significant, diagnosed psychopathology, such as psychotic disorder. For those who suffer from social isolation or exclusion, the value of the therapist self-disclosure is that the client can feel heard, in their unusual experiences and related to by another. Even the sharing of everyday experiences can, in itself, be inclusive and de-stigmatising (Ziv-Beiman et al., 2016).

Often self-disclosure is seen to be at the heart of relational practice. In relational theory, with the dyad-centric approach, self-disclosure can be a means to elucidate on issues such as affect regulation, defences, and transference - countertransference enactments. We can make these issues more understandable to the client, which can be both enabling and empowering. However, there is a risk that when we are challenging a client, we are entering into their unconscious internal world where there is repression and resistance. For example, if, in our disclosure, we are raising significant sexual issues, we run the risk of being profoundly misunderstood, particularly when these topics arise within an erotic transference. Erotic transference is a point at which disclosure may happen involuntarily (Maroda,1999). As clinicians, we need to consider using more than anodyne, or remote clinical language. However, we risk causing offence, breaking the therapeutic alliance or leaving ourselves vulnerable to attack, especially when relating disclosures of countertransference.

We need to be confident that by disclosing a transference interpretation we are not engendering misunderstandings, particularly when we are challenging issues surrounding the client's acting out and malign regressions. We are not only allies but catalysts for transformation and generation. We encourage our clients to understand and own for themselves, their introjections, their identifications, and projections, which can bring about change.

Offering an alternative perspective or sharing our coping mechanisms or abilities, at the same time as attempting to gauge our client's reaction, requires a degree of sensitivity and receptiveness to how the intervention is received. By enabling an element of client agency in the self-disclosure and allowing the client to explore their self-experience, they can feel that they are a decisive agent within a mutual dyad (Aron, 1996). Thereby addressing the central theme of asymmetry, within relational work.

BIOGRAPHY

Danielle Tanner is a mother of three children, a wife, and a relational body psychotherapist. She trained with Silke Ziehl, of the Entelia Institute at The Open Centre in Deep Bodywork/ Postural Integration. She furthered her training with Dr Asaf Rolef Ben-Shahar in Integrative Mindbody therapy (IMT).

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Deepest gratitude for her teachers and to her supervisor, Nick Totton.

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Therapist Self-Disclosure: The Illusion of the Peek-a-boo Feather Fan Dance Part II: A Risky Business

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Received 2nd February 2017, accepted and revised 13th July 2017

Abstract

This article is Part II of a two-part exploration of therapist self-disclosure. These papers view therapist self-disclosure as an integrative concept, in that it can promote a movement towards a deeper, more authentic therapeutic alliance, whilst advancing therapeutic change. Part II continues a discussion on the role of self-disclosure in relational body psychotherapy, and explores the intricacies, challenges and risks of self-disclosure.

The paper begins with an examination of the unique challenge that the Internet poses for therapist self-disclosure and the protection of privacy. This is followed with an exploration of accidental, inevitable, unspoken, and unconscious self-disclosure. There is an account and discussion of a clinical vignette to illustrate a self-disclosure that led to a breakdown in client trust, contrasted with two clinical examples demonstrating how the deliberate use of self-disclosure can lead to positive outcomes for the client and the therapeutic alliance. Following is an enquiry as to whether we, as therapists, have full control over the boundaries of self-disclosure, particularly when engaged with relational body psychotherapy and touch. The article concludes with a discussion on how we can regulate disclosure, and ensure safety for ourselves and our client.

Keywords: Therapist self-disclosure, relational body psychotherapy.

International Body Psychotherapy Journal *The Art and Science of Somatic Praxis*
Volume 16, Number 3, Fall 2017 pp 21 - 33. *ISSN 2169-4745 Printing, ISSN 2168-1279 Online*

Introduction

The notion of risks and rules are inherent within the literature on self-disclosure. The nature and the degree of self-disclosure varies with each theoretical orientation, from the classical psychoanalytical schools who view it as unequivocally counterproductive, to the humanistic schools who view therapist self-disclosure as an important tool to facilitate authentic connection (Peterson, 2002).

The discourse about self-disclosure abounds with conversations about the concept of boundaries. Defined as 'the ground rules of the professional (therapeutic) relationship' (Barnett, 2011:p. 316), boundaries are in place to provide a sense of safety for the client, and reinforce the belief that the therapist will act in the client's best interests (Pope & Keith-Spiegel, 2008). However, within relational work, therapeutic boundaries need to be permeable. As relational body psychotherapists we are in touch with clients, and our boundaries allow for mutual influence and yet should offer containment and holding for intense affective experiences.

We can honour traditional parameters of safety within an ethical frame, whilst in the interests of therapeutic transmutation encourage openness.

Therapist self-disclosure is a calculated risk, which we take. When we share our thoughts or struggles, we need to consider as to whether it is suitable and therapeutic. The practice of ethically-sound self-disclosure is far from being a simple, straight-forward, or even intuitive matter for the thoughtful clinician. Instead, it is an art form that depends on the psychotherapist's ability to integrate theory, experience, and self-awareness. Even with consideration, our self-disclosure can carry serious negative consequences, in that it can hurt or alienate the client, damage the therapeutic alliance, diminish trust in our professionalism or competency, or even cause a premature termination of therapy (Audet, 2011).

This article begins with an examination of modern day challenges, such as our diminished privacy due to the influence of the Internet, which may preclude complete anonymity for therapist and client. The challenges of being a relational body psychotherapist is then considered, where it is posited that in the formation of a 'real' or authentic relationship between therapist and client, therapist self-disclosure is an inevitable event that occurs both deliberately and unconsciously. In light of how much information is transmitted non-verbally, there is an exploration of whether the issue of 'border control' is a fantasy, and that in practice we may not be able to fully protect ourselves from exposure. As self-disclosure involves risks and vulnerability this paper concludes with an exploration of issues of safety, and the mechanisms we can employ to ensure it.

Self-disclosure in the digital age

A central area of discussion in self-disclosure regards how much anonymity we can preserve in this modern age of the Internet and algorithms (Zur et al., 2009). The pervasive nature of modern technology and in particular the Internet now dictates, to a certain degree, our disclosure. For instance, the Internet has become a primary source of information or voyeurism for the current or prospective client. Self-disclosure on social media has become an important part of many people's lives. Sharing status updates can support many positive outcomes, such as social validation, relational development and social control. However, it can also cause context collapse, increased vulnerability and a loss of privacy. Social media and changes in cultural attitudes to disclosure and perceptions of privacy are shaping both our ability to remain unseen/unknown and altering our accessibility (Johnson & Paine, 2012). A client may instigate a Web search, which could reveal personal information about their therapist which would have previously been inaccessible.

With the advent of the digital age, there have been other significant cultural shifts. Professional attitudes towards self-disclosure have evolved with cultural attitudes. The walls between doctor and patient have been breached and broken down with the societal adaptation of the ideology of 'consumer and provider' in healthcare. The client has become more empowered, more discerning and more demanding of credentials and personal information. In the media, there has been a move towards promoting more extreme and uninhibited public self-disclosure. Reality television, blogs, and social media platforms like Instagram, are leading the way in this public exposé. This is coupled with the willing compliance of members of our populace to submit their lives to comprehensive scrutiny and the uncensored voyeurism that accompanies this social climate (Andrejevic, 2002, Zur et al., 2009). If we have a media presence and act as a healthcare profession, whether we choose to or not, can we truly hide who we are? Are the feathers being plucked from our Peek-a-boo fan, or do we unwittingly shed them? There is now a very real chance we will find ourselves naked in front of our clients.

Accidental (involuntary reactions), and inevitable (expressions of self-identity) self-disclosure

Non-verbal cues or body language are not always under the therapist's full control, and it is this form of communication that clients are more attuned to than to verbal communication (Knapp and Hall, 1997). Non-verbal communication is often the means by which much of our information about the other and ourselves is transmitted (Knoblauch, 2000, Stern, 2004), and verbal communication may account for less than 7% of our communication (Mehrabian, 1972). While verbal communication is only a small part of what we do (and this is both good sense and largely accepted), we are still trying to talk our way out of trauma. Therapists are continuing to engage in dialogue alone rather than with the body. There is the question of whether we can conceal anything at all when there is the added element of relational touch in our work. Each intervention, like a burlesque dancer and her elaborate fan dance, allows another part to be seen. However, we may reveal more than we intended, as we strive to hide parts of ourselves.

In a relationship with the client, the therapist constantly reveals through their preferred theoretical model, explicit countertransference and analytical stances. Even interpretations made in the therapeutic encounter are self-disclosures; they both demonstrate opinion and the existence of a different and separate mind. Our body provides physical evidence to the 'other' of both our physical and emotional well-being. Our tiredness, the signs of a sleepless night, illness and, inevitably, our mortality are all on prominent display. We become the 'analytic object' (Murphy, 2013, Yalom, 2002).

Inadvertent self-revelation seems inevitable. We disclose aspects of ourselves - our biography, origins, values, attitudes, preferences - simply by our physical presence. The style and frequency of our intervention, all provide unspoken information to the other. The therapeutic setting, the decor of our practice, any personal artefacts, our physical appearance/ dress, accent, all provide clues (Zur, 2007). As does the way we relate to our client, the issues we attend to or not, our bodily movements, animation, and our choice of words (Knapp & Hall, 1997). Even our decision to be a therapist all disclose who we are and aspects of our life, whether we choose to or not. Our biographies and an unfolding engagement as client and therapist will further disclose who I am in context to the other. In being authentic, even if I am neither intentionally concealing nor revealing, my experience of situations will be transmitted and embodied within our dialogue.

We carry all the symbols of our production, as our socio-cultural history, race, gender and social demographic, colour our perceptions and preconceptions, and are disclosed to the other - they have only to interpret the signs. They are all part of the complexity of the therapeutic situation. What is manifest has therapeutic meaning. This manifestation is a constant, that is present throughout the analytic setting for both participants, and it is the construct in which the intersubjective relationship is founded. All of these elements require consideration if we are to offer an inclusive setting to a diverse population. This becomes even more pertinent when we work in a small, religious, or rural community setting (Knox et al., 1997), as we are more visible to our clients.

Not all disclosures are spoken.

After the Manchester bombing, many of my clients were affected by the attack, some directly. Clients were visibly shaken by this latest event in, what some of them perceived, a culmination of 'disasters'. Terrorism, natural disasters and unrest have affected my community in the last few years, from the devastating flooding of our local area which left people homeless or financially ruined, to the Orlando mass shooting in 2016, the Trump inauguration, and the local elections. How do we meet our clients if we have a shared traumatic reality? I was also struggling to navigate the same

stormy waters. My clients were bringing their shock, anguish and despair at the seeming craziness and danger of the world into the clinical space, and an authentic, yet regulated response, was being asked for. Over the last few years, fear and threat in our society have become a potent figure in my clinical practice. Traumatic events are part of our shared social reality and have shaken people's sense of security. This shared grief demanded a conscious disclosure of my authentic response; it required a therapeutic response that went beyond witnessing and processing. The changing landscape of our world is impacting on what is considered appropriate regarding self-disclosure in the therapeutic relationship (Tosone, 2011). Shared trauma alters both what clients ask and what therapists reveal.

In one such moment, I was with a lesbian client, who worked in Manchester, near to the site of the bombing. She had attended those who had been affected by the blast the day before. Aroused by the same bodily sense of horror, fear and impotence in the wake of this event, I sat in silence with her. I did not want to convey a dissonance between my bodily presence, the felt sense, and my verbal communication. I was tearful, yet connected by the same sadness, whilst regulating (by staying present, attuned, breathing and embodied). I felt that this regulated sharing provided the much-needed antidote to the senseless violence and disconnected horror.

Maroda (2009) describes how the therapist's expression of emotion towards the client, 'serves to complete the cycle of affective communication that was insufficiently developed in childhood'(p.20), in that appropriate emotional disclosure provides a 're-education' and provides a 'much needed human connection and comfort'. The self-disclosure although non-verbal, was nonetheless a powerful intervention. The key factors of embodiment and regulation allowed for a regenerative experience so that we could pull back, both from the present challenges and its resonant traumatic early relational experiences. For my client, these experiences included the terror as a child in a violent, unstable family home and the fear of being physically attacked for being 'different'.

Unconscious self-disclosure

If self-disclosure is a feature of our therapeutic approach, then whether we disclose or not with a particular client should be, as much as possible, a thoughtful choice. It should be open to reflection, by both the therapist and the client within the dyad.

However, what happens when self-disclosure occurs outside of the control of the therapist? I have found within the scope of my practice that unconscious self-disclosure can readily occur, particularly when naturalistic trance is generated. I have also found that in the moments whilst 'entranced,' that self-disclosure can be both reciprocal and unavoidable. Within the somatic and emotional experience of the transference and countertransference, there is, like emotional contagion, a transmission of emotions and information that cannot be entirely one-way.

Unconscious self-disclosures are also called 'unwitting self-disclosure' or 'self-revelations' (Gans, 2011; Jacobs, 1999; Levenson, 1996). These unintentional, unconscious self-disclosures appear to be so ubiquitous that the question of whether we can control them at all may be redundant (Aron, 1996, Renik, 1999). Suchet (2004) suggests the possibility of communication between the unconscious of the therapist and the unconscious of the client, that is outside of the control of the therapist.

In my practice, clients have known facts about me that I had not disclosed. For example, I had a client who repeatedly dreamt I was pregnant, even before I had told my mother about my actual pregnancy, or another client who felt, inexplicably, sad and noticed I was grieving when I had not mentioned the death of a friend. There may be ways that countertransference is experienced by a client, ways that go beyond words. Clients know their therapists, often through means outside of the control, and perhaps even the awareness, of their therapist.

Unconscious self-disclosure is that which is simply known by the client without been spoken. By what mechanism is this occurring, and is it an inevitable event? There is the question of whether there is a choice to transmit or receive unspoken information or to make our inner experiences accessible to the other. Can we keep ourselves hidden, when we do not wish to be seen?

There are levels of communication that we cannot always know or control. Some of what we communicate, both as a therapist and a client, may be an expression 'which cannot be put into words at all' (Reich, 1949/ 1970:361). Moreover, unconscious self-disclosure is not solely the therapists' domain. I worked with a social worker, who had an uncanny knack of enabling sexually-abused children to open up to her. Without disclosing her childhood biography of sexual trauma, her body disclosed it to all that needed to hear. The children would often respond to her, where others had failed, with the words, "well, you understand, don't you?"

Within this field, through touch and the qualities of empathic somatic resonance, permissiveness and stillness, there can be a communication which is 'subliminally conveyed and known, with clear comprehension' (Sills, 2006:211). We become true telepaths, 'transparent to each other' (Totton, 2003:202), and our clients come to know us as we know them.

In the following clinical vignette, I explore the serious implications that can arise as a result of an unsuccessful self-disclosure.

Vignette

Lisa came to see me, during the Christmas period, as she was suffering from vertigo. Unable to work, she was becoming depressed. She led a very busy life, working as a manager for the social services, as well as raising two young children. Her symptom had come on suddenly and violently.

As she spoke about her condition, a pain began in my chest and was becoming intolerable. I began to feel disorientated. Immediately, I noticed that our environment was changing, the room blurring. We were communicating in a deep cocoon of connection. I wondered how I got there. She was still talking, but I was not listening to her words. I felt sadness, a poignant, raw grief that caught my breath and hollowed out my throat, as though I had experienced a loss or death.

Stopping her mid-flow, to ask her, "have you experienced a sudden loss this Christmas?" She stared at me blankly. I continued, "a significant loss of someone that was very close, that you had a deep, intimate friendship with, that was confusing and disorientating?" She began to cry while explaining how her best friend of many years, had cut her off and ceased all communication. Her world had been rocked off its axis. I continued, "has it happened before in your relationship?" She nodded.

The communication of her body was clear and succinct. The words entered my mouth without any processing. I spoke what I felt and saw, not a visual image, but a 'knowing' that I would have difficulty explaining, other than to say that I felt the resonating words come from her to me. The pain in my chest did not subside until several hours later. After the session, she called to re-book. She returned to therapy, only on the precondition that, "we didn't do that again", and that I did not "read her mind."

In that shared space, I felt I had entered into their intimate and female friendship of long-standing. Friends who did not need to speak to be understood, and who communicate in an unspoken tongue. I had no right to be there. My sudden speaking of the unsaid broke the tension of connection. Speed had been my undoing. Our interaction created fear in her and mistrust. My disclosure had touched upon a cultural fear of the unseen and, while I could argue that intuition motivated me, she felt that is was unnatural. This disclosure created a fracture, which still has not been healed.

Discussion of vignette

Resonance and disclosure, both spoken through the body, and through verbal interactions, are a risky practice. Each relationship we form and co-create can change us both. When information is disclosed, the tension within the relational dynamic can be strengthened or broken. Through a maturation process, the relational practitioner learns the appropriateness of each disclosure (Aron, 1996). Disclosure of countertransferential material can sometimes disrupt the therapeutic relationship if shared prematurely or, as the case above illustrated, when poorly executed, partially due to the merging that occurred in the naturalistic trance. I simply spoke what I felt or 'saw,' without pausing to consider what our relationship was, or how appropriate it was for this particular client. Self-exposure has therapeutic significance only if it is related to the clinical material presented, in that it should be connected to the client's thoughts and ideas to make a difference (Zur, 2007). In this instance, my intervention was as disorientating and isolating to Lisa as the action of her friend.

This disclosure was an inner knowing (that I was aware of her grief she was experiencing and its cause). I was shaken and deeply troubled by this incident. I felt ashamed of my hasty self-disclosure, the disturbance that it caused my client and of the therapeutic rupture. I had used resonant feelings, but I had also disclosed intuitive, even spiritual aspects of the self, and my disclosure had informed my client of the existence of these parts, and of the realm in which we were also conversing. In one respect, this was not self-disclosure, but a sharing of an unspoken communication. However, without client agency, this sharing can be meaningless or create fear and asymmetry.

On reflection, I was slowly able to see how I could have altered the disclosure to make for a more productive interaction. I can imagine that had I shared my thoughts less directly and more skilfully, it would have made for a creative and dynamic interaction. With Lisa, there was an opportunity to use my own bodily resonant information as a source of curiosity, rather than a statement of fact. I could have informed Lisa of the sensations I was noticing, and the feelings ("I notice that as you are describing this sensation of vertigo I am feeling disorientated.... that I have a pain in my chest, that is intensifying...") and asking her if these sensations had anything to do with how she was feeling ("can you relate to any of these sensations in relation to how your feeling?"). This gentler and more communicative dialogue may have been more digestible, less invasive and therefore, more helpful to my client.

I am also aware that when I notice these direct 'inner knowing' within myself, that they cause me to feel uneasy and this anxiety contributes to my need to 'spill' it all out. I often feel dissociated, or panicky and fearful, when I disclose my telepathic understanding to my clients. I feel these unpleasant feelings correlates to my unwillingness to contain them within myself. I too, do not trust these messages, even though they have proved time and again to be factually accurate, and I feel shame at my experience and voicing of them, convinced by my inner critic that I am simply a 'fraud'.

I feel through this experience that I could have collapsed, however, the converse happened. I am coming to trust my 'knowing' more, and as my confidence grows in recognising them as a reliable source. I am developing my capacity for holding and containment. I have the opportunity, through recognising my own reactions to an inner knowing, that I could instead allow myself more time in the session, to process and contain the 'knowing'. By tracing my client's responses (through their body and mine) during self-disclosure, as a means of becoming more attentive, I can thereby safeguard us both.

These lines of communication which allow for subconscious disclosure are an interconnectedness. By recognising the connection between us all, we can navigate these energetic 'strings', in which we can become entangled or enmeshed, or on which we can 'glide' (Rolef Ben Shahar, 2012).

Not all mistakes are equal

One of my most painful 'mistakes' has also been the most regenerative. Claire, a transgender client, was recounting a hilarious and vivid account of an incident where she felt able to exert a powerful degree of control and superiority over someone. I remarked, "well that's the kind of man you are..." I had been joking with her, and abruptly I stopped. Mortified, I remember physically recoiling back from my words. Inflamed with embarrassment, I immediately apologised for my error. I have worked within the transgender community for several years and being culturally competent, and engaging sensitively with positive expressions of self and identity with my language, has always been paramount.

She looked at me coldly, and then in her eponymous style, she fired back, 'well...I wonder why you made that pronoun mistake?' Supported by our relationship, she chose to engage with my accidental disclosure. It had been a mistake in terms of etiquette, but together we looked deeper into why I had made it. I apologised, yet it was not stupidity that drove me to say it, but a naming of the 'elephant in the room'. (Later on, in supervision, I also recognised my part, as the outspoken child in my family of origin, who spoke out the truth, no matter how dire the consequences.) My mistake led me to a more authentic self-disclosure of an inner conflict (or ambivalence). I could make my inner dialogue transparent, in that I was able to discuss the 'I' that supported her and celebrated her, and the 'I' that felt uneasy when she displayed her power and intellectual dominance. I also disclosed the feeling that, perhaps, I had subconsciously rejected her as a female, as I held a core belief that she was different to me as she experienced privilege in her former life as a man.

This error allowed us both to speak more about gender identity, an issue that I had become complacent about. By acknowledging my hidden prejudices, she was able to explore her own doubts. It allowed us to explore how she truly felt after her 'operation', and how she had felt more of a woman before the 'endgame'. Now, with the medical complications of her surgery and the resultant infections, she felt less womanly and more asexual.

In the sharing of my 'non-understanding', I came to know my client better. I was moved to reflect if any of us are that certain of our gender identity? Transgenders can have a radical discontinuity between their sexual pleasures and actual ('real') body parts (Macdonald, 1998). Before surgery, my client's sexual expression had required an imaginary participation in an orifice that she did not actually possess. Her sexual pleasure was integral to her fantasised body. Once she was free of the appendage that she felt constrained her, she could not relate to her post-operative body as that of the body she had previously imagined. This emergent realisation was crushing and had led to her current melancholia. Her shame had prevented her from disclosing this before.

My attempt to be seen as one of her 'tribe' was a function of my insecurity and had been preventing me from being more empathically attuned. Without becoming insensitive, I let go of the mantles of self-righteousness and 'right on' ness that I had been clinging to, and I became more open to hearing about her actual experience, and more attentive to my self-experience. I also became more aware and was able to elucidate my own held sense of what I identified in her as male - the sense of privilege which I felt she must have experienced as a white, middle-class male, together with my own feelings of inadequacy/ inferiority that I had been ignoring, and the unease I had embodied. It was a difficult interaction, however this exploration was both helpful to Claire and led me to a more comprehensive understanding of my prejudices and misconceptions. In turn, this led me to a greater understanding of my client, and the transgender/ gender non-conforming community. Sadly, being perceived as a male grants privileges in this society, and I came to see that these privileges exist within a transphobic society, and are often unknown to transgender men.

This issue of privilege is a sensitive and complex one, and not without peril. This year, the author and feminist Chimamanda Ngozi Adichie, publicly suffered the hurt and wrath of the transgender community, as a consequence of entering into a dialogue on this subject. Arnold Mindell, once said that, as therapists, we must be willing to be 'shot so full of holes' that there is nothing left to hit (personal communication with N. Totton, 2017). Personally, I hope my mistakes will not be so openly executed. By engaging with disclosure, I can see that mistakes are inevitable, and often co-created. Moreover, mistakes and failures are an integral part of life, and, therefore, psychotherapy -

'In both life and therapy, mistakes are invaluable because they *bring us up against reality*- force us to recognise what is real, rather than what we imagine, fear or hope for' (Totton, 1997:317).

Within relational philosophy, there is the understanding that if the therapist experiences, and then disowns his or her negative countertransference regarding their client, there is a risk of unconsciously communicating these reactions through our behaviours. Denying these responses may, in turn, erode the patient's sense of reality, and rupture trust in the therapist, thereby repeating the original traumatic event they experienced with their significant caretakers (insincere/ neglectful parents) (Renik,1999). By owning our countertransference reactions, and appropriately disclosing them to the client, thereby supporting their reality, the therapist provides a 'corrective experience', thus increasing the client's trust in the relationship and strengthening the therapeutic alliance (Audet, 2011). Ferenczi argued (1928,1933) that it is precisely this process of rupture, reconnection, and repair that leads to the curative power of the therapeutic relationship, influencing much relational thinking on enactments (Aron, 1996; Benjamin, 2004).

A Risky Business: Intricacies and Challenges in Self-disclosure

Self-revealing disclosure brings about an emotional closeness. However, there is also a potential for engagement with the other's pre-Oedipal state, which is all the more pertinent when we are interacting with a client with early attachment issues. In this state, we are affecting a sphere of attachment and intimacy, and speaking the 'mother tongue.' Within this realm, we can enter into the dyadic nature of the mother-child relationship. Infants have had the ability, 'to engage with interpersonal communication from birth' (Stern, 2004:85) and responsive awareness towards different self-states of the other, which continues throughout life (Trevarthen & Aitken, 2001). In the concept of 'reciprocal mutual influence' (Schore, 2003), we are dealing with highly skilled, sensitive, and attuned clients, well adapted to looking past the feathers of our Peek-a-boo fan.

Our body is often the vehicle on which others' projections, and even fantasies, ride. Do we not think that, despite these projected identifications, the other may see what also lies under his own illusion? Moreover, that they may well have a keenly observant eye that sees the subtleties of unspoken communication, and of our bodily disclosures? Do we so firmly hold the belief that it is only us, the 'trained' therapist that can hold the paradoxical injunction, that is, two world-realities at the same time?

Are we not modelling behaviour to a client? The art of mirroring, empathy, active listening, resonance and, thereby, providing them with the therapeutic tools that we ourselves have developed? Therapy provides tutelage in the subtle nuances of attunement, body scanning, therapeutic touch and empathic resonance. Would it not be arrogant of us to believe that over time our client would not be as capable of learning through observation and felt experience, to match and even surpass our artful work, and see the unspoken?

With each self-disclosure, the person of the therapist comes more into view, and this can become clinically complex, especially when sensitive issues enter the therapeutic field. For example, the therapist's sexual orientation, disclosures of major personal loss and the processing of grief, or disclosures of serious illness (Cohen, 2005; Silverman, 2001).

Therefore, internal and external supervision should be imperative. Our inner supervisor (Casement,1988) can be the guiding voice in our decision on whether to disclose, and the client's own psychopathology, both medically diagnosed or not, should be taken into consideration. However, it should not be precluded on this basis. Therapists sharing unusual or 'odd' (Nelson, 1997:85), even paranormal experiences, including seeing visions, auditory hallucinations and feelings of paranoia, can create a sense of the universality of such experiences, rather than maintaining the erroneous belief that just 'mad' people have them. Simply sharing the information of the prevalence of such feelings can create relief. It does not predicate that we are agreeing or endorsing particular beliefs, but we can have a genuine empathic response to someone suffering. Also, we can impart an understanding of why someone would develop such a belief system, given his or her contextual history or situation.

Clinical work with diverse populations has increased awareness of race, culture, class, gender and social justice in the therapist relationship (Altman, 2009; Perez-Foster et al., 1996). Issues in cross-cultural treatment have become more clinically relevant regarding self-disclosure (Moodley & Lijtmaer, 2007, Moodley et al. 2013). Thus, regardless of theoretical persuasion, inflexible adherence to therapeutic boundaries without regard to the client's unique cultural circumstances may result in 'recreating shaming, oppressive experiences for racially and ethnically diverse clients, most of whom may have histories of discriminatory, shaming, and oppressive experiences' (Barnett, 2011: 407). There has also been an identification of social barriers that may be preventing culturally diverse clients from disclosing their feelings or thought processes in the transference. Research suggests that minority clients disclose more to therapists that are similar in race, culture or ethnicity (Perez-Foster et al., 1996). Conversely, it would be difficult for a therapist, especially an immigrant, to conceal their nationality, language, and accent.

Issues of power, attunement and trust (although not exclusive to working with minority client populations), are central to 'cultural competence' in practice. Therefore, the therapist needs to be more alert and responsive to these individual needs of the client. They need to be more aware of their transferential material or prejudices, and the therapist may need to disclose more (Leary, 1997). In cross-cultural dyads, the therapist must be even more vigilant in their self-disclosure. Issues of discrimination, prejudice, over-identification and even hatred could be triggered within the relationship. In this complex, relational matrix the therapist could be driven to self-disclose, to avoid the anxiety of the Unknown, or they can be unwittingly seductive in that they are deploying self-disclosure to avoid difference, by concealing their our autobiographies of class, nationality or location.

Developing mechanism of safety in disclosure

There are two issues regarding safety and disclosure. The clients' safety and the safety of the therapist, especially therapists that don't necessarily want or choose to expose themselves.

Regarding the issue of self-protection, can we intentionally hold information back? Can we truly hide our innermost thoughts or feelings? In reality, is there the possibility of concealment? When we move into altered states of consciousness or shared, naturalistic trance and resonance with our clients, can we still preserve our boundaries? As a relational body psychotherapist, so much of us is 'on show'; most of our bodily expressions are transparent to the other. I choose to enter into a shared

space, to go there with my client, and enter into their reality. How do we protect ourselves in this shared space of transparency from unwanted invasion? How can I choose what is revealed? No one is entitled to all of us, not even them.

Within the discipline of relational body psychotherapy, through attunement and somatic resonance, there can develop a shared space, where the separate subjectivities of the two participants can become indistinguishable. As a body psychotherapist, the non-dualistic integration of verbal and our intuitive, and unarticulated knowledge is a dynamic interaction. As well as paying attention to the body's explicit communication, the embodied therapist uses the 'felt sense' (Gendlin, 1996) to move towards a non-verbal, 'unnarrated' implicit knowing (Stern, 2004). Thoughts, feeling and ideas can be shared, they do not belong, to one or the other. This process can be mutual and reciprocal. The transference of the client and the countertransference of the therapist can become transmutable. In this shared, intersubjective field, unconscious communication can prevail in the here and now (Parlett, 1991). In this sense of 'jointness,' both parties experience the mutual satisfaction of surrendering to the merging within the dyadic relationship, yet, at the same time safeguarding separateness (Solan, 1991). Jointness is a regulated act, where the therapist seeks to maintain 'jointness' rather than symbiosis. This is a delicate balance of perceiving and concealing.

Increased self-awareness and attentiveness improves our ability to discern our client's material and our own empathic inferences. Mindfulness can allow for a more controlled, embodied dialogue (Kabat-Zinn, 1990, 2005). We can, like a skilled poker player, learn to physically and energetically choose to close or open the gateways of transmission. Through body awareness, I can hold back what I disclose, and develop the skill necessary to monitor and check what my body reveals to the other. By cultivating this awareness, I can form a safe therapeutic container. Mindfulness and careful observation of our internal responses may provide some self-regulation, and our self-reflection can guide us.

There can develop a shared trance of self-disclosure. As we enter into a relationship we 'open' up to a shared space or field of resonance. Within this relational process, we agree, even if the words are unspoken, to a therapeutic intimacy which can lead to a greater scope of mutual disclosure. It is on this relational edge that we, the client and the therapist, negotiate what feels safe enough and appropriate for us. We protect our client from over exposure of our subjectivity so that they may be supported in their autonomy, unbeleagured with the sight of too much flesh, too soon.

Conclusion

Through this discussion, we have seen how self-disclosure has been perceived by many different fields of psychotherapy. Slowly, the profession's attitude to this intervention has changed and continued to evolve. There have been criticisms and concerns around its use, which continue to be debated.

Self-disclosure demands both a rigorous form of self-enquiry and self-regulation. As a relational body psychotherapist, I have come to recognise embodied markers for safe disclosure. I keep a curious watch on my somatic experience within the interaction, aware that resonance is a mode of communication, which is both reciprocal and can be honed. The relational positional stance acknowledges that there are three 'bodies' in the room. All are legitimate objects - the body of the therapist; the body of the client and the intersubjective body (Aron & Anderson, 2015). In each meeting, this is created afresh. If the disclosure is appropriate and sensitively executed, the shared body should have the capacity to tolerate the impact. In relational body psychotherapy, there is not just the psyche, but an embodied intersubjective third. This third body can be felt, and its energetic charge can be sensed by both the therapist and the client, and in this space, disclosure can occur through the body or the spoken word.

An embodied relational approach allows a body psychotherapist to distinguish between a response that is their own subjective experience and a response that is empathically driven by the other. Through external verification and a growing development of these senses we, as practitioners, can hone our ability to differentiate and clarify ownership between the emergence of our material, and those reflections of the clients' material. The relational approach invites therapists to 'move away from classical neutrality and open themselves to being vulnerable, to disclose their own experiences, and to tread common ground with their clients' (LaPierre, 2015:p. 94). However, it also demands responsibility. The therapist must know their own body, and be willing to learn from their mistakes.

A mindful self-disclosure will recognise that the interaction is a therapeutic conversation, where the therapist makes a conscious choice to share material with the aim of co-processing the emerging experience and recalibrating their view, should the need arise. The emphasis in the relational approach is on creating new relational patterns rather than offering analytical interpretations, explanations or insights on the nature of the experience.

To be authentic or 'real' does not mean that, in a relationship, we share indiscriminately. The therapist's personal voice, in a mutual dialogue, should serve the process and the client. This embodied and bodily inquiry relies on the body psychotherapist's attunement and responsibly shared sensations and associations that relate to the client's own bodily phenomena (Mitchell, 1993). Self-disclosure is also a technical decision, within our chosen modality understanding of whether or not it will be a therapeutic action. Disclosure and non-disclosure is a clinical decision, and the client will decide by staying or leaving therapy whether the technique was suitable. What we leave unsaid, what we speak about explicitly and what we allow to unfold as a natural developmental progression requires sensitivity and regulation. This regulation is informed both by technical understanding and the body.

Disclosure should be a gentle dance between risk and the deepening of a relationship. In relational body psychotherapy, we rely not solely on techniques, but on our art, the art of being with another person, and of being ourselves with another. It is an alive and dynamic art that requires commitment and loving kindness, in that, we respect our client's boundaries, and they too may be respecting ours.

Can we dare to meet the other with less rehearsal, to place ourselves to be more open to criticism? In doing so, we may seize the unique opportunity to meet the rawness of human encounter. Knowing the risks we take, we can utilise and embrace this intervention. We can step into a brave new world, one in which we can drop some of the feathers from our peek-a-boo fan, and even recognise the illusion of the fan. As the drop feathers drop, we deepen our practice in the art of becoming Real.

BIOGRAPHY

Danielle Tanner is a mother of three children, a wife, and a relational body psychotherapist. She trained with Silke Ziehl, of the Entelia Institute at The Open Centre in Deep Bodywork/ Postural Integration. She furthered her training with Dr Asaf Rolef Ben-Shahar in Integrative Mindbody therapy (IMT).
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Deepest gratitude for her teachers and to her supervisor, Nick Totton.

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Integrating Daniel Quinn's cultural criticism with body psychotherapy perspectives

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Received 2nd March 2017, accepted and revised 9th May 2017

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Abstract

We, in the field of body-oriented therapies, seem to agree that an adaptive body-mind connection is essential for the maintenance and restoration of health, and that socio-cultural effects can strongly damage it. Some traced back the historical origin of chronic body suppression to the beginning of civilisation (Fogel, 2013). Cultural criticism provides a model to explain the properties of civilisation, defined here as a complex socio-economical system characterised by totalitarian agriculture, settled lifestyle, mass-size population, constant exponential population growth and territorial expansion, and social stratification (Quinn, 2009a). Civilised lifestyle could lead to a discrepancy between biological and cultural evolution, and abandonment of evolutionarily adaptive self-regulatory (Bárdos, 2003) and social (Von Rueden & Van Vugt, 2015) strategies. We suggest that the consequent homeostatic dysregulation together with the pattern of domination might contribute to a damaged body-mind connection in the civilised culture, and interact with personal and family stories of trauma. We propose for the therapists an affirmative approach: explore the part of the clients' suffering that originates from civilisation, reveal it and empathize with it. We also suggest that the process of helping clients get in touch adaptively with their body resonates with helping society get in touch sustainably with the ecosystem, and that the two approaches could fruitfully interact.

Keywords: Body-mind connection, evolutionary medicine, cultural criticism, Daniel Quinn, civilisation

International Body Psychotherapy Journal *The Art and Science of Somatic Praxis*
Volume 16, Number 3, Fall 2017 pp 34 - 46. *ISSN 2169-4745 Printing, ISSN 2168-1279 Online*

Introduction

A basic assumption in the field of body psychotherapy is that the personal attitude towards the body has a fundamental effect on mental and physical health and well-being (Lowen, 1967; Young, 2010). An adaptive body-mind connection may be characterised as an attitude of integrating body experiences and needs into behaviour and of dealing with one's body with an accepting and responsible attitude (Mehling et al., 2012; Tihanyi, Ferentzi, Daubenmier, Drew, & Köteles, 2017). In contrast, a maladaptive body-mind connection could be characterised

by concepts such as: objectified, disciplined, over-controlled body (Teall, 2015), avoidance and neglect of body sensations, or even exclusive amplification of pain and other sensations of discomfort (Bakal, Coll, & Schaefer, 2008; Köteles & Doering, 2016), suppression of bodily needs and exploitation of the body's capacity (Fogel, 2013). It is also often assumed in our field, that the mere process of growing up in our culture risks the trauma of socialisation, that is, a developmental self-wounding and suppression of some parts of the self in order to survive, especially that of body needs, embodied pleasure, and emotions (Berman, 1990; Brown, 2012; Reich, 1980; cited in: Totton, 2003). Hence we, as body-oriented therapists, might meet with wounds in our clients' (or our own) body-mind connection which were initiated by the socio-cultural environment.

To help healing socio-cultural wounds, it is important to identify the basic features of the socio-cultural environment which promotes maladaptive attitudes towards the body, and the historical origin of these features. Most frequent answers mention modern Western life, especially its fast pace, materialism, consumerism, globalisation, industrial revolution, either secularism or religion, dualistic worldview (dating back to antiquity)(Totton, 2003). Freudo-Marxian discourse about self-objectification, repression, exploitation, domination and power are also apparent in the answers (Fromm, 2012; Marcuse, 1955). It is also assumed that (some level of) body suppression is an inherent part of human evolution, and adaptive body-mind connection on the population level is yet to come (Aposhyan, 2004; Totton, 2003). However, some body-oriented therapists trace the origin of body suppression back to ancient times, 6000 BC and the appearance of patrism (DeMeo, 1991), or even to the Neolithic agricultural revolution, understood as the beginning of civilisation (Fogel, 2013; Totton, 2011). Fogel also underlines that an adaptive body-mind connection and socio-cultural tradition, namely the one to be found in tribal cultures, were apparent in the vast majority of the history of human species, and still is so in some surviving groups, while Totton (2011) emphasises that the domestication of plants and animals came together with the domestication of ourselves and our bodies, and a spontaneous, connective 'wild' state of mind can be (re)learnt through various means, including therapy.

Cultural criticism: The origins and features of civilisation

To understand more precisely the features and historical origins of civilisation, we can turn to a field outside of, and rarely if ever mentioned in the literature of body psychotherapy: Daniel Quinn's cultural criticism. In our article, we define cultural criticism as a non-scientific discourse which is interdisciplinarily related to history, cultural anthropology, ecology, and evolutionary science. Its scope is to gather the fundamental narratives behind cultures, and make them explicit by understanding the evolutionary history, socio-economical system, and lifestyle of different human populations. By explicitly formalising the fundamental cultural narratives, cultural criticism aims to build a discursive understanding of the functioning and history of individual populations, which is, on the conscious level, mostly unavailable for individuals sharing the in-group belief system thereof.

In his works, Quinn (2009a) points out that the Neolithic agricultural revolution, which is usually understood as a primarily technological change, can also be interpreted in a way that it affects not merely the tools and the operational knowledge thereof that a human population utilise, but rather the fundamental relationship between a population, their culture (and its basic assumptions), lifestyle, and environment. According to him, civilisation may be understood as a complex socio-economical system characterised by a specific type of agriculture, settled lifestyle,

mass-size (or, even, global) population, constant exponential population growth and territorial expansion (as long as there is where to), urban development, and social stratification (Quinn, 2009a). Members of civilisation will perceive their society and themselves as separated entities from the rest of the world and especially from the community of life (see also Totton, 2011). Also, they will consider their social system both as 'developed' (with respect to nonhuman life and non-civilised societies, which are considered 'primitive') and the only inherently human way of life.

The aforementioned agricultural system appears to be of special importance in Quinn's (2009a) interpretation of the sociocultural mechanism and narrative of civilisation, as it is the central means of food production for the population. According to him, this type of agriculture is an attempt to gain complete control over a given piece of land with respect to what sort of species can live or feed there and what sort of species cannot. The common practice results in the cultivation of species which serve as food or other resource for humans or for the food of humans. Other species, which do not, are usually labelled as superfluous, harmful or dangerous, and therefore allowed or even doomed to be destroyed. Also, generally, the totality of food requirement of the population is aimed to be produced by agriculture. For this reason and for the attempted complete control, Quinn (ibid) uses the term 'totalitarian agriculture' to distinguish it from other forms of agriculture.

This attempt to produce all the required amount of food by growing it and by controlling the ecosystem of a given piece of land requires an extreme amount of work in terms of time and energy (Lee, 1979). The extreme amount of work needed in totalitarian agriculture may be also attributed to the generally monocultural fashion in which it operates: farmers create vast pieces of land with a fragile and unstable ecosystem, which is more prone to collapsing or suffering ecological catastrophes (Quinn, 2009a). The fragility and instability of totalitarian farming needs to be counterbalanced by excessive work and preparation for the worse by means of storing extreme amounts of food or other products. On the other hand, totalitarian monocultural farming is a lifestyle which on its own does yield an extreme amount of food (or other products) (Quinn, 2009a). This excess (food) production could in theory be invested in less working hours or higher level of life standard, life expectancy and comfort. Still, historical observations show that since the agricultural revolution the major part of the population (predominantly members of the lower social classes) has had to work hard, long, and much during their life in generally low if not miserable conditions, and high life expectancy is a luxury which has been available only recently and only for the highest social classes. However, a study that compared twenty different results on this subject revealed, that peoples who live in a tribal social system have an increased chance to reach their seventies, provided they are alive at their fifteenth birthday, independently of their social status (Gurven & Kaplan, 2007).

A possible solution for this apparent paradox lies in the social system of civilisation: the minority (higher social classes) appropriating the fruit of the majority's (lower social classes) work by force, and thus coercing them to work actually more than would be enough to sustain their lives (Bookchin, 1982). This train of thought, of course, may also be found in (neo-) Marxian discourse, but there it is usually attributed to a necessary historical development or to the defectiveness of human nature. Quinn (1997), however, argues that the coercive, ruling attitude and hierarchy that characterises civilisation are neither necessary nor innate for humans, which is supported by the existence of non-hierarchical human societies (Meritt, 2001; Quinn, 1997). Quinn (1997) attributes this type of behaviour or attitude to the fundamental cultural narrative of civilisation, which makes its members believe that hierarchy, and civilisation in

general, is a necessary and inevitable part of the human condition. Also, he closely relates the hierarchical social system to the coercing, ruling attitude reflected in the practice of totalitarian agriculture, observing the parallelism of domination over lower social classes and domination over nonhuman life. As an example, in small-scale societies leadership is based on trustworthiness, personal experience and connections, and is rather a coordinative function, exerting authority mostly when the group needs it (an emergency, for example), while in large-scale societies, leaders are elected rather based on appearance and second-hand information or are chosen by other leaders, which gives space to misguidance, and possession of power by possibly unsuitable (for instance, narcissistic, overconfident) individuals (Von Rueden & Van Vugt, 2015).

The combination of hierarchy, appropriation of products, and an excess yield of available food also has ecological consequences (Quinn, 1997, 2009a, 2009b). As it was experimentally shown, populations grow or decrease in connection with the amount of food available for them (Calhoun, 1973). This causal connection between population size and food availability works for humans as species, too (Hopfenberg, 2003) (despite individual attitudes towards birth planning), and it explains the constant and exponential population growth since the agricultural revolution. According to cultural criticism, population growth in turn has been the reason for the aggressive territorial expansion throughout civilised human history, contributing to warfare (Diamond & Bellwood, 2003; Quinn, 1997, 2009b). Famine is also seen as correlating with the combination of hierarchical society with a type of agriculture based on totalitarian control: it is a unique characteristic of such a population that even though there is more than enough food, there are people who are starving (this does not contradict the process of excess food fuelling population growth as it may be observed that usually more children are born in poor families than in rich ones)(Quinn, 1997, 2009a). The growth of settlements into towns and cities may also be explained along these lines: any type of agriculture requires a more or less settled lifestyle, and totalitarian agriculture yields a vast amount of food which in turn causes oversized populations: the result is masses of people living together in a relatively small place (Quinn, 1997).

As a summary, Quinn (1997, 2009a) understands the behavioural pattern of civilisation as follows: growing all the required food in a completely controlling and coercive way of agriculture, generating scarcity by not letting the majority of people freely having it and, thus, coercing them to work excessively or starve when plenty of food is available, propelling a constant and exponential population growth with this excess amount of resources instead, which in turn fuels a constant territorial expansion and an overall domination of the planet's ecosystem and biosphere, resulting in global ecocatastrophes, famine, epidemics and war (suggested by others also: Farb, 1978; Hopfenberg, 2014). This behavioural pattern may be explained along the fundamental cultural narrative (or, in his terms, 'vision' or 'story')(Quinn, 1997, p. 26) thereof, whose maxim may be formulated as *the world was created for man, and man was created to rule it*. In this interpretation, social, ecological, economical, and also spiritual issues and problems of civilisation are but the result of realising (enacting) this cultural narrative.

It was suggested that the ongoing realisation of civilised cultural narratives can potentially lead to the collapse of civilisation, ecological catastrophes, or even extinction of humankind (Hopfenberg, 2009; Totton, 2011). Although it can be thought that civilisation provides relative health and well-being for its members, which compensate for unlikely or rare 'trade-offs' like long-term extinction, wars, ecological catastrophes, famine and poverty for many, in fact, a growing body of results will be presented in the next section, that shows that civilisation

is rather a risk factor for health, civilised individuals live with more stress factors and less protective factors.

Evolutionary medicine: discrepancy between biological and cultural evolution in civilisation

Evolutionary medicine is an integrative discipline involving findings of evolutionary biology, evolutionary psychology, nutrition sciences, sport physiology, toxicology, archaeology and history which are related to health sciences (Nesse et al., 2010). Researchers of evolutionary medicine suggest that:

> "From a genetic standpoint, humans living today are Stone Age hunter-gatherers displaced through time to a world that differs from that for which our genetic constitution was selected. Unlike evolutionary maladaptation, our current discordance has little effect on reproductive success; rather it acts as a potent promoter of chronic illnesses: atherosclerosis, essential hypertension, many cancers, diabetes mellitus, and obesity, among others. These diseases are the results of interaction between genetically controlled biochemical processes and a myriad of biocultural influences — lifestyle factors — that include nutrition, exercise, and exposure to noxious substances. Although our genes have hardly changed, our culture has been transformed almost beyond recognition during the past 10,000 years" (Eaton, Konner, & Shostak, 1988, p. 1).

In the same paper (ibid), it is suggested that the discrepancy between biological and cultural evolution leads to *diseases of civilisation* that altogether cause three out of four deaths in developed nations, but which are rare among populations whose lifestyles reflect those of our pre-agricultural ancestors. Some concrete examples of civilised lifestyle that risk health:

(1) In higher social classes physical inactivity and sedentary lifestyle (Chakravarthy & Booth, 2004) and as we propose, mentally overloading work also, while in lower classes physically demanding non-ergonomic work.
(2) Lack of free time, qualitative and quantitative sleep problems (Bárdos, 2003), and disruption of other biorhythms (Chakravarthy & Booth, 2004).
(3) Qualitative malnutrition (deficiency in important nutritive factors, e.g. vitamins, microelements, fibres) (Lallo, Rose, & Armelagos, 1980), in lower classes quantitative malnutrition as well, in higher classes quantitative overfeeding and lack of fasting periods (Caramoci et al., 2016; Chakravarthy & Booth, 2004).
(4) Civilisation also fostered epidemics (G. a. W. Rook, 2010),
(5) while a counter-attack against epidemics, hygiene revolution, exterminated gastrointestinal commensal or pseudocommensal organisms necessary for health (G. A. Rook & Lowry, 2008).

Social support is a factor which is also mentioned in evolutionary medicine, and furthermore exerts a huge effect on civilised life quality. It is suggested that human species was evolved to live in small scale, egalitarian tribes organized by face-to-face personal connections, while individuals in the large-scale, complex societies of civilisation tend to play the role of 'a conscientious employee in the faceless corporation and the dutiful citizen in the metropolis, but a surprisingly high proportion of them crave more intimacy' (Vugt & Ahuja, 2011, p. 6). Hierarchy and the consequent social inequalities increase morbidity rate through the subjectively

perceived socio-economic status (Sapolsky, 2005). The shift from small-scale to large-scale society also decreases the cultivation of personal connections through verbal communication, and more strikingly, through touch, even though we are evolved to practice them regularly (Mithen, 1996), and we need them for balanced self-regulation, pain reduction, and mental and physical development (Björnsdotter, Morrison, & Olausson, 2010; Bystrova, 2009). Taking child-birth as an example, in civilised societies separation of the new-borns from the caregivers, loss of breastfeeding, and medical interventions are frequent, they can all disturb birth and have a detrimental effect on development (Olza & MacDonnell, 2010). The term 'birth trauma' was even coined for the effect of disturbed birth, and was suggested to block safe attachment between caregivers and infants (Miklosko, 2013). In contrast, according to observations made among a group of Amazonian Indians, the Yequanas, in tribal populations after an undisturbed birth, infants are carried on the mother providing sufficient dermal contact and the possibility to feed anytime when needed, which besides its important role in a more adaptive individual development, also leads to a lactational anovulation for 5-7 years (an effective built-in contraceptive process) (Liedloff, 1985).

Some suggest that the lack of strong connection between infants and caregivers raises the risk of child abuse (physical, sexual, psychological) (Trevathan, Smith, & McKenna, 1999), and consequent PTSD or developmental trauma disorder in itself can block safe attachment in adulthood (with other adults and the offspring), unless they are healed (Herman, 1997; Levine, 1997; Van der Kolk, 2007). It is proposed that civilised lifestyle can contribute to weakening the family connection, e.g. through extreme workload and lack of time, more frustration, and, according to others, a cognitive thinking style based on dominance and violence (DeMeo, 1991; Totton, 2011).

Lack of sufficient social support and isolation disrupt homeostatic regulation (e.g. immune and endocrine system) and also increase pain (Porges, 2003; Shankar, McMunn, Banks, & Steptoe, 2011). Thus, social isolation and the aforementioned civilised lifestyle factors can interact in a multiplying manner, increase distress, and cause chronic inflammation, chronic diseases, mood disorders, discomfort and pain in the body, and finally decrease life expectancy. To a limited extent, some genetic adaptation to civilised lifestyle (for instance, lactose tolerance) (Diamond, 2002), and epigenetic adaptation might also occurred (e.g. tolerating abundance of food) (Harpending & Cochran, 2009). Moreover, general intelligence was found to exert a buffering effect on the discrepancy between biological and cultural evolution (Kanazawa, 2004). However, considering the results of evolutionary medicine, the capacity of these buffers seems to be insufficient in protecting against all the challenges of civilisation. These civilised risk factors can also resonate and interact with the issues we usually work with as therapists: stories of personal development and transgenerational family history.

Maintaining maladaptive cultural variants, the role of body-mind connection

Why has civilisation been sustained by its members despite these strikingly negative consequences?

(1) In fact, archaeology explores several examples of human history, for example from South America, when a group had decided to follow some elements of the civilisation, e.g. totalitarian agriculture, urbanisation, and then they abandoned it (Quinn, 2009a). In the cultural narrative of civilisation, there are two beliefs which may have prevented its members from changing their lifestyles in an adaptive way; and they could be described as '*we have the one and only right way for people to live*', and '*man was born a totalitarian agriculturalist and a city builder, and that*

our way was ordained from the beginning of time' (Quinn, 1997). Accepting these beliefs might lead to an interpretation in which all the aforementioned negative effects of civilisation could be considered as trade-offs, which are worth being paid for the development of humankind, and where the abandonment of civilisation necessarily appears as a relapse to the dangerous, miserable, and short life of the primitives.

(2) Another possible formulation of the aforementioned two beliefs is nicknamed by Quinn (1997) as "the Great Forgetting" (1997, p. 242): conceiving of non-civilised human life as primitive and their lifestyle as dangerous, miserable and short, as if civilised human beings would have forgotten all the realistic (and, many times positive, with respect to civilisation) qualities of tribal life, discussed in the previous sections of this paper. It is worth noting that all the findings related to the real nature of non-civilised human societies are rather recent; the first source discussing the relativity of civilisation is, from 1887 (Powell & Boas, 1887). Before that, a realistic comparison of different cultures was not conceivable. However, in these recent findings, most of the examined tribal societies might have already been attacked or disturbed by neighbouring civilised populations.

(3) Finally, a fulfilling human life is 'meaningful' (Ryff & Singer, 2013), understanding and predictability are basic human needs (Berne, Steiner, & Kerr, 1976; Max-Neef, Elizalde, & Hopenhayn, 1992). Quinn (1997, 2009b) also asserts that societies need some 'vision' or 'story' (cultural narrative) to realise. The rather puzzling attachment to civilisation despite its dysfunctional and harmful effects on everyday life may be also explained along these lines: human beings appear to crave for meaning and structure, even if the specific ones they have is maladaptive for them.

We suggest that the phenomenon of maladaptive body-mind connection (described in the Introduction, such as turning against the body, judging it negatively, blaming the body to be weak and dysfunctional or avoiding and ignoring it) can be partly understood as an effort for reduce the cognitive dissonance between the cultural incentive that 'civilisation must continue' and the fatigue, distress, pain and other body complaints increased in civilisation. Another civilised feature which might disrupt body-mind connection is the pattern of control, hierarchy, and dominance (in contrast with the tribal patterns of cooperation, egalitarianism), which we since the childhood absorb from our caregivers and others and can use it as a pattern for how to treat our own body (Bakal et al., 2008). A maladaptive body-mind connection is a key mediator in blocking health behaviour and engraving the harmful effects of civilised lifestyle, and at the same time it contributes to the continuing of civilised culture.

Discussion, therapeutic aspects

In this paper we summarised arguments from the field of cultural criticism of Daniel Quinn and evolutionary medicine in order to shed more light on the mechanisms involved in the civilised culture's disruptions of body-mind connection. We focused on the maladaptive features of our current lifestyle and cultural narratives, and concluded that civilisation could be accounted for a vast majority of contemporary physical and mental problems and diseases, and this effect is mediated by the disruption of personal connection with the body.

The intention of body psychology and other sciences to introduce a paradigm of embodiment, that is a functional connection, co-operation, or even equality between 'body'

and 'mind' is similar to the intention of cultural criticism to introduce a memetic collection where humans are part of the ecosystem and 'nature', and not the ruler of it. In fact, (body) psychotherapy can help either to maintain civilisation or to shift from its cultural narratives. A therapeutic process which wishes to make the client feel OK not just with oneself and persons around, but the world (Birtalan, 2017), accepting the maladaptive features of civilisation as they are and letting go of the stress caused by them can (1) bring more comfort to the client, and at the same time (2) weaken motivation to discover the cultural reasons of discomfort and change them. On the other hand, a therapeutic process can also bring to consciousness the discrepancy between civilised lifestyle and needs, (1) increasing the motivation to change the lifestyle, but (2) also decreasing the probability to feel integrated into civilisation and (at least in the short-term) increasing subjective suffering.

Therefore, we propose to deal with the impact of civilisation on our clients with an affirmative attitude. The spreading affirmative approach in psychotherapy, which states that some problems of our clients might originate from or strengthened by social and political effects, was used mostly with minorities (Glickman & Harvey, 2013; Ritter & Terndrup, 2002; Schlosser, 2006). However, also for clients who belong to the majority of the civilised society, it seems important to affirm that (at least) a part of their problem stems from the predominant cultural environment (rather than/besides personal maladaptive mental development and history). Concrete elements of how to deal affirmatively with civilisation in a therapeutic process: (1) accepting or proposing the connection between the problems of the client and civilisation (lifestyle, social isolation, environment). (2) Being aware that turning towards the body and ceasing body suppression can reveal and amplify negative body experiences that may be caused by current cultural-environmental factors. (3) Providing information to explore such factors, and empathising with the difficulties of accepting or changing them. (4) Exploring which body needs are dissatisfied in the life of the clients, and supporting them in finding ways to satisfy these needs: how to use free time, how to reform working hours, or how to find a job that is more satisfying. Some therapists even started to establish communities and villages which provide an alternative place to live (Totton, 2011). In a therapeutic process that misses the affirmative approach, a client might feel that all the problems (also in connection with work, social isolation) stem from personal biography, and that the only solution to decrease suffering is to change oneself, and not lifestyle and environment – which is not always the case. The detrimental effect of familial and societal suppression on the self and body was highlighted many times in the literature of (body) psychotherapy (Conger, 2005; Orbach, 2009; Rolef Ben-Shahar, 2015; Totton, 2006), and the analysis of civilised lifestyle can supplement and provide details to this notion (Totton, 2011).

Another significant learning from Quinn's cultural criticism, relates to the price of sharing narratives of the civilisation. The critic faces the possibility of ecological catastrophes and the threat of extinction, and fear, depression and helplessness are understandable results. Many try to avoid such news and information (Totton, 2011). However, from the view of cultural criticism, humans were and are able to live in a sustainable life, proved by tribal societies, and a cultural shift could still prevent extinction (Hopfenberg, 2009). Moreover, tribal functioning is not only possible in hunter-gatherer or horticultural societies of the ancient times or outside of the territory of civilisation, but also in urban environments (Meritt, 2001).

This paper intends to introduce aspects of evolutionary medicine and Quinn's cultural criticism in the discourse of body psychotherapy, and not to investigate all the related results

and topics. Discovering to which extent the 20th century (body) psychotherapy thinkers (e.g. Freud, Reich) realised the effect of the Neolithic agricultural revolution and civilisation, can be the scope of a future research. Many aspect that could reveal the connection between personal body-mind connection, consequences of civilisation, and discrepancy between biological and cultural evolution remain to be examined, like sexuality, unemployment and homelessness, jurisdiction, war trauma, intergenerational relations and rites of passage, religion, existentialism, and spirituality, industrial and technological revolution, environmental psychology, pollution, information boom, and more. The often mentioned benefits of civilisation should be further examined (for example, mortality during and after childbirth, technical development). Moreover, the non-scientific model of Quinn is yet to be tested. However, in our opinion, the conclusions of cultural criticism resonate with the assumption of body psychotherapy, and we propose that further interaction of the two fields would be fruitful.

Conclusion

The belief that the mind possesses power over body seems parallel to the belief that dominant humans possess power on inferior ones, dominant cultures possess power over inferior ones, and humankind in general possesses power over other species and the overall ecosystem. Or to put it in another way, being in touch or out of touch with ourselves, our body, seems equivalent with being in touch or out of touch with others and the world (Totton, 2002). On one hand, what we, as body-oriented therapists can learn from cultural criticism is a model showing a stem of maladaptive body-mind connection. We can use such information in our therapeutic sessions in order to give more empathy to and affirm the cultural origin of our client's problems and help the clients understand (and maybe accept and cope with) them. On the other hand, cultural criticism could also profit from body psychotherapy, as we offer tools and experiences for helping individuals shift from the dominant, exploiting, and expanding attitude towards a more adaptive one, first on the intraindividual level, that is - the personal connection with the body.

Acknowledgment

The authors would like to thank to Balázs Birtalan for introducing and navigating us in the field of cultural criticism, Márton Szemerey, Árpád Kántor and the other teachers of the Hungarian Association for Body Psychotherapy for their inspiring lectures, György Bárdos, Ferenc Köteles, and Leander Steinkopf for their communication on evolutionary approaches. This research was supported by the Hungarian National Scientific Research Fund K 124132 and K 109549.

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Learning from Sabina Spielrein: charting a path for a relational drive theory

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Received 15th November 2016, accepted and revised 21 April 2017

> "This demonic force, whose very essence is destruction (evil), at the same time is the creative force, since out of the destruction (of two individuals) a new one arises. That is in fact the sexual drive, which is by nature a destructive drive, an exterminating drive for the individual, and for that reason, in my opinion, must overcome such great resistance in everyone."
> S. Spielrein, 1909, in a letter to Freud

Abstract

The authors critically reflect on the insistence of late Stephen Mitchell, who is considered to be the founder of relational psychoanalysis, on omitting biological drives from the relational psychoanalytic theory and defining relationality in categorical and exclusionary terms as incompatible with Freud's drive theory. It is argued that while Mitchell's motives were understandable, the split between relationality and drives is no longer justified. It is suggested that the pioneering work of Sabina Spielrein, in particular her seminal paper *Destruction as The Cause of Coming into Being* (1912), can help provide conceptual tools for reintegrating relationality and drives and charting a path for a relational drive theory. In Spielrein's text, the sexual instinct is conceptualized as a thrust towards interorganismic merger – "transformation from I-ness to We-ness" – a process that intensifies the psychophysiological processes of growth and change. The sex drive for her, then, is fundamentally a relational drive. The authors additionally comment on the phallocentricity and heteronormativity of the drive theory as we know it and suggest tools for developing a relational theory that could make room for women's and queer subjectivities. Case material is used to illuminate the theoretical concepts.

Keywords: Sabina Spielrein, Mitchell, drive, relationality, postmodernism

International Body Psychotherapy Journal *The Art and Science of Somatic Praxis*
Volume 16, Number 3, Fall 2017 pp 47 - 62. *ISSN 2169-4745 Printing, ISSN 2168-1279 Online*

Esther's memory: in my second year of graduate school in clinical psychology, the psychodynamic theory teacher asked the students to vote for either drive theory or object relations, based on what we found more convincing. Everyone in the class voted for object relations, expect for two men (one of them gay, the other, a good friend of mine, a Marxist ecofeminist with a degree in women's studies) and myself, who went for the drives. Others in the class had a hard time with our choice, pointing out that the Freudian drive theory was reductionist and socially conservative.

A discussion ensued about how one could describe heterosexual intercourse without falling into the Freudian active male-passive female dichotomies, and my friend said, "Why, intercourse is the vagina squeezing and sucking in the penis!" I forget how the discussion evolved from that point on, but what I learned from the professor's question was that a theory that could hold both sex and relationships was too much to hope for: it was either one or the other. I subsequently trained in relational psychoanalytic work and relational psychoanalysis became my home and professional identity. But in my heart, the old love affair with the drive theory lived on.

Destruction of the drive theory as the cause of coming into being of the relational theory

Stephen Mitchell was doubtless one of the seminal figures in the late 20th century psychoanalysis. In 1983, he and Jay Greenberg co-authored the influential text *Object Relations in Psychoanalytic Theory,* in which they argued that many different psychoanalytic theories, including various object relations theories, self-psychology and the interpersonal (Sullivanian) psychoanalysis, were in agreement about one central point: that the psyche was formed and defined by interpersonal relationships, not biological drives. Through the publication of this text, relational psychoanalysis, the school of thought that has since profoundly affected the fields of psychoanalysis and psychoanalytic/psychodynamic psychotherapy, was conceived. Mitchell went on to outline the principles of the new movement in his subsequent books, including Relational *Concepts in Psychoanalysis* (1988), *Hope and Dread in Psychoanalysis* (1993), *Influence and Autonomy in Psychoanalysis* (1997) and *Relationality* (2000). In addition to his intellectual contributions, he played a pivotal role in founding the institutions of the relational school: the journal Psychoanalytic Dialogues and the headquarters of the relational training - the New York University Postdoctoral Program in psychotherapy and psychoanalysis.

In his early works – *Object Relations in Psychoanalytic Theory* (1983), co-authored with Greenberg, and *Relational Concepts in Psychoanalysis* (1988) – Mitchell postulated that relational theory was virtually incompatible with drive theory. This claim is stronger in *Relational Concepts,* a more mature work: "The strategy adopted in this volume has been to develop an integration of the major lines of relational-model psychoanalytic theorizing into a broad, integrative perspective – from which the concept of drive, as Freud intended it, has been omitted" (p. 60). Freud, according to Mitchell, chose not to integrate relational and drive theories, focusing exclusively on the drive theory (which, it may be argued, contains certain relational components within it that neither threaten nor challenge its reliance on the drives as the primary explanatory feature). One can imagine Mitchell stating something like, 'I am choosing to do the same,except that at the fork where one would choose between relationality and drives, I am choosing relationality.' "That is not to say that they cannot be put together – any array of disparate concepts can be joined if one is clever enough. The question is whether it is conceptually and clinically economical – whether it is *useful* to do so" (Mitchell, 1988, p. 54).

Mitchell based his reasoning on two assumptions: (a.) drive and relational models represented two distinct sets of models – the only question was whether or not the two sets of models could be compatible (he leaned towards the conclusion that they were not), and (b.) drives could not be contained within the relational theory – to deal with drives, one would need to contend with the whole package of a drive-based theory, which needed to be accepted on its own terms as it were. In other words, while relationality could be claimed to already be present within the drive theory, it was not possible to similarly find room for the drives within the relational theory – there was no symmetry.

There are questions we could ask about these assumptions. For instance, are relationality and drives really so far apart from one another? Is dividing all psychoanalytic theories into drive-based vs. relational necessary or helpful? Why cannot relational theory contend with drives?

Perhaps the most important question of all, which Mitchell curiously did not ask is, what is the cost of developing a full-scope psychoanalytic theory that altogether excludes drives, in terms of that theory's capacity to explain and predict aspects of human experience? He made no ontological claims with respect to biological drives – he never claimed they did not exist. Assuming, then, that Mitchell did believe drives to exist, acting as motivational factors that influenced the individual's choices – what would the theory lose by leaving them out? The argument that integrating relational and drive models is not economical or useful is a curious one – are these good enough reasons to let go of them? Is being economical what is most important for a good theory, or is it its explanatory power? Can a whole range of bodymind phenomena whose physicality is quite pronounced, at times excessive (Stein, 2007): sexuality, aggression, pregnancy and childbirth, and more – be fruitfully thought about with no reference to biology?

An additional question of much relevance, one that Mitchell sadly did not live to ask – is whether it is still important now, thirty years down the road, when we already have a broad corpus or relationally themed texts – a relational "canon" (Harris, 2011), when the relational school has formed a distinct identity, and with its institutions flourishing nationally and internationally – to maintain the split before relationality and drives? Was this step of ceremonially casting away drives perhaps mainly "useful" – to use Mitchell's word – at the onset, to differentiate from Freud and mark the territory the new relational theory would occupy? When speaking of hypnosis, Mitchell (1997) suggested that Freud wished to differentiate psychoanalysis from hypnosis precisely because psychoanalysis emerged out of hypnotic work. Therefore, wrote Mitchell: "It was crucial for psychoanalysis to differentiate itself from its ancestor, hypnotism, and its reliance on the personal power and influence of the therapist… Where hypnotism added influence, psychoanalysis removed historical influences; where hypnotism directed and shaped, psychoanalysis liberated and released" (p. 8). We may argue that Mitchell's relational conceptualization was similarly defined and created against Freud's drive theory, and it was necessary for him to create that binary in order to establish his views as autonomous.

Was the issue of "economical" theory-making primarily Mitchell's own individual concern – a very understandable one? Forging an ambitious new theory is no easy task, and perhaps throwing away what he considered to be the drive theory made it easier for him to integrate a vast body of other psychoanalytic theories – object relational[1], self-psychological, interpersonal and even humanistic-existential ones (e.g., Erich Fromm's), which differ substantially from one another. Excluding drives may have helped Mitchell in his important and difficult undertaking of theoretical synthesis. That he could not find a way to make drive theory part of that innovative synthesis does not mean that this cannot be done in principle.

Postmodernism and its pressures

Letting go of drive theory by relational psychoanalysis can also be understood as the payment of dues to what was one of the most influential cultural and intellectual forces at the time the relational movement was conceived – namely, postmodernism. Unlike the relational

[1] While Klein's theory is arguably steeped in drive theory, recognizing biological drives both as primary contents of infantile fantasy and as causative of the later development of symbolic thought, Greenberg and Mitchell (1983) classified her theory as relational, by overemphasizing its object relations aspects and deemphasizing the drive aspects.

formulations, drive theory was difficult to reconcile with the postmodern emphases on aspects like language and culture, experience as socially constructed, and moral and ontological relativism. Fortunately or unfortunately, the exclusive grip of postmodernism on Western culture may be beginning to loosen (Eshelman, 2008; Huber, 2014). Additionally, with the maturing of social theories of sexuality, their contrarian aspects are becoming less pronounced - recognition of the importance of critiquing social forces that shape sexuality may no longer require insistence that everything about sexuality is only social and nothing is biological. Unless viewed through the programmatic lenses of postmodernism, the relational view of the human being as an emergent sociopsychological phenomenon must not exclude its understanding as a (socio)biological organism.

Have you met? Sabina Spielrein

Sabina Spielrein (1885-1942) was a Russian-born psychoanalyst. Initially a patient of Jung's, she subsequently became his student, colleague and intimate friend. She was in contact with Freud, discussing theoretical and intellectual matters with him both in person and in writing, and presented to the Vienna Psychoanalytic Society. She also maintained professional and intellectual ties with Vygotsky, Luria and Piaget (the latter had at one point been her analysand). Her theoretical work on both sexuality and language acquisition is innovative and profound, and it is a shame that she is not more widely read.

Although Spielrein's name has been popularized in recent years, thanks to texts and films that have been produced about her, such as Covington & Wharton's (2006) *Sabina Spielrein: The Forgotten Pioneer of Psychoanalysis,* Marton's (2006) *My Name Was Sabina Spielrein* and Cronenberg's (2011) *Dangerous Method,* there is still a tendency, both in professional circles and popular culture alike, to think of her primarily in the context of her relationship with Jung, rather than as an important theorist in her own right. This disturbing trend is carried to the extreme in Cronenberg's film, where Spielrein is depicted as engaging in sadomasochistic sexual practices with Jung. A number of professional papers, notably Lothane's (1999) *Tender Love and Transference: Unpublished Letters of CG Jung and Sabina Spielrein,* concern themselves with the question whether or not the relationship between the two was ever consummated - a question that doubtless bears heavily on Jung's reputation as a physician and analyst but is irrelevant when it comes to evaluating Spielrein's own contributions to the field.

Destruction as the Cause of Coming into Being: drives in relationality, relationality in drives

In Destruction as the Cause of Coming into Being, Spielrein raises the question of the negative emotional reactions such as anxiety and disgust, commonly accompanying sexual activity. Other theorists, she states, have linked these to the taboos on sexuality and resulting sexual inhibitions that exist in our (i.e., European) culture. She argues that there is a deeper reason for these reactions, one that goes beyond the socially sanctioned negative attitudes towards sex. The fear and disgust, Spielrein suggests, are already embedded within the sex drive itself. Because during sex, intimate contact occurs between two individuals – one enters the other – the processes of "destruction and reconstruction, *which are constantly occurring during normal circumstances too,* occur particularly intensely[2]". According to Spielrein, in the course of the sexual act, the male element merges with the female, which, in turn, becomes destabilized and assumes a new form, mediated by the "foreign intruder"

[2] This sentence was translated from the original German. The available English translation appears inaccurate.

(Spielrein, 1994, p. 157/Spielrein, 2011).[3] There is no way for an individual not to know – if only indirectly, through the emotions s/he is experiencing – that her or his organism [the choice of the word – "organism" – is significant, as it could be understood as referring to both body and mind] is being destroyed and reconstituted. Anxiety, fear and repulsion, then, are the organism's natural reactions to the subjectively known objective fact of its own destruction.

Spielrein further elaborates the biology of reproduction to demonstrate or explain how and why sexual intercourse causes destruction and reconstitution: the male and the female cells unite, each losing its own individuality to give rise to new life. In lower organisms, she notes, the parental organism dies in the process of giving life to the new generation. While humans do not fully die in this process, the difference, she claims, is merely quantitative. The sex cells contain the genetic memory of the entire organism and their merging is a significant event, mirroring the merger of the individuals occurring during the sexual act.

It is unclear whether Spielrein understands the biology of conception as the most real or profound aspect of what happens to individuals during sex, nor whether she believes the merger to be less complete in instances where no conception occurred in the course of the sexual act. My own (Esther's) impression is that she views the merger of the cells, the physical merger of the copulating couple and their psychological merger as different aspects of the same event, neither being primary or exclusively causative of the others but rather, all being interdependently causative – a "dependent co-arising" (Macy, 1991), to use a Buddhist term.

Next, Spielrein makes an unexpected move (unexpected, that is, insofar as we expect drive theorists to downplay the importance of mother-infant primary bonds), stating that "we could just as readily derive everything from the nurturing instinct rather than from sexuality" (p. 159). In other words, the basic drive operating in the arena of primary caregiving is no different from the one guiding adult sexual relationships: it is the (relational!) drive to dissolve the boundaries of the ego and merge with another person – being destroyed and reconstituted in the process. Spielrein also admits that sexual activity, for some people, can primarily be motivated by the need for nurturance: "Although the need for nurturance cannot be entirely replaced by coitus, we often see overwhelming sexual desire in undernourished individuals" (p. 159).

Spielrein then argues passionately against ego-psychology. Human psychic life, she states emphatically, is guided by unconscious impulses that lie much deeper than the ego and are ultimately unconcerned with our egoic-level reactions of pleasure or pain. In fact, she suggests, citing both Mach and Jung, the ego is composed of many parts and inessential – "the chief characteristic of an individual is that he is "dividual" (p. 160). She goes on to demonstrate the counter-currents of differentiation (generating an egoic experience) and assimilation (transcending the ego and shifting into a "We" mode) in art, dreams and various forms of psychopathology, arguing that even in cases of artistic autoeroticism (of which she sees Nietzsche as a prime example), the artist's experience in producing his work of art is often one of getting destroyed and reconstituted by what he creates. In the last part of her paper, she explores the mythological motifs and images of coming into being through destruction.

[3] The menacing connotations of the word "Eindringling","intruder" and the phrase "fremden Eindringling", "foreign intruder" (appearing in the 1994 English translation as "unfamiliar intruder") are apparent – suggesting that Spielrein thought of intercourse as inherently violent. Such unreflective blending of maleness and violence can, of course, be argued to have the effect of naturalizing male sexual violence, and would hardly be tolerated in a contemporary text.

The main reason, Spielrein explains, that we overlook the destructive aspect of the sexual drive is because in the normal experience, the sensation of coming into being is somewhat stronger than that of getting destroyed – yet we should not forget that the coming into being was made possible by the destruction. The sexual instinct, she maintains, which is also the instinct of preserving the species (distinct and in a sense opposed to the individual self-preservation instinct), "expresses itself psychologically in the tendency to dissolve and assimilate (transformation of the "I" to the "We")" (p. 174[4]).

> Self preservation is a "static" drive that protects the existing individual from foreign influences; preservation of the species is a "dynamic" drive that strives for change, the "resurrection" of the individual in a new form (p. 174).[2]

We can see how for Spielrein the species' preservation instinct is fundamentally a relational instinct that forces the individual (illusory to begin with, as at the deep levels the human psyche is not differentiated – it is the species' psyche) to surrender (to use Ghent's, 1990 term) to We-ness with others, whether one's caregivers/care receivers or sexual partners. Though the act of surrendering is objectively dangerous, certain to destroy the individual as s/he was prior to that act, and therefore evokes fear and repulsion, in health, the relational instinct to surrender nonetheless wins over.

Though "dividual", precarious and uncertain, the individual is, in Spielrein's theory, assumed to exist prior to the action of the drive – there is someone there whom the sexual drive can destroy. This differs substantially from Freud's overarching view that drives, as dynamic forces, exist prior to any structural formations, and it is only through their action that structures like the ego come into being (Laplanche & Pontalis, 1973; Schmidt-Hellerau, 2001, in Bass & Michels, 2002). One implication of this pre-drive individuality is that an individual can be presumed to have a measure of subjectivity and agency enabling him or her to choose how to encounter the drive. Another is that, unlike two drives, two individuals can enter an intersubjective relationship.

While Freud did acknowledge "the social drive", as one of the many different kinds of drives that he postulated (Laplanche & Pontalis, 1973), for Spielrein, the major drives themselves (sexual and nurturing drives) are social and relational in essence. That the relational striving to transcend the ego and merge into We-ness is, for her, the core of the drives, is also what accounts for the non-dualism of her understanding of drives: unlike Freudian theory (from 1920 on), which viewed the life and death drives as competing with each other, she conceptualizes destruction and coming into being as the effects of one basic drive. Dying and becoming are, for her, not in conflict – rather, they are interdependent, and parts of the same process. Viewing the destruction or death aspect as predominant, a separate force rather than part of the continuous cycle of dying and being reborn is, for Spielrein, a neurotic symptom: "In neuroses, the destructive component is predominant and, in every symptom, voices its opposition to life and genuine destiny" (p. 173).

Spielrein's *Destruction as a Cause of Coming into Being inspired* Freud's theorizing about the death drive, as he stated in a footnote to *Beyond The Pleasure Principle* (1920) and it has been argued that Jung's concept of transformation also owes much to this text, which Jung read closely and edited yet failed to reference in his own 1912 *Symbols of Transformation,* despite

[4] Here Spielrein's views markedly differ from Freud's (1920) view that interorganismic merger increases the vitality of each individual organism participating therein – and hence, desired by the organism in the hope of increasing its own aliveness, irrespective of the production of new life or ensuring survival of the species.

his promise to do so (Bettelheim, 1983; Skea, 2006). Klein knew and cited Spielrein's work (Vidal, 2006), though not *Destruction* specifically. While it is not known whether Winnicott ever read this text, it seems to anticipate his much later work on the destruction of the object as a precondition for its survival and usability (1968). Spielrein's tightly-packed text contributed to Freudian theory, analytical psychology and possibly object relations as well. Today, over 100 years since its publication, *Destruction* is still fresh and full of nutrients. The author's marvelous capacity to refuse widely accepted dichotomies beseeches us to make use of her work to enrich relational psychoanalytic theory and practice by undoing what seems to be an unnecessary dichotomy between relationality and drives.

Does it have to be all about procreation?

A major problem that we are prone to encounter as we attempt to incorporate drive theory in general, and Spielrein's thinking on drives in particular, into relational theory, is the phallocentricity and heteronormativity of the drive theory as we know it – including Spielrein's thought. *Destruction* emphasizes procreation, understands sexual desire as driven by the reproductive instinct, and equates sex with (unprotected) heterosexual intercourse. For our purposes, these formulations are problematic on many counts: they fail to take into account the advanced contemporary technologies of both pregnancy prevention and pregnancy initiation, enabling millions in the first world and beyond to have sex without pregnancy risks– or, alternatively, to get pregnant without sex.; They are ignorant of the uncontestable facts that penis-vagina intercourse is neither sufficient nor necessary for the majority of women to orgasm – hence, unless only male satisfaction is considered important, intercourse cannot be the only or the main sexual act in heterosexual sex, and that women's sex drives persist well beyond the childbearing age – and, of course, they are completely dismissive of same-sex sexual desires and practices.

Mitchell was passionate about depathologizing homosexuality (e.g., Mitchell, 1981) and this may well have been one of his motives for disidentifying from the drive theory, whose essentializing preoccupation with the differences between the sexes and their biological functions made homosexuality sound like an aberration in need of an explanation if not correction. Whether or not this was his conscious intention, letting go of biological essentialism did help make relational psychoanalysis more gay-friendly, in both theory and practice. The problem, however, is that the baby – drive theory – has been thrown out with the bathwater of homophobia.

Articulating a non-phallocentric, non-heteronormative relational drive theory: steps and directions

Is psychoanalytic drive theory inherently phallocentric and heteronormative? Not anymore than psychoanalytic theory and practice are in the general senses. While legacies of sexism and homophobia cannot be erased, the relational movement has certainly taken giant steps to advance feminist and queer perspectives in psychoanalysis. It is certainly possible to develop a relational drive theory that could match other aspects of relational theory in its feminism and queer-friendliness. Doing so would require taking a close and honest look at biological instincts and drives while still keeping one's feminist and queer glasses on – a challenging project no doubt, but think of the rewards!

What follows is an outline of some of the directions for integrative biopsychological theorizing that could help make this kind of theory possible. We hope that this paper would ignite further endeavors to bring the two together.

Drive as organismic rather than merely evolutional

Thinking of the biological sex drive as primarily physical under the Darwinian model entails the danger of falling into "anatomy is destiny": if it is physical, then it must be a function of the specific form the body can take, based on that body's sex – which in turn can lead to gender-essentialist theorizing about male vs. female sex drives. This Darwinian/Newtonian logic represents a linear causality that no-longer befits the complexity of thought characterizing contemporary science and psychotherapy. Alongside anatomy is destiny, we can understand drive within the conceptual framework of "the body as agency", where drives are seen as means of expressing, relating and motivating us as bodies. However, a shift in understanding body might be needed if we are to follow drives as embodied, lest we are back before we know it to the naturalization of female masochism, male sexual aggression, female monogamy, male non-monogamy, all females are born to be mothers, and so forth.

To avoid the trap of gender essentialism, we may begin by tracing back Freud's original formulations regarding the sex drive as energetic (1959). According to Lowen (1990), Freud initially thought of the libido as physical energy, but having failed to prove the existence of such physical energy, later redefined it as psychic energy. Freud's attempt resulted from his attraction to, and reliance on Darwinian evolution theory. Freud's relationship with the body was satiated with causal thinking, viewing the physical as the origin of the psyche and attempting to track psychological phenomena to their primary somatic processes (Capra, 1982). Psychoanalyst and neuroscientist Eric Kandel (2001) shared Freud's belief that mind functions could one day be fully explained in biological terms. From this perspective, the body is seen as a primary process, devoid of subjectivity and incapable of relating. While we cannot refute the evolutional aspect of embodiment, we wish to suggest that another body exists, an organismic body that is emergent – neither alienated from its drives nor a slave to them, but instead a unified organic system seeking both to preserve its being (body as biology) and to connect with other beings (body as object seeking). This view is the central understanding in body psychotherapy which originated in the work of Wilhelm Reich and culminated in contemporary relational body psychotherapy (Hartley, 2009; Young, 2012).

Reich has returned to the physical energy formulation, and his student Lowen (1990) spoke of bioenergy, which he defined as "the energy of life", a concept based on and closely related to Bergson's elan vital. However, there is an essential difference between Freud's view of the body and that of Reich's and Lowen's, and it is the latter view that can be of help to us on our quest to re-embrace drives within relationality. While Freud viewed the body either in mechanical terms or as an unruly primary process, both Reich and Lowen recognized the body's agency and its capacity to self-organize. "For too long," wrote Lowen (1965), "Western thought has regarded the body as a mechanism, an instrument of the will, or a repository of the spirit. Modern medicine, for all its advances, still holds to this view. We do not take our bodies seriously except when something goes wrong" (p.316). Should we agree to see body not merely as primary process but also as organized and emergent process (subsymbolic, if you will, Bucci, 1994), that is - as sociobiological organism, we may be able to cease treating the body as an other, and re-identify with our embodied being and embodied relating. Otherwise, "the body as means of expression, the body as I-me, is easily forgotten" (Svensen & Bergland, 2007, p.44).

Whether defined as primarily physical, primarily psychic, or neither/both, a drive that is originally and ultimately energetic (and organismic) can be seen as expressing itself in both the body and the mind – any body and any mind. Such an understanding relies on seeing the bodymind as both functionally-identical (bodymind) and complementary (body-mind). A drive so envisioned necessarily exceeds the body as a vehicle for evolutional procreation, or of other

causal dogmatism and determinism. Therefore, drive cannot be confined to one or another set of sex organs. Its emergent and creative purpose may be envisioned, in line with Spielrein's formulations, as transcending individuality in the service of promoting life and unity yet does not have to be as narrow as procreation.

The aggressive drive, the sexual and even the death drive, could thus be seen as serving both the function of the organism as a body wishing to express itself (the complementary, yet separate body-mind), and the function of the organism as a body wishing to relate (representing the bodymind). Paraphrasing Winnicott, Orbach (2003) argues, "There is also, I suggest, no such thing as a body, there is only a body in relationship with another body" (p. 10). We wish to claim that both are true. The body as distinct from the psyche (body as biological) and the body as relationship (bodymind as an emergent object-seeking phenomenon) are in dialectic and complementary tension with one another, weaving relationality and drive. Within this tension, drive is a function of our organismic creativity, which forever seeks others to co-embody with. As Totton (Asheri, Carroll, Rolef Ben-Shahar, Soth & Totton, 2012) phrased this: "Our body bathes in and soaks up the embodied presence of the other; we catch fire from them; we breathe them in and metabolise them; we reverberate to their rhythms, and our own rhythms shift to echo them. Out of this meeting of realities, a third, shared reality is born."

The drive that is not one: making room for multiplicity

Irigaray's (1995/1977) critique of the Freudian theory of sexuality – which, for our purposes, can also be applied to Spielrein's drive theory – focuses on its phallocentric totalitarianism:

"Psychoanalytic discourse on female sexuality is the discourse of truth. A discourse that tells the truth about the logic of truth: namely, that *the feminine occurs only within models and laws devised by male subjects.* Which implies that there are not really two sexes but only one. A single practice and representation of the sexual (p. 86)."

As Irigaray's analysis aptly shows, there is no room in the Freudian theory, with its obsessive emphasis on penis-vagina intercourse and reproduction, for the particularity of women's experiences of their own sexed bodies and sexual desires – e.g., the intimate experience of having one's labia rub against each other, the ability to feel sexual arousal and pleasure in nearly every part of one's body, thus experiencing one's entire body as an erogenous zone, and the subtle pleasures of lesbian eroticism.

> "I love you who are neither mother (forgive me, mother, I prefer a woman) nor sister. Neither daughter nor son. I love you - and where I love you, what do I care about the lineage of our fathers, or their desire for reproductions of men? Or their genealogical institutions? What need have I for husband or wife, for family, persona, role, function? Let's leave all those to men's reproductive laws. I love you, your body, here and now. I/you touch you/me, that's quite enough for us to feel alive (p. 209)".

In line with Irigaray's suggestions and her poetic illustration of her ideas, it is vital, when reengaging drive theory, to make room within it for multiplicity. Drives and sexualities need to be studied phenomenologically, in an experience-near (Kohut, 1977; Rapoport, 2011) fashion, with curiosity about the infinite variety of sexual desires and practices alongside the recognition of the unifying universal themes. Irigaray specifically focuses on desires and pleasures associated with having a female body. Equally important is to keep opening up the space for queer, bisexual, transgendered and intersexual subjectivities, to enable the articulation of the particular sexual desires of the elderly and the differently abled and to continue studying ways in which cultures both facilitate and impede our access to our bodies and desires.

Can Spielrein's basic idea about the sex drive as the drive to surrender to relatedness ("Weness") coexist with this interest in multiplicity and variety of desires as subjectively experienced? Is it useful to have her formulation in mind even as we acknowledge that, on the level of our differentiated subjectivities, we feel "driven" to have different kinds of sex and for different reasons? The subjective desire may be for touch, or it may be for affective discharge, an energetic boost, an experience of closeness with a loved one, or to form/validate/change one's own identity. We may feel driven to penetrate, to possess, to give of ourselves, to experience parallel play, to disentangle ourselves from our last partner. We may even at times be driven to procreate – less common as a motivation for sex but still an option! Does distinguishing between the unconscious, undifferentiated, universal driving force that Spielrein describes and our highly differentiated individual subjectivities address the problem of prescriptive totalitarianism that Irigaray points to? When viewed as organismic, drives become dynamic and changing alongside the subjectivity, rather than sublimating to enable socialization

Animal studies

Research on sexual behavior and gender patterns among non-human animals can be helpful in developing a non-heteronormative, non-phallocentric drive theory. Homo- and bisexual behaviors have been observed in at least 450 species, spanning every major geographical region as well as every major animal group, and there is abundance of evidence that animals in a wide variety of species routinely engage in sexual activities that are entirely unrelated to reproduction (Bagemihl, 2000). Such activities seem to serve no "function" besides the obvious ones of pleasure-seeking and/or affectionate bonding. In light of these observations, any formulations squarely equating sex with heterosexual intercourse or the sex drive with the procreative function appear preposterous. Such conceptions appear to be based on little more that the vestiges of the Victorian sexual repressiveness and some of the heavily dated preoccupations of the late 19th century medicine and biology. Natural scientists of that era attempted to systematize human sexuality, by subjecting it, in line with the positivist Zeitgeist, to principles of rationality and goal-directedness as well as by establishing rigid, essentialist and complementary notions of what constitutes maleness versus femaleness. Needless to say, many of these notions are to this day alive and well in biological sciences. The natural world itself, however, does not always manifest clear distinctions between male and female behavior patterns, is not consistently patriarchal and most definitely not all heterosexual. Relational psychoanalysis, along with other contemporary social sciences, has decisively differentiated itself from natural sciences and this differential has made it easier for it to position itself as a feminist and queer-friendly discipline. Nonetheless, avoidance of everything biology-related should not be a pre-condition for feminism or queer-friendliness. We should keep reminding ourselves that oppressive phallocentrism and homophobia have much more of a stronghold in animal sciences than they do in the animal world.

Could nature and nurture hit it off with each other?

While the social pressures to ally with one or the other end of this dichotomy are relentless, we really need to learn to think integratively should we be able to describe complex natural-social phenomena with any degree of accuracy. Instead of maintaining contrarian positions, e.g., that gender identities and roles are entirely independent of biological sexual characteristics or, conversely, fully defined by them, we need to be looking more closely at how (biological) sex and (social) gender bidirectionally impact each other's development – including how sexual-biological characteristics develop in response to social realities (Fausto-Sterling, 2012), and how body and

culture are in dialectic relationship with one another (Appel-Opper, 2010; Rolef Ben-Shahar, 2015). For instance, instead of assuming that the sex drive, in its basic form, is equivalent to the procreative drive, we can direct our attention to social mechanisms that encourage individuals to experience and interpret their sex drives in certain ways and not in others. For example, it is useful to look at how women and queers are pressured to ignore various aspects of their sex drives and how in pronatalist societies, individuals of all genders are likely to experience a stronger procreative drive than people living in societies where procreation is relatively deemphasized (Weisz, 2014). An integrative look of this kind would be qualitatively different and nurture different sensibilities than either altogether discounting the sex drive, as Mitchell did, or assuming it to be phallocentric and heteronormative, as Spielrein did.

Relational body and drives: a dialogue

A relational drive theory would need to be a theory of a relational body - a body that is emergent and subjective and that can interact with biological drives in ways other than mindlessly submitting to them or heroically conquering them to prove its autonomy. In Freudian theory, body is an object of the Id; the only choices available to it are submitting and rebelling. As Butler (1990) points out, Freud established links of signification between corporeality and femininity - the feminine was the body, while the masculine was the universal abstraction. Objectification of the body, then, is closely related in Freudian thought with the passivity and masochism that is attributed to femininity. Granted, objectification has its place in erotic imagination but this done-to (Benjamin, 2004) reading of the body allows little room for intersubjectivity. If we are to envision a relational drive theory, we need to learn to think of the body's relationship with the drives in the language of curiosity, exploration, mutuality and play, alongside that of power, conquest and possession.

Master narratives tend towards absolutism and exclusion of the other. While Freud's theory is highly biologically centered, Mitchell's is mind-centered. The challenge is to develop a theory that might enable us to think of ourselves, fluidly and interchangeably as bodies, minds and bodyminds, sometimes as unified, other times as split, along the lines of Benjamin's thinking on intersubjectivity and Spielrein's on sexuality: continuously shifting between recognition and objectification, destruction and reconstruction. A relational drive theory requires a creating of a language that acknowledges the power and vitality of the drives while also acknowledging the subjectivity and agency of the body.

An illustration from Asaf's clinical work

Rob is psychoanalytic psychotherapist, thirty five years old. He left Italy fifteen years ago and moved to England, a move he saw as necessary for allowing himself to be openly gay. He sought therapy due to his uncontrolled sobbing around sex. For the last eight years Rob has been in a committed relationship with Michael, the first serious and long-term relationship he had. He described their relationship as loving and passionate, and continuously growing. Yet every time Rob was penetrated, he described a wave of terror flooding him, upon which he would begin to sob uncontrollably. This scared both him and Michael, and impacted their sex life and love life.

Having attempted to understand this in his analysis for a few years, Rob was recommended to seek body psychotherapy, and came to see me. At first, we tried to continue looking at his terror through the object relations lenses, focusing on parental and religious disapproval, his own homophobia and his abandonment anxiety, as well as issues of power and powerlessness. In our work, Rob kept trying to provide graphic details of his and his partner's sexual relationship, while

I endeavored to phrase these in relational terminology, perhaps out of my own fear of engaging with homoerotic countertransference.

After a year of us working together, and during a shared therapeutic exploration that involved touch, Rob lay on his stomach, fully dressed, and I placed a hand over his back. This touch, with me in control - "topping" - allowed me to engage in homoerotic fantasies that I dreaded to entertain with him looking. It was safe enough for me to play. Long minutes passed with very little happening, and I found myself drifting away. My hand felt heavy on his back, and for a moment I could not differentiate my hand from his back; it was as if they were glued together, part of the same tissue. This had a profound effect on me; there were drops falling on Rob's back and it took a moment for me to realize these were actually my tears. Yet I was not dissociated. This felt frightening and at the same time completely engrossing and promising. I wanted to remove my hand and leave the room, but also to leave it there forever, to never part. "Every time Michael comes inside of me," Rob broke the silence, "I feel that I die inside of him, that I am consumed by our togetherness. I seek it and fear it and the intensity of this feeling frightens me." Rob turned to see if I understood him, and saw my face, and my tears. Another pause ensued, following which he asked, "But how come this doesn't freeze you?" My answer was simple: "Because I could see you".

There are many possible ways of interpreting and understanding our interaction. It is important to say that following that session, Rob had a major shift in his experience of sexual contact. He realized that it was not his sensations and feelings that were the problem, but rather the way he conceptualized them as meaning something negative about his relationship when in fact, "it was a real celebration to realize my capacity to surrender to Michael and to our connection, and it sure is as terrifying as it is blissful."

Could it be beneficial to view the therapeutic interaction, and Rob's struggle in general, through the integrative drive-theory-object-relations lenses? To consider his body as both pleasure-seeking and object-seeking - an emergent bodymind that both craves and dreads an intersubjective experience?

In his analysis, Rob's body-dread was interpreted as inferred – as representing a pattern of relating (fear of annihilation, homophobic, a response to superegoic paternal disapproval etc.) and not directly of the body. But in our encounter, and in our enactment, it was an organismic dread – not merely a psychological fear, but a desire-and-fear enmeshed together in Rob inasmuch as he was an embodied organism. To return to Spielrein's conceptualization, we can understand the embodied-dis-course between us (and the enactment), and the intercourse between Rob and Michael as having both drive and relational components – a felt-and-embodied opportunity to die as an individual and be reborn as a third, then let the thirdness die and be recreated in our renewed individualities – a process as terrifying as it rewarding. This may be viewed as a subsymbolic (Bucci, 1998) or polyrhythmic (Knoblauch, 2011; 2012) demonstration of the somatic primacy of intersubjectivity.

What touch offered us, and what penetration offered Rob was organized, yet not symbolized. It was an invitation to relate to his relationship as both physical and relational, and consequently invited processing that demanded drive-based as well as relational conceptualizations. Attempting to address Rob's terror without attending to Rob-as-body would not only miss something fundamental about the pain, but also rob him of the potential held therein: Rob was able to experience unity, getting lost, enmeshing with his loved one. In my understanding, his sexual experience was an evidence of health, of his capacity to surrender. Such a deep surrender into the body-in-relation necessarily also entails annihilation dread, but of the bodymind, and not simply of the psyche. Rob's experience of sexual contact, and our shared experience of touch, demonstrate

the organismic and non-lineal (or procreative) essence of drive in general and sexual drive in particular: it being about an organism seeking to express itself and experience pleasure, while connecting with another in body and mind. This was a place where bliss and hell were intertwined, illustrating the philosopher Ananda Coomaraswamy's (1940) argument: "No creature can attain a higher grade of nature without ceasing to exist" (p.6).

Surely, this short case illustration can be explained separately by drive theorists and object relationalists. We hope to have demonstrated that there is value in holding both, and that these may complement rather than exclude one another.

Drive-Relational Synthesis

Once we have disentangled the sex drive from procreation and acknowledged the multiplicity of ways in which it can be experienced, we can return to Spielrein's basic formulation concerning sex drive: namely, that intimate physical and emotional contact with another human being necessarily entails intensification of the processes of psychophysiological self-change (destruction and coming into being) – and that in its most general form, the sex drive can be thought of as the drive to surrender to overwhelmingly intimate contact with another in order to produce thirdness. While Spielrein had in mind the production of the physical third – a child – her idea can be expanded to include the psychological, relational third, or the intersubjective field, as conceptualized most extensively by Benjamin (e.g., 2004). The radical organismic transformation of one's subjectivity and identity that this process entails can, as Spielrein suggests, explain the common reactions of fear and avoidance of truly intimate sexual contact – the kind that was occurring between Rob and Michael. In Ghent's (1990) words, "the ultimate direction (of the surrender to intimacy with another) is the discovery of one's identity, one's sense of self, one's sense of wholeness, even one's sense of unity with other living beings" (p. 109). What we learn from Spielrein is that sexual contact can enable the individual to experience a particularly powerful form of surrender, one that can be experienced as death and lead to a profound individual transformation, physical as well as psychological. Our individuality as we knew it prior to the encounter, dies and is replaced with the experience of the thirdness, subsequently leading to the birth of new individuality. An integrative Spielreinian-relational formulation along these lines could provide a basic conceptual framework for a relational drive theory.

Summary

The cultural forgetting of Spielrein was, of course, no coincidence. She was omitted, because she was a woman, because she refused to give up her intellectual autonomy by allying herself exclusively with either Freud or Jung and because her integrative, drive-relational view of human psychology was too daring and excessive to be truly appreciated in the analytic climate of her time. Our ambitious hope for this paper is not to create a fully hermetic relational drive theory, but to ignite a dialogue and discussion, to bring Sabina Spielrein back from the periphery of psychoanalytic thinking into the center and reconsider the reconciliation of drive and relationality, of body and psyche, in a way that is perhaps only possible today, over thirty years into the establishment of the relational turn. Now that relational concepts and practice are widely accepted, perhaps it is possible to go back and pick up the pieces we left behind, and bring our shamed and exiled body, with its wishes to express and connect, with its wild and untamed desire to relate and manifest, back into the center stage of theoretical discussion. We wish to reclaim the space of the bodymind in theory since, to be truthful, it has never left the field of human relatedness, only the science of human relatedness.

Should our endeavor be successful, a separation which was once deemed essential can now begin to melt and relational psychoanalysis may enjoy both the wealth of drive theory, with the conceptual tools that it offers for recognizing our organisms as biological, and the richness of relational theory, which allows us to conceptualize the ingenuous ways in which our organisms relate and seek connection. Perhaps, as Sabina Spielrein finally assumes her place of honor alongside Freud and Mitchell, and her libidinally charged brilliance, her daring to speak as a desiring subject in the era of female masochism and penis envy, and her willful determination to integrate where others split, will become something that psychoanalytic culture can grapple with. For us, opening up to Spielrein's legacy has stemmed from, and in turn fostered, our desire to connect as well as our connection to our desires. Learning from her means learning to appreciate how synthesizing desire and connection is not only possible, but essential for fully understanding our human organismic experience.

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The Triphasic Cumulative Microaggression Trauma Processing Model Informed by Body Psychotherapy

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Third Edit and Resubmitted for the Somatic Counseling Psychology Masters Paper requirements of a master's degree in Body Psychotherapy
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Received 16th April 2016, Revised and Accepted 31st May 2017

Abstract

Microaggressions are influential on identity formation and are daily occurrences in many individuals' lives. This article explores the formation and effect of internalised maladaptive messages derived from microaggressions in interpersonal relationships, institutions, and dominant culture. The impact of microaggressions on the nervous system and the delineation of the categories of microaggressions are discussed. Nonverbal communication, the body's role, and the interaction of identity intersections of multiple marginalised identities are considered.

The Triphasic Cumulative Microaggression Trauma Processing model is designed to discover internalized maladaptive messages from chronic microaggressions, evaluate these messages, and integrate the awareness gleaned to mitigate their adverse impact. The model merges concepts from Sensorimotor Psychotherapy, Dialectical Behavior Therapy's Safe - Place visualization, Identity theory, Traumatology, and processing through cognition, emotion, and body sensations for trauma related to internalised maladaptive messages. The use of meta-processing through metaskills is emphasized throughout the proposed model.

A case study in conjunction with a detailed description of the model is incorporated to create a distinct picture of the Triphasic Cumulative Microaggression Trauma Processing model's operation.

Keywords: Trauma, microaggression, body psychotherapy, internalized oppression, identity

International Body Psychotherapy Journal *The Art and Science of Somatic Praxis*
Volume 16, Number 3, Fall 2017 pp 63 - 72. *ISSN 2169-4745 Printing, ISSN 2168-1279 Online*

It is a delicate act to nonjudgmentally analyse and transform the maladaptive influence of culturally-normed acts as they relate to the diverse levels of social power and identity development. This article is the investigation of the traumatising impact on the whole individual from chronic exposure to microaggressions. The Triphasic Cumulative Microaggression Trauma Processing model's (TCMTP) main focus is the nervous systems automatic trauma responses activated by identities formation by dominant microaggressive cultural norms influence (Burke & Stets, 2009). The relationship between identity and socialisation may assist in the formation

of internalised maladaptive messages (IMM). The body and nonverbal communications role in microaggressive interactions and therapy are conveyed herein. A discussion of the categories of microaggressions; microassaults, microinsults, and microinvalidations are incorporated. Mindfulness, the therapeutic relationship, and the co-use of metaskills are fundamental in the success of treatment with this model. Principles from Sensorimotor Psychotherapy and the concept of processing through cognition, emotion, and body sensations for maladaptive trauma responses (Ogden et al, 2006) are at the core of the model. An adaption of a Dialectical Behavior Therapy's (DBT) technique, the Safe-Place visualization is transformed into the Sanctuary meditation (McKay et al, 2007) as a tool for integration. A brief discussion of Somatic Experiencing (SE) and Eye Movement Desensitization and Reprocessing (EMDR) is integrated to highlight the novelty of the model. An implemental case study in the creation of the TCMTP and an outline of the model close this discussion

Microaggressions and their Impact

Our identities are products of "cultural conditioning" (Sue et al, 2007, p. 280). Individuals formulate and perceive identity through culturally normed messages (Burkes & Stets, 2009). The internalised maladaptive messages are self-assertions that may inform an individual's core identity, becoming accepted and internalised and, ultimately, forming self-inflicted and externally forced internalised oppression (Bailey et al, 2011). Internalised oppression may impact the multiple intersecting identities discussed by Jun (2010): religion, disability, socio-economic status, age, language, sexual orientation, race, ethnicity, and gender. Intersectionality of these multiple identities are defined by Szymanski and Henrichs - Beck (2014) as the "cumulative" and "interactive" (p. 29) experiences of an individual. Identities are not always syntonic and add complexity (Nettles & Balter, 2012) and underscore the development of a greater frequency of psychological disturbance (Szymanski & Henrichs-Beck, 2014). Internalised maladaptive messages are transmitted across generations through microaggressions, causing damage and "perpetuating the cycle of internalized oppression" (Bailey et al, 2011).

Jun (2010) identifies this form of intergenerational trauma as unconscious, complex, and difficult to process. These unconscious prejudices "are activated automatically and influence individuals' perception and judgment" (p. 113). Maladaptive intrapersonal processes for coping with these microaggressive messages present as hopelessness and an inaccurate self-perception (Szymanski & Henrichs-Beck, 2014). Huynn (2012) claims that microaggressions are ambiguous in nature and may be dismissive of an individual's experience. Torres and Taknint, (2015) address that microaggressions "negate the experiential reality" (p. 393) of the individual experiencing and perceiving them. For instance, Latinos may be treated as "perpetual foreigners" (p. 393) or experience others assuming they are inferior.

The cumulative effect of the many forms of microaggressions and their impact on identity formation and maintenance is a pivotal research topic. There is an emergence of a body of research that illustrates the impact of the adverse effects on well-being from microaggressions (Owen et al, (2010); Sue et al, 2007; Wong et al 2013). Holder et al (2015) discuss the impact of chronic exposure to microaggressions as having a "deleterious and cumulative physiological impact over time" (p. 165). The profound impact on the intrapersonal level is reflected in an increase in psychological dilemmas, depression, and low self-esteem (Owen et al, 2010; Sue et al, 2007; Wong at el, 2013). On the interpersonal level it creates disproportionate access to power and creates relational distress (Johnson, 2010; Sue & Sue, 2013). The institutional level impact of microaggressions was considered as a catalyst for "disparities in employment, health

care, and education" (Sue et al, 2007, p. 272). Wong et al (2013) assert that more research is needed to better understand the macro level or "systemic-level" (p. 16) impact from cultural norms and microaggressions. These norms change over time and have an impact on identity formation.

Social interactions in the form of microaggressions are a powerful means of social control (Johnson, 2010). The imbalance in social interactions in the form of microaggressions are learned and they can be unlearned (Johnson, 2010).

The interest in microaggressions has come to the forefront of clinical and academic literature (Holder et al, 2015; Huynn, 2012; Nadal, et al, 2014; Sue et al, 2007; Sue & Sue, 2013; Torres & Taknint, 2015; Wong et al, 2013). The prominent definition of microaggressions introduced by Sue et al (2007) is stated as "brief commonplace daily verbal, behavioral, and environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory or negative racial slights and insults to the target person or group" (p.273). This definition will be used for the impact on all identities and forms of microaggressions. Three categories of microaggressions are proposed: microassaults, microinsults, and microinvalidations (Nadal et al, 2014; Sue et al, 2007; Wong et al, 2013).

Microassaults may be either covert or overt (Wong et al, 2013). They are defined s as overt discriminating acts or attacks (Sue et al, 2007, 2013) such as using the labels to identify someone as a spic, faggot, and kype, and deliberately serving individuals experiencing disability last.

Microinsults are defined as unknown to the perpetrator, but clearly convey a hidden insulting message (Sue et al, 2007). An example of a microinsult is the assumption of the "hidden message" that "black and Latinos are less capable intellectually" (Sue & Sue, 2013, p. 155). Microinvalidations (ibid) are defined as acts against the individual which are "unintentional and usually outside the perpetrators' awareness" (p. 155-156). For example, complimenting Asian Americans for speaking good English or repeatedly asking them where they were born.

The current discussion would benefit from delineating the "subtle and blatant" aspects of microaggressions (Wong et al, 2013). The covert dynamic of microaggressions are subtle and line up with the unconscious acts and automatic responses to stimuli. The blatant acts are conscious actions and overt displays. On the neurobiological level, this would be described as the difference of automatic responses activated by the nervous system (covert, unconscious, automatic) and the conscious choices (conscious, overt, deliberate) we make.

The body and nonverbal communication are important factors in transmitting and mitigating microaggressions (Johnson, 2010; Sue & Sue, 2013). Koch (2014) addresses the body in therapy as the use of "basic human capacity in order to restore health, access resources, and diminish suffering" (p. 1). He highlights the importance of body feedback from postures when dealing with oppression and trauma. Microaggressions are expressed through nonverbal communication (Carter, 2007; Johnson, 2010; Sue et al 2007,) and are a means to control another (Johnson. 2010). Non-verbal communication is performed through movement and "nonverbal cues are happening with lightning speed" (Prenn, 2014, p. 318). The concept of lightning speed in reactions to nonverbal communication supports the understanding that nonverbal communication is an "unconscious element of the interpersonal interaction" (p. 83) and "is the locus for the most common means of social control" (p. 83). Sue et al (2007) describe the nonverbal elements of microaggressions as "dismissive looks, gestures, and tones" (p. 273). The use of nonverbal microaggressions may be a means to express an imbalanced hierarchal relationship (Johnson, 2010). Individuals who feel that they are unbiased in their conscious mind may still carry these messages and unconsciously, recapitulate them in interactions with

others (Sue & Sue, 2013). Therapists have the duty to keep in their awareness their culturally bound discriminatory messages and personal biases that inevitably enter the therapy process (Owen et al, 2010).The therapist's own self-assessment of identity is an important factor towards their ability to recognise these messages and biases (Mindell, 1995a). In therapy, the power differential is explicit in the professional/client relationship. The therapist must keep the power differential in perspective at all times. Verbal and nonverbal interactions create the interpersonal field of interaction where messages and biases are transmitted (Johnson, 2010).

The body may be the key to discerning microaggressions through noticing what nonverbal movements are present in therapeutic interactions. Prenn (2011) discusses that the nonverbal creates "dyadic attunement" (p. 313) in relationship with clients. The job of the therapist is to intentionally attune or mis-attune with the nonverbal movement qualities of the client. Misattunement in dealing with cultural material may become microaggressive if the therapist is unaware of their own nonverbal language in session. Another element for attention is attuning with the internalised oppression of the client, creating a microaggressive environment. The practical approaches to dealing with microaggressions outlined by Nadal et al (2014) include: awareness of the link between mental health and microaggressions, the use of psychoeducation as a means of raising awareness to the different forms of microaggressions and giving the client language to discuss microaggressions, and validation of the existence of microaggressions.

Major Trauma Clinical Approaches

Widely researched, trauma theory found that overwhelming stress profoundly influences the function and development of both existential and biopsychosocial systems (Abramovitz & Bloom, 2003). Helms et al (2010) define trauma as a set of psychobiological reactions to events perceived as devastating or life jeopardizing. Mindell (1995b) illustrates the commonalities of the symptoms of post-traumatic stress disorder (PTSD) and the effects of long-term shaming (Owen et al, 2010). Ogden and Minton (2000) highlight that trauma impacts the whole individual and explain how trauma symptoms may be cognitive, emotionally, and somatically based.

The messages received from microaggressions may silence, invalidate, and humiliate individuals, having a lifelong effect on the "identity" of the individuals experiencing them (Sue & Sue, 2010). Exposure to this form of dominant cultural perspective has been linked to substance abuse (Sue & Sue, 2013) and other forms of self-destructive behavior (Bailey et al 2011) in those who experience cumulative microaggressions. Microaggressions create maladaptive messages that influence identity formation (Burkes & Stets, 2009), may be a form of traumatic stress (Torres & Taknint, 2015), and evoke immediate trauma reactions (Helms et al, 2010). The physiological reaction to traumatic stress is the activation of the nervous system manifested as hyper or hypo arousal (Carlson, 1997; Carter, 2007). Ogden et al (2006) noted that the nervous system may go into a "rapid mobilisation…in response to trauma-related stimuli" (p. 26).This rapid mobilisation may create hyper or hypo arousal in the nervous system. The nervous system must be in the zone between these two poles of arousal, termed as the window of tolerance in order to process information. The ability to simultaneously think and talk about experiences, feel a congruent emotional tone and sense of self, integrate information on the cognitive, emotional, and body levels are all dependent on the nervous system staying within the window of tolerance. I believe that investigation of the perceptions and reactions to microaggressions is central to mitigating these rapid mobilisations.

There are various clinical approaches to deal with major trauma. Eye Movement Desensitization and Processing is a form of psychotherapy created in 1987 by Francine Shapiro

(Andler, 2013). EMDR's goal is to reduce the effects of distressing traumatic memories by engaging the brain's adaptive information processing mechanisms (Andler, 2013). Somatic Experiencing developed by Levine (1997, 2010) incorporates the nervous systems functioning, focuses on the client's perceived body sensations, and cultivates self-regulatory skills. Sensorimotor Psychotherapy is a method that integrates somatic processing with cognitive and emotional processing in the treatment of trauma (Ogden & Minton, 2000). Evidence supports the idea that somatic techniques can provide relief of persistent and complex trauma symptoms (ibid). McKay et al (2007) discuss Dialectical Behavior Therapy's "safe-place visualization" (p. 31) and experientially explore the traumatic response of the nervous system's regulation through mindfulness, visualisation, skill building, and awareness of the five senses. Metaskills incorporates therapeutic immediacy in processing traumatic material. Mindell (1995a) defines metaskills as the capacity to stay in the present moment experience on multi-levels. Therapeutic immediacy is the real-time reactions of the client and the therapist in the session (Iwakabe & Conceicao, 2015) and is the foundation of this work (Mindell, 1995a). Metaskills create co-awareness of what is happening internally in the client, the therapist, and externally in the relational field. Metaskills are used by the therapist and taught to the client.

Based on my clinical experience, implementing this technique while working with microaggressions, may alter the clients' perspective on microaggressions and how they relate to it through their cognition, emotions, and bodily sensations. The client may be able to craft how they identify with the culturally normed IMM.

Triphasic Cumulative Microaggression Trauma Processing Model

This model has been developed through 7 years of my subjective experiential studies at the Evergreen State College and Naropa University and clinical practice with one on one and groups interactions. The model progressed from multi-modes of expression: music, drawing, meditation, and movement.

In the following section, I create a snapshot of the work with a client that sheds light on practical aspects of the model. Identifying information was omitted to protect the client.

Zac was fifty-one years old when we started our work together. Six years prior he was injured in an accident and sustained a traumatic brain injury (TBI). He was unable to obtain gainful employment and was challenged to stay emotionally, physically, and cognitively regulated. This constant dysregulation impacted his ability to perform basic daily activities. When at home the act of performing light housework was almost unbearable, the clanking of dishes and the sound of running water was too much for his system. He was unable to drive due to the overstimulation produced. In public, he would become fearful of judgment for his strange behavior. He would walk slowly and stagger in grocery stores and others would give him what he perceived as judgmental glances and would move away from him. Zac found that others were more patient and less avoidant when he used his cane in public. Judgment was the main theme in the work with Zac he judged himself harshly and had a paralyzing fear of judgment from others. When Zac spoke of his feelings of judgment he would respond with an automatic hyper or hypo arousal state. When dysregulated in my presence he would cry often, his body would twitch, and he was extremely sensitive to light and sound. Zac's ability to function was limited to this repetitive nervous system response. He was unable to process in session and we would focus on building skills to modulate his nervous system and return to the window of tolerance.

He experienced the linear thinking and the hierarchal power structure of the current social structure (Sue & Sue, 2013). The philosophy of more is better without the consideration of the

impact was inherent in his upbringing and identity schema. Though Zac was raised in a middle-class environment he now held a lower socio-economic status (LSES). The current research denotes that LSES is a contributing factor in higher rates of health problems, depression, and lack of a "sense of control" (Sue & Sue, 2013, p. 192). Myers et al (2015) found that economic status microaggressions creates "chronic socioeconomic stresses" (p. 244) and is a risk factor in "chronic diseases and psychiatric disorders" (p. 244). Zac also experienced a fully able existence for forty-five years before the accident and his disability. O'brien et al (2015) delineate how individuals' experiencing disabilities perceptions of judgment from peers create barriers to resources. They elucidate how teachers have been unwilling to change their instruction to accommodate individuals with disabilities, creating microaggressive learning.

The transformation from able bodied to disabled and a middle-class status to LSES was a pivotal element to our work. The onset of these marginalised identities and their intersections created disruptions in his identity schema. The impact of microaggressions received from these marginalised identities created disparities in his identity consistency. We uncovered messages that influenced his identity and ultimately his ability to function. Zac was raised in a family where the main goal was for the family to outwardly present as "perfect" and behind closed doors, Zac experienced overt microaggressive experiences from his father and mother. His mother gained control by presenting as emotionally absent, judgmental, and through passive slights. He described his father by controlling with an overbearing and highly judgmental attitude. Zac was continually bombarded with the messages that he was not enough. Zac's identity was initially formed through the combination of these parenting styles and means of interacting. The impact on Zac from growing up in a microaggressive family of origin created IMM. These IMMs were solidified and reconstructed into deeper and altered marginalisation after the accident.

I will now outline one session where Zac was processing an IMM from the combination of his LSES and disability status with the TCMPT. This is a two-part vignette it shows the model in action and provides a detailed expression of Zac's present moment experience. A clear-cut outline of the model is shown in figure 1.

Figure 1

The Discovery Phase

Objective: Discover the current IMM.

- *Find entry point into processing material (cognitive, emotional, or bodily).*
- *Find a statement to express IMM.*
- *Process statement on all levels.*
- *Turn statement into an "I" statement.*

The Evaluation Phase

Objective: Experiential practice of IMM.

- *Find most accurate representation of IMM through posture.*
- *Find movement that expresses the IMM posture.*
- *Move posture while speaking the IMM.*
- *Find the opposite posture and opposite corresponding message.*
- *Repeat the first three steps with the opposite posture and message.*
- *Feel the space between the two movements.*

The Integration Phase

Objective: Integrate IMM and OCM into current identity schema.

- *Body scan.*
- *Visualization of a sanctuary through sanctuary meditation.*
- *Find imagery, senses, bodily reactions, and emotions that arise.*
- *Write the opposite corresponding message in the sanctuary.*
- *Body scan.*
- *Discussion in attempts to integrate into identity schema.*

The discovery phase's purpose in the work with Zac was to discover the IMM incorporated into his self-construct and find the entry point into processing material (cognitive, emotional, or bodily).

In this particular session, the entry point Zac found was through emotion. He was experiencing sadness, and when I asked him to locate the sadness in his body, he described his sadness as a deep well in his chest pulling inward, creating tightness. I suggested him to find a statement to express his IMM. The words that expressed his feeling of sadness were "not enough". This "not enough" corresponded with the many microaggressions he had experienced before the accident and subsequently with the alterations of his identity. The next task was for Zac to notice what occurred on all levels when he felt into "not enough". He was then asked to turn these words into an "I" statement. Zac's IMM "I" statement was "I am not enough".

The objective of the evaluation phase is to experientially practice his IMM that stemmed from microaggressions. Zac was encouraged to find the most accurate body representation of his IMM through posture. Once he had found the posture, he was invited to use metaskills and remain with this posture. He was then asked to find the opposite posture of the IMM. Zac mindfully moved between each posture. The following step was for Zac to locate what movement emerged from the first body posture. He was encouraged to repeat the movement while speaking the IMM "I am not enough". He then found the opposite of the IMM movement and the opposite corresponding message (OCM). The OCM the client established was "I am enough". He moved mindfully between the initial movement and its opposite while speaking the IMM and the OCM. As an ending to this phase, Zac processed verbally the IMM, OCM, and the images, feelings, and body sensations that occurred in this exploration.

The integration phase's intention is to find the liminal space between the messages on all levels. This phase uses the OCM in a guided Sanctuary meditation. Zac was guided through a body scan as the first step. He was asked to visualize a peaceful place in his mind. Questions such as "are there any people or animals in your this place?" were used to stimulate imagery. I asked Zac questions to bring in the five senses. He was encouraged to notice what was in his sanctuary. Zac then was asked to write the OCM on any object and with anything in his imagined place. He chose to write the OCM "I am enough" on the floor and on a hanging picture frame suspended from the ceiling. A final body scan was used to bring him out of the meditation before he engaged. Details of the meditation were then discussed. In this particular mediation, Zac envisioned a light bright room adorned with soft ivory fabrics, crystal, and gold. He could now incorporate light and bright spaces with soft textures in his daily life to assist self-regulation. The integration phase was the space for Zac to rewrite or reform how he interacts with these messages internally as part of his relationship with self and externally in his interpersonal relationships.

Other messages Zac worked with were "I am not worthy" and "I am not able". The next steps in this work were to teach Zac self-directive exercises. In these exercises, he conveyed his current experience with the model format and minimal guidance. These exercises were used to build a self-practice aimed at self-regulation and self-reliance. The results gathered from our time together were an increase in ability to drive independently, success in navigating basic life skills, and developing the ability regulate his nervous system in different environments. He did not regain the ability to obtain gainful employment, yet he started to investigate what work he could do with the capacity he had.

Conclusion

The Triphasic Cumulative Microaggression Trauma Processing models main premise is processing microaggressions influence on the body, emotional, and cognitive levels, for nervous system regulation, integrating IMM, and transforming self-construct. The TCMTP is unique from similar clinical approaches by its application with cumulative microaggressions and the use of meta-processing. The TCMTP is designed as an investigative tool and reparative instrument to rewrite internalized maladaptive messages. The ability to navigate intrapersonal, interpersonal, institutional, and cultural relationships differently may be cultivated through this work. The next step for this model is to include a timeline creation or coherent narrative of the IMM. This timeline is formulated by investigating where IMMs collectively repeat throughout a lifetime. Further implications include research that illuminates the generational pattern of relationship with IMM through the TCMTP framework in group settings. Long-term research using this framework with multi-systems of thought and multi-discipline approach would be beneficial in this investigation.

BIOGRAPHY

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She wants to acknowledge the professors at both institutions that have supported her through her educational journey.

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The Body Remembers Volume 2: Revolutionizing Trauma Treatment
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International Body Psychotherapy Journal *The Art and Science of Somatic Praxis*
Volume 16, Number 3, Fall 2017 pp 73 - 77. *ISSN 2169-4745 Printing, ISSN 2168-1279 Online*

Trauma is pervasive in our lives, from smaller situations that trigger feelings of inability and fear to larger catastrophes that render our entire being useless as we careen out of control. Be it a result of human inflicted acts of violence—war, terrorism, genocide— or the result of natural occurrences such as hurricanes, tsunamis, and wild fires that leave us feeling victimized, isolated, abandoned, people walk through their lives numb to their reality. Their senses are overwhelmed; scenes flash in as if happening now, not then. People exist in the past as if it is the present. And when these people become our clients, when in fact these people are in part, ourselves, we, as therapists, need to offer hope and possibility to move from then to now, to live a better quality of life than what we are experiencing in the current moment.

But, how?

There are many interventional therapies promoted as "cures" for trauma. I've been trained in Eye Movement Desensitization and Reprocessing (EMDR), the Emotional Freedom Technique, aka, tapping, and Trauma-Focused Cognitive Behavior Therapy (TF-CBT) to name but a few of the approaches available to treat trauma. I have also been trained in and experienced body-based interventions that include focusing on somatic experiences and markers such as breath rate, heart rate, temperature, internal sensations (fluttering, nausea, shaking, quivering, flushes of heat in the cheeks, etc.) and more. I remember Bessel van der Kolk speaking at a conference years ago in California's Bay Area; he was on stage talking about this trauma treatment where you simply wiggle your fingers in front of the client's eyes (referencing bilateral stimulation as used in EMDR) and their traumatic memories are cleared, gone. He clearly was simplifying a long and intense process for trauma treatment, which he skillfully addresses in his much later publication, *The Body Keeps the Score* (van der Kolk, 2014). I attended his keynote address around the start of my master's degree program in clinical psychology with a focus on somatic psychology (2006). There, I was introduced to the work of Babette Rothschild.

The Body Remembers: The Psychophysiology of Trauma and Trauma Treatment (Rothschild, 2000) was required reading for my course on trauma and trauma treatment. With a background in education, my knowledge of trauma and any interventions to address its impact were limited to personal experiences, certainly nothing clinical nor research based. Rothschild's work intrigued me.

She has since published what I will call a companion book entitled, *The Body Remembers Volume 2: Revolutionizing Trauma Treatment* (Rothschild, 2017) and what she calls a stand-alone book. It is clearly not a revision of Volume 1 but rather an expansion of the foundations she previously

established; as well, she furthers her contributions to the field of trauma and its treatment. She writes that "this may turn out to be a controversial book" (xiv) as she intends to broaden current options available to therapists and their clients. Rothschild hopes this edition will be required reading for university courses and other training courses. Having just finished reading volume 2, I concur—this is a must read for students and practitioners just entering the field of trauma treatment.

Why this book when so many other books are available that address trauma and its treatment?

For starters, I want to highlight Rothschild's attitude. I found her disclaimer in the Introduction of the book refreshing and indeed potentially challenging for some readers—"truth, per se, does not exist, at least not in psychotherapy" (pg. xv). She writes that "every book, training program, method, intervention, and so on in psychology and trauma therapy is based on theory and speculation . . ." (pg. xv). And she includes herself in this cluster. Rothschild offers her opinions and her experiences to address her approach to trauma and its resolution. She is not offering the one and only, the one true treatment. She qualifies her stance using details, even down to the necessity of revising verb tenses during client narratives (using past tense verbs—for example, 'was' not 'is'— matters in trauma and trauma memory resolution, see page 180), and she expands current knowledge such as her view of the autonomic nervous system's role in trauma and its resolution.

As well, she believes that differing points of view are essential for growth and development in any field of study; she notes that where there is only agreement, there is stagnation. She hopes readers will feel challenged rather than put off by her opinions and that conversations will ensue. Her discussion on evidence-based practice and the inherent bias that exists fascinated me; a topic I'd like to visit further.

Beyond her basic attitude, her writing style stands out. Rothschild writes with a familiar voice, simple sentence structures and user-friendly language, with definitions for terms if necessary. Her content is easily experienced and absorbed—she wants readers to understand her. She offers quick points of reference such as: "There is no medication or treatment for PTSD that helps more than 50% of clients" (pg. xv); "No one treatment stands as superior to any others" (pg. 3); and "PTSD is, really, all about losing control" (pg. xix). She is clearly a teacher/trainer, a supervisor, a presenter, a "bestselling author" as well as a practiced therapist who believes in herself and her work—this self-confidence comes through in this text creating, for me, a sense of interest, acceptance, and curiosity with the willingness to question some of her premises and explore other thoughts.

Most importantly for many readers, of course, is the contents of the book itself. Volume 2 is consistent with Volume 1—it weaves applications of body awareness, body memory, and body resources as adjuncts to trauma treatment and includes descriptive case studies with annotated therapy session transcripts to clarify and demonstrate the concepts introduced (note all client presentations are collages of many not based on any one actual client). All work is directly related to clients diagnosed with PTSD, as defined in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (American Psychiatric Association, 2013). Rothschild writes that the ideas offered in this book might be applicable in different situations but her focus and confidence is for use with PTSD. In addition, she notes that the practice offered in this text may prove more complicated with clients with concurring diagnoses, which is common place with PTSD.

Rothschild is clear that, in her mind, the most important goal in any trauma treatment is to improve the client's quality of life. And while many treatment approaches are based on working with the client's traumatic memories (be it reliving them, revising them, or extinguishing them), this is not necessarily in the client's best interest. Some clients have no interest in reviewing their traumatic memories and others are simply unable to do so safely. Rothschild thus offers new tools

to make trauma memory resolution safer.

As in Volume 1, Volume 2 is divided into two parts: (1) Theory and Principles; and (2) Applying Theory and Principles. Part one contains four chapters: Revolutionizing Trauma Treatment: Trauma Recovery versus Trauma Memory Resolution; Precision ANS Regulation; Safety Requires all the Senses: Sensory Stabilization; and Revitalizing a Lost Art: Trauma Treatment Planning. Part two includes four chapters: Simple Resources Modulate and Even Heal Trauma; Making the Most of Good Memories: Powerful Antidotes to Traumatic Memory; Pacing, Portioning and Organizing; and Adapting Mindfulness, MBSR and Yoga for those with PTSD. There are the obligatory acknowledgements, references, and index as well as an insightful Appendix entitled, Trauma Therapist Beware: Avoiding Common Hazards that shares common and "widespread mistakes" that Rothschild has noted in others and in her own work. She hopes "to make the topic of therapeutic errors more comfortable to look for, admit to, and talk about for the benefit of colleagues and clients . . ." (pg. xxiii).

Because Rothschild does an excellent job highlighting the main points of each chapter in her introduction (see pages xxi-xxiii)[1], I will share a few brief points that stayed with me from Chapters 1 and 2 that I felt were pertinent to her subtitle: Revolutionizing Trauma Treatment.

Chapter One

Rothschild poses a potent question: What is happening to our profession such that "we have become so fixated on the *memories* of trauma that we are not paying full attention to the needs of the *person* who was traumatized?" (pg. 9). She means to "challenge the current assumption that clients must process memories of their traumatic experiences" (pg. 10) noting that this approach is "outdated and overrated" (pg. 11). Trauma recovery in her mind consists of three components: understanding that the traumatic experience is over and in the past; freedom from or the ability to manage symptoms, including flashbacks and dissociation; and improved quality of life (pg. 11). She is not saying no to memory work but she does ask readers to consider options without it, if this is better for the client.

To create a foundation for trauma work, Rothschild dedicates much of the first chapter to Pierre Janet and his trauma treatment structure. As she notes, many practitioners have not heard of his three-phase approach and quite honestly this felt like new information for me (concepts I may have learned in graduate school but are long since forgotten). According to Rothschild, Janet defined a three-pronged system to heal from past trauma in the latter part of the nineteenth century that includes:

Phase 1: establish safety and stabilization, regardless of how long it takes
Phase 2: process and resolve trauma memories
Phase 3: integrate/apply gains from phases 1 and 2 into everyday life, which also incorporates making meaning of the traumatic experience that may lead to greater understanding and a shift in one's point of view.

The critical point is that clients should never move into phase 2 until they are safe, stable, and functioning well on a daily basis. The reality is, recalling traumatic memories can be dysregulating and retraumatizing. We develop defenses to cope with traumatic experiences including dissociation, repression, and avoidance. Bringing up the past challenges these defenses; we lose the ability to regulate or compensate for the overwhelm. We've all heard terms like titration, pendulation, and window of tolerance associated with trauma work for good reason. We need to bring clients into their memory

[1] Readers who are interested can read this information on Amazon.com with the 'look inside option', 'first pages'. https://www.amazon.com/Body-Remembers-Revolutionizing-Trauma-Treatment/dp/0393707296

narratives (a) if they are stable, (b) if they are willing, (c) and in such a way that they are seeing it as a scene outside of themselves that can be viewed, addressed, discussed without triggering ANS dysregulation and retraumatization. In some instances, successful work in terms of safety and stabilization may preclude the need to even enter Phase 2—old memories do not have to be reprocessed for clients to improve the quality of their lives, nor should clients be forced to revisit their past traumatic memories.

Rothschild also explores trauma informed therapy where one works in the context of the event—acknowledging that it occurred and validating the symptoms—but focuses on stability, symptom relief and "reclaiming a sense of control over body, mind, and life . . ." (pg. 17). She offers the following evaluative criteria for trauma recovery on page 19:

Reasonable reduction of symptoms and full control over those that persist, including:
- Ability to come out of dissociation
- Proficiency at stopping a flashback
- Secure skills to calm anxiety or panic attacks

Fulfilling their life role as:
- Student
- Parent
- Worker

Quality of life is felt and observed to be considerably improve

General stress management is much improved

Ability to distinguish trauma triggers from the actual event

There is further discussion on successful ways to address Phase 2, memory work, and definitions for treatment goals. She also brings in Peter Levine's work and the work of narrative therapist Charlie Lang as examples of current applications in the therapy setting.

Chapter Two

Dysregulation in the autonomic nervous system and its role in trauma and its treatment is covered extensively in Chapter 2. Rothschild created a special color-coded chart based on "the left-to-right color scheme inspired by both the United States' and the United Kingdom's terror threat warning-level posters" (p. 39). She offers six distinct yet overlapping degrees of ANS arousal, three levels each within the sympathetic nervous system (SNS) and the parasympathetic nervous system (PNS), making a new and essential distinction between trauma-induced hypoarousal and low arousal caused by lethargy or depression. Her hope is that the "table will resolve difficulties and fill in gaps not addressed in most standard two column ANS charts" (pg. 39). I appreciated the chart itself as well the distinctions between Lethargic (PNS 1), Calm (ventral vagus, PNS II), Active (SNS I), Flight/Fight (SNS II), Hyperfreeze (SNS III) and Hypofreeze (Dorsal vagal/collapse, PNS III).

The core idea is the importance of monitoring our clients' ANS responses (arousal) and using our observations to inform our next steps. For instance, noticing if a client's facial expressions lose their animation, if their respiration quickens, if their skin tone changes may indicate the need to slow things down or even stop what is happening to reduce arousal and stabilize the client before moving on. Rothschild's goal in Chapter Two is twofold: to offer a new tool (said chart) and to expand readers' knowledge of what to look for and what to do about what they see and hear from their clients as well

as sense in their own body (pg. 30). Questions she intends to clarify include:

When is arousal at a level where integration is possible?
How will I know when my client is on the verge of a freeze state so that we can avoid it?
When is it okay to continue what we are doing in therapy?
What would indicate it is time to put on the brakes?

Within her discussion of ANS basics and application, Rothschild offers a more in-depth look at the different freeze states where she offers her hypothesis: "There are two distinct types of hypoarousal" (pg. 44). One comes with a sense of giving up, a lethargy that accompanies depression, apathy, grief and so on, and one that results from an "over-the-top PNS III traumatic arousal that causes a possible life-threatening collapse" (pg. 44). Therefore, it is necessary to differentiate between the two when working with clients in this state before determining an intervention strategy.

Coming Together

Chapter Three focuses on the body, on the structure and function of the sensory nervous system and its importance in client care. Practitioners' unexperienced in and more curious about a more body-based approach to ANS regulation and trauma treatment will find this chapter useful. The remaining chapters in The Body Remembers offer tools, strategies, resources to be incorporated into trauma treatment.

There is much information for newcomers to the field of body psychotherapy and to trauma and its treatment to be gained by reading this book. For those more proficient, with decades in trauma treatment themselves, the book might read a bit basic; however, there are slices of insight and lines of commentary that deserve a look and ongoing conversation among supervisees and students in your charge, with colleagues in general, and with those working with clients diagnosed with PTSD.

BIOGRAPHY

Nancy Elizabeth Eichhorn, PhD is a writer, an investigative journalist, and a credentialed educator with degrees in clinical psychology with a somatic psychology specialization, education and creative nonfiction writing. She is the founding editor-in-chief of Somatic Psychotherapy Today, co-editor of the International Body Psychotherapy Journal and an editorial assistance for Body, Movement and Dance in Psychotherapy. She currently teaches and works as a writing coach, an editor and ghostwriter. Her writing resume includes newspaper and magazine articles, chapters in professional anthologies, including When Hurt Remains: Relational Perspectives on Therapeutic Failure, About Relational Body Psychotherapy and The Body in Relationship: Self-Other-Society. She is an avid hiker, kayaker, and overall outdoor enthusiast. Nature is her place of solace and inner expression.
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Having a Map Matters
Merete Holm Brantbjerg

International Body Psychotherapy Journal *The Art and Science of Somatic Praxis*
Volume 16, Number 3, Fall 2017 pp 78 - 80. *ISSN 2169-4745 Printing, ISSN 2168-1279 Online*

In her new book, *The Body Remembers Volume 2: Revolutionizing Trauma Treatment,* Babette Rothschild includes what she calls a new 'tool', which is, in effect, a table and chart that identify the autonomic nervous system (ANS) and the effects of ANS arousal in the therapeutic setting. It is designed to help therapists better monitor, evaluate, and regulate client ANS arousal states thus making trauma treatment safer through observation and modulation.

The information as graphically depicted in this book represents what I call a 'map'. Babette and I have been colleagues for many years in the same professional field, and we share a common passion—we like making maps. Furthermore, we like to keep working with them until they have reached a level of precision that is helpful not only to ourselves but also to other trained trauma therapists – and to clients.

A map, inherent in its design, provides both sign posts of what is considered 'normal', which in this case are noted as a calm state and an active/alert state, as well as oscillations away from the norm, which here include a move from calm to lethargic and a move from active/alert to either flight/fight, hyper freeze or hypo freeze. The map's purpose is to include information regarding the named states with both verbal identifiers, (i.e., apathy, depression, safe, clear thinking, ready to act, react to danger, prepare for death), and visual markers, what to look for from a body based perspective (muscles, respiration, pupil dilation, skin tone and so forth).

Babette Rothschild has taken up the challenge of making a map that holds a differentiation of both sympathetic and parasympathetic arousal states – both in the "normal life" range of activation and in the range of life-threat. Inclusion and normalization matter when working with trauma. One aspect of being stuck in unregulated trauma reactions and patterns is that experiences weren't named, normalized and included in the first place. If the state I experience is named in a map, it exists outside of me, it is normal, I share it with others, I have a subgroup for it. The sympathetic states in Babette Rothschild's map include: active/alert (SNS I); fight/flight (SNS II) and hyper freeze (SNS III). The parasympathetic states include: lethargic (PNS I), calm (PNS II, aka ventral vagal), and hypo-freeze (PNS III, aka dorsal vagal collapse).

This is a valuable contribution to trauma-therapy including both therapists and clients who benefit from having a map that covers what they may, in fact, experience when entering the field of trauma.

While some nervous-system states have been named in several 'maps' of trauma-states, most typically known is the phrase, *flight, fight and freeze* - other states are more rarely acknowledged and differentiated; this goes for the parasympathetic ones, hypoarousal, collapse, giving up, etc. The most unusual aspect to include in this

book and map is the differentiation between two distinct degrees of parasympathetic activation; I applaud Babette for including this differentiation in the larger scheme of the trauma therapeutic field.

For many, as noted in the text, this differentiation can be new information. In a general sense, therapists have for a while now considered one frame for hyposarousal— a dorsal vagal stimulated collapse that is considered an extreme PNS arousal state - in Babette's language called "hypo freeze".

The other parasympathetic state is not only a trauma-related state. Babette names it as a 'lethargic' state typically associated with apathy and withdrawal. I suggested this state be included in this new 'map' because of my extensive work in this area.

The lethargic state does not fit within the threat to life category. It is closer to the normal life category, but holds a defensive strategy.

In my approach, the lethargic state is named as a hypo-response in the muscle-system and is understood as the giving up of impulses and emotions. (A parallel to the other known defensive strategy in muscles: tension.)

Babette Rothschild's description of the state focuses on signs from the parasympathetic nervous system (out of the normal range). Muscles go slack, respiration can be shallow, slower heart rate than normal, blood pressure lower. Pupils can be smaller and eyelids may feel heavy. Skin tone can be variable as well as the temperature of hands and feet (warm or cool). Digestion is variable. There is withdrawal from contact and lowered accessibility of the prefrontal cortex challenges integration.

In my work, I track the hypo-responsive state through noticing withdrawal from fullness in the body and with that also withdrawal from contact. Hypo-responsive areas are lacking and leaking energy – they are in a state of low energy, flaccidity, absence etc. A way to start tracking them is to just ask the question: Where do I not feel my body? Are there areas that are more absent than other areas? Areas that have a low energy level?

Whether we track this state through focusing on signs from the parasympathetic nervous system or through focusing on lowered presence in the muscle system, it brings us to include a state that is often overlooked.

Hyporesponse or the lethargic state is different from deep hypoarousal/hypo freeze. It is not about our survival – it is a coping mechanism, a defense pattern, we all use to manage life. We can withdraw, go into this state of lowered energy as a protection to feel what life is doing to us.

Making the differentiation between these two levels of giving up – the deep hypoarousal and the hyporesponse/lethargy – opens up the possibility of developing methods to work with giving up in different ways depending on the depth of the reaction.

The recommended intervention for the lethargic PNS I state in Babette Rothschild's model is to gently increase energy in the body, in a way that is gentle and well-paced (Brantbjerg, 2012). This is the kind of intervention I have specialized in for many years. In my experience it makes a significant difference in trauma-therapy.

When challenged or stressed, we typically react with both tensing up and giving up, which probably also means that both the sympathetic and parasympathetic arousal kicks in. Both reactions are there in the body and a normal tendency is to polarize between them. We can easily polarize between the parts of us that have energy enough to push through and the parts of us that withdraw and give up.

If we take the time to track the given-up parts and learn how to build up energy in them, we can get out of the stuck inner polarity and with that access a more filled out inner authority, that supports empowerment and resilience.

Building up energy in given up parts brings us closer to integrating what is held in these parts of us, that we in the first place went away from through withdrawal.

Doing this kind of work as part of approaching trauma means that we have more capacity to stay in charge and participate in regulating the dosage we work in. This goes both for the therapist and the client—a more equal cooperation between care-seeker and caregiver is supported.

Working with hyporesponse/lethargy prepares us for relating to the deeper giving up – the hypoarousal/hypo freeze state. If we know how to build up energy in low energized parts of us, access and integrate the information that is hidden inside the giving up, then it is easier to accept the existence of hypoarousal. We don't need to be pulled into collapse – we can learn to stay on the edge of it and include it as part of our natural survival reactions.

Babette's intention in writing about the lethargic state was to bring the concept of two variations of hypoarousal to the foreground, especially in relation to trauma work. Acknowledging and accepting the presence of these differentiated states will potentially impact trauma work, offering clarity for intervention strategies, as well as offer support for both the therapist and client: noting a lethargic state offers the opportunity to take responsibility for one's own exploration of its presence and its remediation instead of submitting to it.

BIOGARPHY

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Character strengths interventions: A field guide for practitioners. by Ryan M. Niemiec

Reviewed by: Monica Spafford, New York University

International Body Psychotherapy Journal *The Art and Science of Somatic Praxis*
Volume 16, Number 3, Fall 2017 pp 81 - 83. *ISSN 2169-4745 Printing, ISSN 2168-1279 Online*

Positive psychology is rooted in the idea that human beings want to thrive and engage in things that enrich their experiences and cultivate a meaningful life. In his 2014 book *Mindfulness and Character Strengths: A Practical Guide to Flourishing*, author Ryan M. Niemiec discusses how practicing mindfulness can help individuals identify, understand, and apply their character strengths and create a pathway to a fulfilling life. He takes readers through Drs. Christopher Peterson and Martin Seligman's program Mindfulness-Based Strengths Practice (MBSP), relays inspiring success stories about finding meaning via MBSP, provides useful handouts to guide readers through MBSP, and gives tips for practitioners such as how to apply MBSP to different settings and situations.

Mindfulness and Character Traits received praise for its revolutionary perspective. It reads like a self-help book, perfect for individuals who want to learn how to personally achieve mindfulness and discover their character strengths; however, it wasn't written with the goal of teaching practitioners how to implement MBSP in their practice with their clients. With that in mind, Niemiec (2018) wrote his recently published book, *Character Strength Interventions: A Field Guide for Practitioners* for practitioners. Additionally, he focuses more on the core of positive psychology, character strengths and less on how to achieve mindfulness. He educates the reader on the foundations of character strength interventions, relays evidence to support his claims about the usefulness of character strength interventions, and explains countless interventions step-by-step providing practitioners with a useful handbook.

Character strength interventions are about getting clients in touch with their strengths and finding ways to utilize those strengths to cultivate meaning and enrich their lives. Interventions specifically focus on character strengths, which Niemiec defines as "positive traits/capacities that are personally fulfilling, do not diminish others, ubiquitous and valued across cultures, and aligned with numerous positive outcomes for oneself and others" (2). As a baseline, before getting into specific interventions he outlines seven core concepts of the science of character. First, there are 24-character strengths that make up a "common language that describe what is best in human beings" (2). Second, character strengths are multidimensional therefore they are not discrete; rather, they exist on a continuum. For example, the character strength of creativity is not such that an individual is either creative or not, but rather indicates how much, to a certain degree, this person employ creativity in his/her day-to-day life. Additionally, each character strength is multidimensional so, for example, kindness involves a degree of compassion, generosity, altruism, etc. Third, character strengths will be expressed differently depending on the circumstances and are therefore "shaped by the context" (7). Culture contributes to context and can strongly

determine how character strengths are expressed. Fourth, people have many character strengths that are expressed in different degrees and different combinations. Fifth, all character strengths matter, and sixth, all character strengths can be developed. Finally, it is one thing to be in touch with our strengths and another to actively use those strengths but it takes both to achieve positive outcomes.

Niemiec explains the 24-character strengths and their dimensions. He shows practitioners via research-based interventions how to help clients get in touch with their own strengths and utilize their strengths to achieve positive outcomes. Niemiec presents the interventions organized into different categories based on how they help the client progress. The first category is ways to help the client become aware of his/her strengths. Niemic suggests the first step is to take the VIA survey which assesses an individual's 24-character strengths. Then practitioners can conduct an intervention to help clients get in touch with their strengths. For example, they may have their clients identify one of their top character strengths that they value and write about why the character strength is important and meaningful in their life. This intervention is said to help clients understand and acknowledge their strengths and appreciate the importance of them in their life. Niemiec claims that this intervention supports self-affirmation theory and cites research that shows that value affirming exercises help increase self-clarity, improve health, education, and relationship outcomes, and protect against various stressors. The second category is ways to help clients use their strengths. For example, a practitioner may ask clients to choose one of their character strengths and find a new way to use that strength each day for one week. One study showed that participants who were assigned to use their strengths in new ways "experienced elevations in happiness and decreases in depression for 6 months" (172). Other categories include: finding meaning in their strengths and engaging with them; forming/enhancing/or restoring positive relationships; managing problems/developing resilience; setting goals and achieving goals; and boosting well-being via mindfulness. Additionally, interventions that focus on specific character traits like gratitude are included.

Niemiec offers 12 additional activities that better lend themselves to emerging ideas and theories. For example, one exercise asks clients to name one strength, list three healthy thoughts they have when experiencing that strength, name the emotion or feeling they have when they are expressing that strength and identify the sensations in their body that accompany that feeling, then determine what that strength looks like in action (240). Other exercises focus on helping clients get rid of bad habits, master strengths, and spot secret strengths they may not have known they had. Additionally, Niemiec includes troubleshooting, multiple appendices including one that explains the VIA classification of character strengths, and references to papers said to be relevant to character strengths interventions. Niemiec astutely points out that we still have much to learn.

Character Strengths Interventions: A Field Guide for Practitioners has received praise for its ability to connect science and practice by bringing research to life in practical ways. This book is a good tool for clinicians looking to deepen their knowledge, ground it in research, and build a repertoire of useful techniques to help clients via a character strengths approach. *Character Strengths Interventions* is a must read for clinicians who believe in using strengths-based interventions or who are interested in learning more about positive psychology in practice.

BIOGARPHY

Ryan M. Niemic is Education Director of the VIA Institute on Character. He is the author of several other books, an award-winning psychologist, certified coach, international workshop leader, and is an adjunct professor/visiting lecturer at several universities.

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Character Strengths Interventions: A Field Guide for Practitioners Written by Ryan M. Niemiec Commentary by Nancy Eichhorn

International Body Psychotherapy Journal *The Art and Science of Somatic Praxis*
Volume 16, Number 3, Fall 2017 pp 84 - 87. *ISSN 2169-4745 Printing, ISSN 2168-1279 Online*

I read, I review. I rarely comment. The difference? I offer glimpses into a book, noting the content, the writing style, the potential impact on a reader, often sharing my personal reactions to the material with a familiar first person writing style. An academic commentary proposes both a different tone and approach. One that offered a challenge until I realized that a commentary is just that, a personal reaction pinpointing part of the material that potentially impacts either me personally or my field of study and interest, in this instance psychotherapeutic interventions that offer clients and ourselves a way forward.

I read Ryan Niemiec's newest publication, *Character Strengths Interventions: A Field Guide for Practitioners*, with no background experience in positive psychology, no concept of what character strengths are or how to integrate them into my life or my professional work. I quickly learned that character strengths are positive traits that are core to our being—our identity—and our doing, aka our behavior (pg. 2). There are 24-character strengths that represent a common language said to describe what is best in human beings; these then represent pathways to six virtues that are noted to be universal in human beings across religions, cultures, nations and belief systems, which are: wisdom, courage, humanity, justice, temperance, and transcendence. It is important to note that these are not the type of strengths commonly thought of such as: talent, intelligence, skills, values, interests or resources. They don't happen in isolation—they are interwoven, they overlap in our lives. They happen in context, and they happen in relationships.

Within the first few pages of the actual body of the text (not counting the Forward or Introduction), I had the strongest impulse to take the Character Strengths Survey, offered "free" of charge online at www.viacharacter.org to "help individuals learn about what is best in them". There is, however, a catch. You can take the 120-item survey and receive a list of your 24-character strengths for free. The list comes in numerical order (1-24), with the top 5 to 7 noted as your 'signature' strengths, defined as a "part of the human psyche", "expressed through thoughts, emotions, volition and behavior", "naturally emerging in communications, verbally, nonverbally and written", and "expressed across all domains of life" (pg. 26). Other subcategories include phasic and lower strengths. Niemiec is clear that the list is not set in stone and that, in fact, therapists need to check-in with clients to confirm if the highest noted are indeed "essential and authentic to who they are, energizing and natural to use, and expressed widely across settings" (pg. 27). The list is not considered a matter of good versus bad but rather which character strengths do you, as an individual, use more frequently and which are perhaps overused and/or underused. The survey process, however, is not totally free. Aside from giving the organization your email address (opening yourself to the potential of more inbox clutter), if you want to use this information to make

changes in your life you need to purchase their report. Two options are offered, the VIA Me report ($20.00) and the VIA Pro report ($40.00), with a special deal for both at $50.00 (which is promoted as the most useful way to work with the material).

According to their website: "The in-depth reports provide key research and in-depth information about signature strengths, tips for using your signature strengths in new ways, in-depth analysis on overusing and underusing signature strengths, and much more"[1].

Daily emails now arrive in my inbox from the VIA organization. This one arrived on October 3, 2017:

Dear Nancy,

Do you hope to get in better shape? Get a promotion at work? Meet new friends?

We all have goals; and research is now proving that linking your signature strengths with your goals increases attainment and overall wellbeing. Furthermore, when you reach a goal that is in line with your core values you will experience greater happiness than achieving a goal that is not consistent with who you are. Read more on the benefits of character strengths and goal-setting here.

Our clients repeatedly tell us that the VIA Me and VIA Pro Reports provided them with a way to view themselves more fully and accurately. The reports helped them understand their own potential and see the tools they have to apply to their future goals. Learn about the tools you have with your own personalized VIA Reports."

Herein lies my comment, perhaps some would consider it a complaint, some more of a rant, some prudent (depends on your signature strengths and their place in your life!). For me, it's a matter of marketing and psychotherapy, about social media and psychotherapy (the VIA organization invites you to follow them on Facebook, Twitter, LinkedIn, and their VIA Blog). It's about being a therapist and promoting oneself, one's process, one's organization to earn an income, to support the structure, the people, the publications and so on. I see this free survey as a hook to gain access to my check book. It's a matter of morals, of ethics.

When do we, as therapists, cross a line between serving our clients' greater good, between being of service to others and being in service to ourselves, our organization, our methodology/approach?

If this survey truly has the power to positively impact peoples' lives to the depth that Niemiec writes, if it is being offered free online, then why withhold results in a format that are applicable in our lives? To say to someone that this report will be life altering, that using the results can change your life for the better including your job and your relationships but then hold the actual keys to success for ransom feels immoral to me, unethical. This free survey should be completely and totally free, with no strings attached. The daily emails marketing the reports, trying to motivate me to buy them as if the in-depth analysis and hands-on use of my

[1] Retrieved from http://www.viacharacter.org/www/Reports-Courses-Resources/Reports/Combo-Package-More-Info-Landing-Page?trk_msg=7M4R32I6D3F4711HK1CA2V18S4&trk_contact=TKPIMT9RCS32A5LIT3G9SGMSS8&trk_sid=5HS8EDH9QPPDBAMCQOBLFOCEF4&utm_source=Listrak&utm_medium=Email&utm_term=http%3a%2f%2fwww.viacharacter.org%2fwww%2fReports-Courses-Resources%2fReports%2fCombo-Package-More-Info-Landing-Page&utm_campaign=Completed+Survey%2c+No+Report&utm_content=Email+3

signature strengths is the golden ring I used to reach for as a kid riding on the carousal—I loved sitting astride the white stallion, traipsing across the countryside in my imagination; and just as potently, I loved the thrill of reaching for the prize. If I could grab hold of that golden ring when I passed by and present it to the operator, I got a free ride.

In my mind, I have to wonder: have we gone so far astray from our oath to do no harm (oh, wait, is that only for medical doctors?) that we find it perfectly fine to promote our process using less than honorable marketing tactics? I receive emails, newsletters, invites to webinars daily, all therapist promotions. The time and money involved in writing all this material, posting it on websites, on social media, creating affiliate relationships with one another to share email lists, to promote one another's products for a slice of the take. It's become the norm, and it's truly bothering me.

I understand it's about making money, and I question if this is the root of our place and our work in this world. Do we focus on how to make money, how to promote ourselves to reach a larger audience, to gain more while working less, or on how to help people grow, learn, heal, flourish in their lives? Am I too naive to believe that if I put people first, the income will follow?

Honestly, I read the entire book and appreciated all that Niemiec offered. I've talked so much about my character strengths that my parents (in their late 80s) want to take the survey so we can discuss the impact of our particular strengths on our family system. I've shared information from the book with colleagues, and I've bookmarked protocols Niemiec offered to share with clients, with friends, and to practice myself. I learned much about positive psychology (its historical foundations and founders; its premise and practices) and about myself, my character strengths.

Initially, I wasn't clear how my signature strengths: (1) appreciation of beauty and excellence; (2) fairness; (3) forgiveness; (4) gratitude; (5) honesty; (6) curiosity; and (7) judgment—defined as "thinking things through and examining them from all sides, not jumping to conclusions; being able to change one's mind in light of evidence and weighing all evidence fairly"—were applicable to my day-to-day life. I opted not to buy the VIA reports!

But with reflection over a week or so, I started to see how in fact I use them, and I even began looking at those at the end of the list and how to incorporate them, making choices and decisions based on mindful reflection (part of Niemiec's mindfulness-based strengths practice, MBSP). For starters, number 24 on my list is 'bravery' defined as "not shrinking from threat, challenge, difficulty, or pain; speaking up for what's right even if there's opposition; acting on convictions even if unpopular; includes physical bravery but is not limited to it". Here I am, being brave, writing this commentary, speaking my mind on what I consider right even if there is the possibility of opposition from readers, from the author, from the VIA organization. I'm integrating number 5: honesty—"speaking the truth but more broadly presenting oneself in a genuine way and acting in a sincere way; taking responsibility for one's feelings and actions" in this commentary while also being prudent (number 18): "being careful about one's choices; not taking undue risks, not saying or doing things that might later be regretted". Well there is some fear here. I usually take the safe road and keep quiet about my opinions—I only review books I like, not wanting to say bad things about a book just because I did not resonate with it.

The book itself is well-written, offers in-depth information, direction, background, appendices, practitioner snapshots and oh so much more. I will continue to suggest it to colleagues who might be interested in the content because, in my experience, if you read

the book, take the time to reflect on the material, do the snapshot activities, practice the protocols yourself before client use, there's much to be gained. I will even recommend taking the survey to people who are going to read the book as well so they can personally integrate the two. As for purchasing the special reports? No way. This type of marketing goes against what I consider morally correct.

BIOGARPHY

Nancy Elizabeth Eichhorn, PhD is a writer, an investigative journalist, and a credentialed educator with degrees in clinical psychology with a somatic psychology specialization, education and creative nonfiction writing. She is the founding Editor-in-Chief of Somatic Psychotherapy Today, co-editor of the International Body Psychotherapy Journal and an editorial assistance for *Body, Movement and Dance in Psychotherapy.* She currently teaches and works as a writing coach, an editor and ghostwriter. Her writing resume includes newspaper and magazine articles, chapters in professional anthologies, including *When Hurt Remains: Relational Perspectives on Therapeutic Failure, About Relational Body Psychotherapy* and *The Body in Relationship: Self-Other-Society.* She is an avid hiker, kayaker, and overall outdoor enthusiast. Nature is her place of solace and inner expression.
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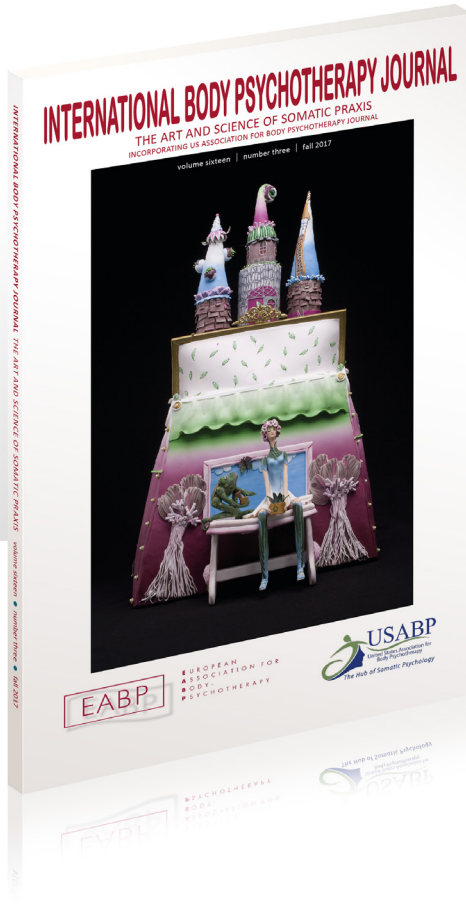

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volume sixteen | number three | fall 2017

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Journal (ISSN 2169-4745)