Risks Within Body-Psychotherapy

By Courtenay Young

Besides all the advantages, there are also some potential risks within Body-Psychotherapy. The four main areas of risk are around Re-traumatization; Abusive Touch; the Breaking Down of Defenses; and Inappropriate or 'Malign' Regression.

There is a differentiation that has to be made between the area in which the risk is likely to show up, and problems that then add to or exacerbate the risk. Problems in these areas often have, as their root, an abuse of power, which is certainly not confined to Body-Psychotherapy. They often happen where the cracks, or failings, in professional practice begin to show and many times the inherent risk is exacerbated by poor or unethical practice. Most professional shortcomings can be put down to inadequate training and supervision, or sometimes to a lack of personal therapy received. And whilst these problems may be found within to the field of Body-Psychotherapy, or other body therapies, many of them were also a product of their time. Even though Body-Psychotherapy predates Freud, it has only really matured as a recognisable professional discipline within the last thirty to forty years mainly from the1960's through the1980's into the early 1990's.

Where Body-Psychotherapy might be at fault, was that, as the different techniques developed, many disciplines or 'modalities' within Body-Psychotherapy recognised the amazing power of working directly with the somatic reality of the body and with some of the underlying dynamics, intricacies and connections of the body-mind. Such modalities were often founded by, and around the work of, a very gifted individual. The training that this individual gave was more of a teaching and a dissemination of that individual's skills and the main emphasis of the training was to develop these skills into a method. There were often not sufficient or appropriate safeguards put into the training, supervision and practice in the early days, and this is something that we, as professionals, have needed to address.

Abuses of the therapeutic relationship or power can occur in any type of therapy, and the main safeguard to such boundary violations is in the therapist actively working for the empowerment of the client. The more we concern ourselves with the techniques of our work as a therapist, the less (perhaps) we are focussing on the power, the wisdom, and the innate good sense of the other person in the room. With the development of much better standards of training, recognisable courses, ethics, and levels of supervision, the frequency or incidence of these problems has decreased considerably. However the inherent risks still remain.

Despite these problem areas, the inherent risks that I shall describe still exist, and the risks still existing in these areas have often been used incorrectly as a criticism of Body-Psychotherapy: i.e. because there are risks in touch, and Body-Psychotherapists often touch, Body-Psychotherapy is therefore risky; because there are possibilities of re-traumatization …

Re-traumatization:

Where any psychotherapeutic work is being done on resolving an area of particular trauma, in the psyche, or within a specific area of the body, whether this is as a result of repeated low-level traumatization, or of a single overwhelming incident, one long-established method of healing was to try to prevent the encapsulation and

isolation of the trauma, which is generally agreed to give rise to further problems, by discharging the pent-up feelings, and then to integrate them into the person's psyche: a little like lancing a boil. However, sometimes the therapist allows the therapy process to accelerate to fast, faster than the client can contain and integrate. This produces more arousal in the client's autonomic nervous system, and this can spiral into re-traumatization.

Recently, Body-Psychotherapists like Peter Levine, (Levine 1997) Babette Rothschild, (Rothschild, 2000 & 2003) Pat Ogden & Kekuni Minton, (Ogden 2001) Nick Totton, (Totton, 2003) and various other authors like Bessel van der Kolk (van der Kolk, et al, 1996) have done much work on this area, written well about it, and this has helped to change much of our fundamental understanding of trauma work. It is now being openly stated that it is almost impossible to do trauma work effectively without using Body-Psychotherapy concepts and teechniques. (van der Kolk, 2004) So this implies a risk-prevention.

However when Body-Psychotherapy first started working in these areas, the received wisdom was that by just "going into" the area of trauma and discharging the feelings (either by allowing the blocks to dissolve, or by circumnavigating the resistances, or by breaking them down) was sufficient in itself for the traumatized area to being to access the body's natural processes and for it to heal.

Other therapists like Janov wrote (even as late as 1992): *"It is possible to relive these imprinted (painful & traumatic) memories and resolve neurosis and physical disease."* (Janov, 1992) Several Body-Psychotherapies, in those days, followed some of these 'discharge' concepts. It is true that sometimes there were seemingly miraculous cures using these methods: but many times the traumatized person must have come away unhealed and even re-traumatized. Sometimes the clients were even accused of failing the method: but really the method had failed them.

One of the inherent risks in working in this way is that the continued effect of such "re-livings" can progressively extend the damage of the original trauma. This is done by a process called "kindling", the model of which implies a "biological memory" of preceding episodes and where the individual's vulnerability increases with repeated episodes of destabilization.

> (The) "symptoms of PTSD are maintained and triggered by day-to-day adverse life experiences" so much so that this can be a "stronger determinant of current levels of symptomatic distress than the original trauma." Damage and a diminution of the person's ego strength is caused by the re-living or re-kindling of the traumatic memories to the extent that "even if the symptoms of the immediate disorder remit, permanent changes may remain in the individual's vulnerability to disordered affect and arousal."
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> (van der Kolk, et al, 1995: p.170)

Many body-psychotherapists realise that important lessons learned from PTSD research can also apply, more widely, to other interventions in their own work. What we realize now is that, in order to help to heal the trauma, we need to stay within, but at the edge of, the client's medium arousal zone. We must "pace" the client's process: we don't force it. As the traumatic memories come back, arousal levels increase. The stress hormones released then suppress the activity of the hippocampus, which deals with explicit memory & contextual thinking, which are exactly the tools that are needed for integration and healing. So we need to work very skilfully and carefully to avoid any re-traumatization, or re-kindling, of these states of traumatic stress.

Therapeutic themes that need to be observed much more pervasively in such delicate trauma work, either in groups or individual sessions, to avoid many of the inherent risks of re-traumatization can be found, neatly listed, in Babette Rothschild's excellent books, which are heartily recommended. She particularly emphasises the need for the development of dual awareness, which is where the client *"can address the trauma in the past, even though it may feel as though it is happening now,"* whilst, at the same time, being *"secure in the knowledge that the actual present environment is trauma free."* (Rothschild, 2000, p.131)

Abusive Touch:

As Body-Psychotherapy developed, so there was an increasing realisation of how fundamentally deprived of healthy touch we all were in our Western society. Books like *Touching* (Montague, 1971), *The Massage Book* (Downing, 1972) and *Loving Hands* (Leboyer, 1977) emphasised the significance and importance of touch. For many, this grew into a general myth that almost any touch was felt to be better than none. It was not until 20 years later that cogent books about the ethics of touch and the dangers of inappropriate contact and boundary violation began to appear. (Hunter & Struve, 1988) (Smith et al, 1988).

There are significant risks inherent in touch. One has allowed someone else to come very close, almost to be intimate. There are many different forms and different kinds of touch. There are a wide range of reasons to touch, and valid reasons not to touch. There is informed touch, and insensitive touch. Touch can be used therapeutically, or it can be abused demonstrating power issues (Conger, 1994). Touch can be healing, or it can be erotic. Touch can also be supportive of regressive states. It can be needed, yet when it happens it can also raise anxiety levels (Rothschild, 2000: p.147). Whatever way or for whatever reason that touch happens, it must be done with very a clear, well-defined and well-informed intention. Body Psychotherapy does not necessarily involve touch. But Body Psychotherapists are also often very well trained in and quite comfortable with touch; skilled at touching; knowing many of the 'why's, the 'how's, the 'where's, the 'when's and also why, how, where, and when not to touch.

Abusive touch is a double insult: it is an abuse of the intimacy of the relationship, as well as a physical insult. It is clear that any grandiose attitudes about therapy, any views about one's special (healing) abilities, significant charisma, secret techniques, or whatsoever (however they are self-described) can impinge on the development of the necessary professional and personal humility and conscience that respects the lack of distance. It is also clear that feelings of privilege, of being above the law, or any particular attitude or social climate which denigrates or works against responsible attitudes, will lead to abuse – in any arena – as well as this special area of touch. This has also been thoroughly discussed in another recent forum (Young 2003).

The privilege of being able to touch another human being must be respected, totally. To be allowed to touch someone is a very intimate situation; and wanting to be touched is to allow oneself to become very vulnerable to another person. Qualities such as love, compassion, empathy, care, respect, and sensitivity must be observed at all times. The use of the word 'touch' also has is a component that transcends the physical in being able to be 'touched' by someone else or to 'touch' someone else deeply. Touch is inherently risky; in therapy, abusive touch is an ever-present risk.

The best method of 'risk-reduction' is excellent training and supervision, beyond that a finely tuned awareness for the minute signals of the other person is essential, but below that, underpinning everything, a clear sense of self and one's

own personal boundaries as well as an inherent respect bordering on empathy for the other person are fundamental.

Kignal (2005) discusses risks within Body-Psychotherapy in terms of "inauthentic contact" which he identifies as either invasive or as a form of deprivation. The therapist goes too far, or not far enough in various areas: sound, touch, movement, breathing, rationality, emotional resonance, etc.

The Breaking-Down of Defences:

One of the founding fathers of Body-Psychotherapy, Wilhelm Reich, defined our somatic defenses as part of our neurotic character-structure and armouring: the rigid muscles are seen, in effect, to hold our repressed emotions. This, in his view, was what was wrong with us, and with the world. Vegetotherapy, his method, works directly on loosening the tense muscles, using (sometimes) quite aggressive techniques to counter the held-in aggression and other emotions. Tension is increased and the emotions are discharged, then the muscles can relax. The therapist works systematically down the body on the various armoured segments, slowly softening the muscles. Character armour melts and the client's true persona, or core personality, is expected to come through undistorted. When the client's defenses have been broken down, that client is vulnerable again, but therapy only really happens in the second half of Reich's discharge cycle: that is in the integration period after the discharge, when a less armoured 'body' learns to survive in a different way. Risk here lies in focussing too much on the "breaking down" part of the cycle, rather than on the more drawn out and laborious re-integration aspects.

Even very gentle and caring Body-Psychotherapists, like Jack Painter, speak about, *"Deep bodywork helped me break down my old armour, the contractions dividing my head, heart and desires"* (Painter, 1986). Alexander Lowen writes: *"This problem is attacked bioenergetically on several fronts simultaneously"* (Lowen, 1971) Language of this type developed a characterized way of working in which the therapist 'attacks' the client's 'neurotic' defenses, and gradually and systematically 'breaks them down'. Many Body-Psychotherapy colleagues now prefer to see these "armourings" as somatized healthy "survival patterns" or previously positive and beneficial coping strategies, some of which may now be redundant or dysfunctional (rather than pathological). This perspective helps such defenses to be identified and gradually discarded like a bad habit.

But when the sort of "breaking down" imagery and methodology was extended, in the 1960's and 1970's, into various extensions of encounter group work that developed into therapeutic violence, (Boadella, 1980), the "breaking down" of the participant's defenses had obviously gone too far. Some of the psychotherapy-oriented cults, as well as some body-oriented therapies and psychotherapies, used methods like: distortions of transference; body manipulations of the "no pain, no gain" type; repetitive motions; meditation-based "unstressing" (relaxation-induced anxiety); hyperventilation; and even more traditional brainwashing principles (sleep-deprivation, diet reduction, etc.) as ways of "breaking down" the old "neurotic" belief systems and somatized patterns of behaviour in order to "breakdown the old", "free the mind" and "liberate the spirit" of their clients and their followers. (Singer, 2003)

Admittedly some of these examples come from outside the field of Body-Psychotherapy, but such a culture of "breaking down" became widespread. The development of personal autonomy was not properly encouraged, which is one of the main goals of psychotherapy, and the "broken down" clients could have dropped into more submissive, obedient and dependent relationships where they were capable of

being manipulated or abused. Within Body-Psychotherapy, I can remember specific instances of being told about clients who had just received "too intense" a "deep-draining massage" (or whatever) and "unfortunately then became psychotic". There was a subtle inference that it was almost their fault, and not the fault of the therapy or the therapist.

Today the "breaking down of defenses" paradigm is still quite pervasive: the risks still remain, even though the abuses have lessened. "Breaking through" not "breaking down" is another frequently found pseudo-spiritual misinterpretation of such therapies. Care should even be taken with fairly reputable or well-tried transpersonal methods such as Stan Grof's 'Holotropic Breathwork' as, if there is an insufficient integration period or follow-up support after a workshop, the person's ego structure can still remain quite disintegrated or blown apart by the sought-after "out-of-body" experiences, liberated only when the "spirit is free" from the defended and armoured body.

The risks are not just from unethical behaviour, power-hungry sects, or inadequate methods. Working directly with the body is extremely powerful and can very easily undercut someone's somatic defences. Therefore special attention must always be given to the finer points of the client's process to ensure that there is no harm done; or what might happen when a client quite suddenly becomes very vulnerable. As therapists, when we are working with a person's defences, we really need to focus, at the same time, on aspects such as: affirmation of strengths; support systems; working only step-by-step and only one step at a time; and especially giving plenty of therapeutic space and sufficient time for integration.

Inappropriate or Malign Regression:

Body Psychotherapy is considered by some to contain an inherent tendency towards regression, and there has been already some good writing about this (Marlock, 1991). Also when touch is involved, some regression is almost always emerging from the work. John Conger writes: *"Touch is our earliest language, and capable of taking us back instantly to our most primitive universe."* (Conger, 1994) Catharsis and regression have always been present in psychotherapy since Freud & Breuer and some aspects of regression can be very positive and healing. People like Balint (1968), Keleman (1979) and Winnicott (1987) have written about this and their work is still of great value to Body Psychotherapists. So this tendency towards regression, and the inherent benefits and dangers, should be addressed significantly in training and supervision work, and perhaps especially the particular level and direction of the regressive tendency in the chosen modality of Body-Psychotherapy.

Regression can occur, when it is not used appropriately, in a seemingly "malign" manner from the therapist. Sometimes the therapist adopts a position of omnipotence, either from the client's expectations, or from their own self-promotions, or both. Certain examples of this type of malign usage stem quite directly from the work of Margarite Sechehaye and John Rosen who used the innovative methods of regression and re-parenting in their work with schizophrenic patients, apparently very successfully in the immediate post-war era: however there was a much darker side to their work that did not emerge till much later (Singer & Lalich, 1996). Janov's influence and the popularity of Primal Therapy was still high. And about this time, Leonard Orr had developed a form of therapeutic and regresssive "energy breathing" technique, akin to hyperventilation, which he called Rebirthing, and later Sondra Ray adapted this therapy into a form of spiritual guidance movement or cult.

There are some very serious criticisms that can be levelled against these types of therapy; least of all that many times these powerful techniques were taught to

unskilled people in weekend seminars. Singer and Lalich judged such work in the following way:

> "Rather than helping clients to become stronger and more independent, most regression therapies, and in particular the rebirthing-reparenting sort, induce in the client and abdication of responsibility and a state of sickly dependence on the therapist. This is a blatant abuse and misuse of the power relationship inherent in the therapeutic process; it is in effect the exploitation of the client's emotional vulnerability. The "Mommy" or "Daddy" therapist who is supposed to parent the client correctly is in fact playing with fire, potentially entrapping and crippling their "children," and causing undue suffering and in some cases long-lasting damage." (Singer & Lalich, 1996)

Unfortunately some of the ideas, methods and attendant risks of therapy being seen as fulfilling this kind of emotional deficit crept into Body-Psychotherapy work. Unhappily also a recent, otherwise good, book on Body Psychotherapy (Staunton, 2002) included a chapter on regression and past-life work seemingly incorporating this type of therapy within the field, which many body-psychotherapy professionals would disagree with. Rubens Kignal differentiates between "strategic regression" and "tactical regression".

> "Strategic regression can be a defence in the service of character pattern against the possibility of new growth. The danger here would be to keep or allow the client/patient to stay at this level, keeping them there would be a manipulative action of the therapist in order to control or subdue the patient, maybe because of the therapist's weakness and fear in letting the patient grow or because the therapist does not know what to do if the person grows. Tactical regression is a spontaneous re-experience of a situation with the objective to progress by solving a traumatic episode and make possible a more mature behavior, in this case the therapist must be very careful with the re-living situation not to stay there long enough with the danger of re-traumatization, which means in the trauma situation the body will assimilate as a repetition of the trauma and not a way out solution." (Kignal, 2005)

People in any form of therapy sometimes just go into a regression, or into a regressive state, and some body-psychotherapeutic modalities are much more open to supporting this, as well as to inducing it. Such a spontaneous regression ("tactical" ?) can be very helpful in uncovering important unconscious material. The uncovered material is worked through later on, integrating it into their psychotherapeutic process. Here the regression becomes a healthy aspect of their process.

But regression can also become malignant. If the client starts to identify with their regressive state (for instance their "child" or their "past life" character), or even to take this to be their "real" self, then we can start to get into very dangerous areas. With an inexperienced therapist, they may be (possibly inadvertently) invited or encouraged to repeat that experience over and over, to reinforce it, and this will carry their regression more into everyday life.

Many symbiotically regressive forms of therapy effectively castrate the client's aggression by not 'allowing' sufficient space for negative transference whereby the client can gain strength, extract themselves from old habits (negative inner objects), take risks, challenge projections, and test out current reality. Some highly regressive processes often involve aggressive or even sadistic manoeuvres by the client with the aim of gaining control or power over the therapy, or even the therapist.

Another of the inherent dangers when working with the body is that clients might use the experiential, affect, somatic-sensing aspect of the body work, which is extremely powerful, to seek the regressive states as a defence mechanism from other things: simplistically, it is easier to be a "child" than to face the difficult choices of a bad marriage (say). It may also be easier for the therapist to stay in a form of benevolent parental role, rather than allowing the client to stand up and walk free. By using methods with a potential regressive component, we may inadvertently allow, or implicitly encourage, the client to retreat into a regressed state where s/he becomes essentially worse off, sometimes more so than when they entered therapy. Jay Stattman, Balint, Boadella and others have emphasised that one of the beneficial components of regression is in the challenge of the unknown, or in the goal of being recognized: when the regression becomes repeated and familiar or is aimed at gratification, then it loses its therapeutic value and can become malignant.

We really need to look at these fairly extreme situations in order to assess properly the inherent risks of regression in any particular situation and we need to maintain awareness of these risk more in our therapeutic consciousness. Some of the burden of, or the responsibility for, this type of malign regressive process can even be 'put' onto the client, so that the therapist then does not need not face their involvement or responsibility: and this is where the risk transfers into the ethics of our work.

So, finally, there must always be a significant emphasis in the therapy and self-awareness installed into the client of the process of "disengagement" from any regression. Without this separation from the regressive process, the chances of both sides acting out in a regressed symbiotic relationship are increased significantly. Again Kignal identifies a particular area of risk: given the power of Body-Psychotherapy, the client can create a dependence, with the therapist as this person with magical powers. Some therapists even buy into this, countertransferentially and the two become locked into fantasy comic-book story that often ends tragically.

Thankfully there are many kinds of spontaneous or semi-induced forms of regression that can be quite beneficial, if handled with skill. These need to be embedded into a context that provides a framework of technique that allows the therapist to help the client move through the regression, despite some of the attractions of staying there, towards an objective, positive, and more present development. In the end, it is necessary for the person to be able to look back and see those states as a regression, having been able to learn something significant from then, and then step clearly and strongly out of them. This can only be done with therapists who are fully aware of all the various risks of malign regression.

Conclusion:

These inherent risks within Body-Psychotherapy, can be added to by unethical practice, power-trips, pervasive theories and doctrines that do not support the empowerment of the individual, lack of awareness, too hurried forms of working, goal-oriented therapy, and insufficient time for integration. They can be reduced by a much better understanding of theory, much more supervised practice, a greater level of awareness of ethical practice, and by significant changes in the culture of the profession.

(NB: Additions in blue were made after the chapter went to the printers.)

References:

Balint, M. (1968) *The Basic Fault.* London, Tavistock

Boadella D. (1980) *Violence in Therapy*: In Energy & Character Vol 11, No 1, Jan 1980

Conger, J. (1994) *The Body in Recovery: Somatic Psychotherapy and the Self.* (p.13) Berkeley: North Atlantic Books

Downing, G. (1972) *The Massage Book.* Harmondsworth: Penguin

Hunter, M. & Struve, J. (1998) *The Ethical Use of Touch in Psychotherapy.* Thousand Oaks: Sage

Janov, A. (1992) *The New Primal Scream: Primal Therapy twenty years on.* London: Cardinal Press

Keleman, S. (1979) *Somatic Reality.* Berkeley, Center Press.

Kignal, R. (2005) "*Risks within Body-Psychotherapy"* [unpublished article]

Leboyer, F. (1977) *Loving Hands: The traditional Indian art of baby massage.* London: Collins

Levine, P. (1997) *Waking the Tiger, Healing Trauma.* Berkeley: North Atlantic Books

Lowen, A. (1971) *The Language of the Body* (p.116-117) New York: Collier Macmillan

Marlock, G. (1991) *Notes on regression:* in Unitive Body-Psychotherapy, Collected Papers, Vol 2. Frankfurt: Afra Verlag

Montague, A. (1971) *Touching: The Human Significance of the Skin.* New York: Harper & Row

Ogden, P. & Minton, K. (2001) *Sensorimotor psychotherapy: one method for processing traumatic memory.* In "Traumatology: An Online Journal, 6(3). www.fsu.edu/-trauma/v6i3/v6i303.html

Painter, J.W. (1986) *Deep Bodywork and Personal Development: Harmonizing our Bodies, Emotions and Thoughts* (p.16) Mill Valley, Bodymind Books

Rothschild, B. (2000) *The Body Remembers: The psychophysiology of trauma and trauma treatment.* New York: Norton

Rothschild, B. (2003) *The Body Remembers Casebook: unifying methods and models in the treatment f trauma and PTSD.* New York, Norton

Schiff, J.A. & Day, B.: (1972) *All My Children.* New York: Pyramid Books

Singer, M. & Lalich, J. (1996) *Crazy Therapies: What are they? What do they do?* San Francisco: Jossey-Bass, Wiley

Singer, M.T. (2003) *Cults in our midst: The continuing fight against their hidden menace: Revised Edition* (pp.135-139 & 172-181). San Francisco: Jossey-Bass, Wiley

Smith, S. (1989) "A Study of Clinicians who use Regressive Work" *Transactional Analysis Journal* 1989, 19(2)

Smith E.W.L., Clance, P.R. & Imes, S. (eds): (1998) *Touch in Psychotherapy: Theory, Research & Practice*. New York: Guildford Press,

Staunton, T. (ed.): (2002) *Body Psychotherapy.* London: Brunner-Routledge

Totton, N. 2003) *Body Psychotherapy; an introduction.* London: Open University Press

Van der Kolk, B.; McFarlane, A. C.; Weisaeth, L. (1996) *Traumatic Stress: The effects of overwhelming experience on mind, body and society.* New York: Guildford Press

Van der Kolk, B: (2004) "Center in the eye of the storm" In Psychotherapy Networker, Jan/Feb 2004

Winnicott, D.W. (1987) *Mataphysical and clinical aspects of regression within the psychoanalytical set-up.* In Winnicott, D.W.: *Through Paediatrics to Psychoanalysis: Collected Papers.* London Karnac

Young, C. (2003) *The Ethics of Touch.* Essay available on EABP website: www.eabp.org