How Deep Tissue Work Can Assist the Release of Post-Traumatic Stress Tension: A Body Psychotherapy Case Study

Bernhard Schlage

Abstract

This case study shows how elements of deep tissue work from Body Psychotherapy allow the release of post-traumatic stress tension in the upper chest. It introduces the so-called 'affect cycle' and shows how the complete understanding of this model offers a therapeutic framework for the use of different Body Psychotherapy techniques, especially during deep tissue work in the body. In this way, the therapist can help the client to achieve the release of traumatic reactions in ways not usually open to discussion therapy.
Keywords: post-traumatic stress release; renew of tissue pulsation; thixotropic effect in Body Psychotherapy

Introduction

While attending a regular session in a type of talking therapy, this client became aware that she was feeling a lack of emotional freedom in her body: she thought that this might be caused by some post-traumatic stress, or chronic tension in her torso (upper body).

Case Presentation

The client was 36 years old, married, and the mother of 2 children. The relationship with her husband had been dominated by negative communication patterns. In her work, she was also searching for a new professional perspective.

She had been participating in a training program entitled: "Dreaming-up Processes" about shamanic dream-work (Schlage, 2010) when some traumatic memories came into her consciousness. Then, in the context of another (different) therapy session, she had remembered situations of sexual abuse in her childhood; and she realised that she was still holding on to a number of bodily tensions originating from that abuse.[34]

At the beginning of the course of Body Psychotherapy sessions, in the initial 'adult attachment interview' (Brisch, 1999; Bowlby & Fry, 1953), she 'presented' her non-verbal behaviour as evoked shyness, i.e. her face downcast, looking at the floor when entering the therapy room.

She had also displayed the typical mannerisms of a person with an "oral" character structure (Johnson, 1985; Keleman, 1983), with a depressed or collapsed 'hole' in her upper chest around the sternum / the area of the heart, and the (so-called) "angels-wings" showing in the back, caused by the protruding proximal parts of the shoulder blades.

Her breathing pattern had been focused on the exhalation part of the breathing cycle, so she tended to feel as if she had lost all her energy, and she said that she did not really feel properly 'grounded'.

Her unconscious movements were small, sometimes seeming centred, though the force of the movements was weak, and their direction did not give any clear orientation, neither for those she was in contact with, nor for herself.

Some of her feelings were predominant, especially her feelings of anxiety and sadness, but ultimately her 'affect cycle' was not very strong; it lacked energy and petered out, and she did not seem to experience any emotional climax or release, and thus she gave the impression that she had tried, rather ineffectually, to evoke a reaction in people that she normally related to, than to fulfil any full release of her emotions. (Erken, Painter & Schlage, 2012)

[34] **Recovering repressed memories** of childhood sexual abuse is not – as many in the media world claim – repeat not anything to do with the (supposed) False Memory Syndrome. These memories have been 'buried' as a form of psychic survival by the child and, when it is safe to do so (as in therapy, or when an adult), they can emerge – sometimes quite shockingly.

Diagnosis

If a psychiatric diagnosis were to be considered relevant, it might be something like: "Asthenic, inadequate or passive personality disorder or neurosis; ICD-10: F60.7" [35]; or possibly "F.43.1 Post-traumatic stress disorder".[36]

Management and Outcome

This client had a total of 42 Body Psychotherapy sessions over a period of 3 years. She had come into contact with me because she participated in a training session (of mine) in shamanic dream-work. Whilst working with her dreams, several

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[35] **Dependent Personality Disorder** is characterized by at least 3 of the following: encouraging or allowing others to make most of one's important life decisions;

subordination of one's own needs to those of others on whom one is dependent, and undue compliance with their wishes; unwillingness to make even reasonable demands on the people one depends on; feeling uncomfortable or helpless when alone, because of exaggerated fears of inability to care for oneself; preoccupation with fears of being abandoned by a person with whom one has a close relationship, and of being left to care for oneself; limited capacity to make everyday decisions without an excessive amount of advice and reassurance from others.

Associated features may include: perceiving oneself as helpless, incompetent, and lacking stamina;

Includes: asthenic, inadequate, passive, and self-defeating personality (disorder).

[36] **Post-Traumatic Stress Disorder:** Arises as a delayed or protracted response to a stressful event or situation (of either brief or long duration) of an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone. Predisposing factors, such as personality traits (e.g. compulsive, asthenic) or previous history of neurotic illness, may lower the threshold for the development of the syndrome or aggravate its course, but they are neither necessary nor sufficient to explain its occurrence. Typical features include episodes of repeated reliving of the trauma in intrusive memories ("flashbacks"), dreams or nightmares, occurring against the persisting background of a sense of "numbness" and emotional blunting, detachment from other people, unresponsiveness to surroundings, anhedonia, and avoidance of activities and situations reminiscent of the trauma. There is usually a state of autonomic hyperarousal with hypervigilance, an enhanced startle reaction, and insomnia. Anxiety and depression are commonly associated with the above symptoms and signs, and suicidal ideation is not infrequent. The onset follows the trauma with a latency period that may range from a few weeks to months. The course is fluctuating but recovery can be expected in the majority of cases. In a small proportion of cases the condition may follow a chronic course over many years, with eventual transition to an enduring personality change (F62.0).

memories from her childhood came up, which, at first, we handled with some 'dream-work' techniques, until suspicion arose of sexual abuse actually happening in her early childhood.

From that time onwards, she entered in to Gestalt Therapy with a colleague of mine, and the "tracking of the original scenario" (Rosenberg, Rand & Asay, 1985) had been done within this setting; in addition, there was also some work on transference had been done in that therapy setting (Greenson, 1967). Yet, after a while, she found that several muscular tensions in her torso were persisting (and these pains seemed to be related to the trauma in her past). She also sensed symptoms typical for trauma, like feeling cold and starting to tremble, especially in emotional situations (Reich, 1967; Levine, 1997). So, she had the desire to utilise some Body Psychotherapy techniques in order to find some greater release from her suffering: thus, she came back into therapy with me.

At the beginning of the Body Psychotherapy work, we had tried to develop a deeper level of trust and contact. Even with her Gestalt therapist – a woman – and now, in contact with me again, her need for safety was primary and thus there had to be a clear contract concerning the obligation to maintain secrecy, and secondly, she emphasised that she also needed safety (very clear boundaries) concerning the contact between her (as a woman and a client) and me (as a male therapist).

We usually started the sessions by talking, and then I often guided the therapeutic dynamic into a form of 'role play' that allowed her to express her need for separation and distance: for instance, one 'role play' setting was where she had to mark out her 'personal space' with a rope on the floor, and then I encouraged her to allow herself to feel different emotions at different places within the marked-out circle. I was interested in what she felt, especially when she was more in the centre, or more at the periphery, and this was accompanied by my questions about what she felt when the therapist (me) came closer to the demarcation of her rope circle, or when the therapist kept more of a distance from her in the 'safe circle'. This role-playing gave her time to discover that she was able to regulate (moderate) her own feelings, and also to discover the distance that she might need in order to feel 'safe' when involved in any interactions, especially with me.

After helping her to learn how to stabilize herself and regulate herself; and having integrated different strategies in order to regulate an appropriate working-distance between us; we went on and tried to explore her reactions to touch in different areas of her body. We began with areas that the client chose for herself, and later on this changed to various other parts of the body, that were chosen by me, her therapist (all within the normal bounds of propriety, of course). We took time to explore her inner reactions to the different types of touch – such as

experiencing warmth or coldness, or tension or relaxation; and we would then engage in a dialogue about the quality of touch and her experiences of that touch.

But also, she allowed herself to sense the actual touch itself: does the skin of the therapist's hand feel separate from her skin; or does it feel like a fusion between both? What was the quality of temperature at the place of touch, and does something from the sensation of the therapist's hand "flow" into her body, or vice versa: can the tension or pain in this area be felt only by the touch of the therapist's hand, or by the therapist through his hand? And does this happen by itself, or is the client able to regulate the direction or amount of any sensation? We also 'tracked' her reactions (Ogden *et al.*, 2006: pp. 262-264) that she felt in the core of her body, depending on the place of touch: either, closer to the periphery, or on more distant parts of the body, in order to find out the different (or maybe even paradoxical) body reactions, in response to the different types of touch and the different places of touch.

Later on, we practised (for about 5 sessions) some of the various "freeing" or "anti-blocking" techniques used in Body Psychotherapy: making the use of breath, movements and sounds, in order to deepen contact with the chosen body parts (Rothschild, 2000): and in changing her awareness in the area of touch, by focusing her breathing into this area (use of breath); following any small or tiny movements that might then be felt in that area (tracking), and trying to increase or reduce these; giving her expression of movement a wider radius, and more strength, or more speed (use of movement expression); making sounds to support her expression, if needed. All this detailed work was designed to support her so that she could develop and deepen her trust in her own abilities of self-regulation and self-encouragement (Schoenaker, 2011). She not only practiced these when in contact with (me) the therapist; but also, with some members of her family. These steps prepared the way for the next phase of our work (which took about another 5 sessions).

So, we then focused on some of her deeper muscular tensions: particularly those that she felt in her upper torso. After a period, during which she felt she needed to re-discover her personal boundaries, especially those with regards to the degree of her nakedness that she could tolerate in this area (exposure of her upper chest area; but not including her breasts), we managed to find ways of me being able directly to touch her ribcage.

As described in another article (Schlage, 2016), we were now using fairly deep and strong physical touch, working together with her breathing, and exploring any internal awareness or movements, to help to reactivate the frozen feelings in this part of her body. As Peter Levine describes (1997) the "counter-pulsation" (which is what he called 'tension' in certain areas) has a tendency to increase

initially; so, at first, the client found herself with a strong 'muscular' resistance towards 'something': her inhalation became fixed; her posture defensive; pressing her wrists to the front of her chest; making fists; and sensing an unknown scream in her throat.

Using the techniques that we had used before, she was more and more able to transform this 'frozen' gesture into some form of movement, and finally even to try different kinds of voice-work (even screaming) to get relief from tension in this area. This is the so-called "emotional climax" (Erken *et al.*, 2012: p. 209) that we had to approach several times, until she developed some trust in this process. We then could focus similarly on the somatic memories that ran parallel to, or were involved in, this process.

While following this path of contact, movement and sound – probably for the first time in her adult life – the client was able to gradually re-connect with her traumatic memories (those that she had only spoken about in her Gestalt therapy); and connect these with her bodily experience; and, in this way, she found herself experiencing a deep state of relaxation after these sessions. Of course, it was not just one singular session that brought about her 'liberation' from these long-established (chronic) tensions. It was a step-by-step-process of her re-connecting with her body, her movements and emotions; of her growing in confidence through these experiences; and occasionally passing through phases of … deep shame, as well as – paradoxically – deep laughter, which emerged several times when repeating this body-oriented process.

In the end, she felt much more relaxed, especially in her trunk and upper chest, and her ability to breathe and the capacity for movement in her shoulders had increased significantly.

For the subsequent phase of her therapy work (which involved the integration of her new emotional abilities into her family relationships), she decided to return to work with her Gestalt therapist, and so we decided to terminate the Body Psychotherapy part of her therapeutic process.

Discussion

In the beginning, this case study opened up difficult questions about interdisciplinary cooperation with other colleagues. Uexküll & Adler (1990) postulate that this is the optimum way of working with psychosomatic or post-traumatic cases in individual therapy: yet, in reality, it rarely happens. Therefore, there is still some research that needs to be done as to how this collaboration could possibly be managed better, in order to improve this 'inter-collegial co-operation' for the benefit of our clients.

Another difficulty that was obvious, was in relation to the different genders of the client and therapist. Body Psychotherapy practice – because of the physical (or even intimate) contact – can present more of a challenge than in most of the talking therapies, since we do not only experience transferential themes in our emotional contact, but we are also going to touch the clients directly, so they will be interacting with us, and we will be in actual contact with them and their fears and needs for safety, and – at the same time – they will also need our support in exploring and, particularly, in regulating the amount and quality of contact. This case study is an example of demonstrating the great importance of giving sufficient time and space for this process, and the actual techniques used are related to those that Greenson (1967) describes.

A third difficulty that this case study presented was the aspect of, or the degree of, traumatization as a result of the early sexual abuse that happened to the client. This difficulty demonstrates how a 'talking therapy' can be helpful for clients to become aware of their memories, and of the abuse that they may have experienced. However, with some clients, this is not sufficient for the somatisation to be released, because of the limitations that the traumatic experience has left in their emotional reactions and body awareness. With some clients, like in this case study, there is a need to help them to reduce or release some of the physical and structural limitations, caused by the 'frozen' emotional wave in their bodily experience.

Here, some of the special techniques of touch that are employed in (for example) Postural Integration Psychotherapy (Painter, 1987), were used to reconnect the client's mental life with her physical contact that helps to restore the unity of body, emotion and memories again (Juhan, 1992). These techniques can also put the person back in touch with the suppressed 'frozen' fight-or-flight reactions, that would have been triggered by the abuse, but were not able to be acted on: hence some of the ambivalence and aggression also present in her reactions.

In this work, I (as the therapist) was deeply touched by the client's courage to confront the reality of her childhood sexual abuse (from a close male relative), and also by her will to understand what had really happened: - this was not in order to see herself as a victim of her past, but also to acknowledge that, in fact, she is a survivor, and that she had re-discovered her natural or healthy strengths and resources, for instance, in her healing (shamanic) practice, and also in her new professional orientation as a volunteer in the hospice movement, caring for people on their pathway towards death (Papadopulos, 2007).

In this case, thankfully, it was possible for the client to confront her traumatic experience, even though this meant a lot of hard work. But, the question comes up: does "healing the trauma" mean: either removing the symptoms of trauma; or

deleting traumatic experiences from the memories of the victims? Actually, there are many other ways of opening up insights that can be used by a client, so that the traumatic experience begins to hold some new possibilities to develop self-authorization and repair self-esteem.

But, there seems little we can do if a client does not have enough personal strength; or if the memories cannot become clear enough; or if they cannot be accessed because of massive repression; or if the former perpetrators are still living together with the client (which is often a problem with sexual abuse in the marriage).

It is therefore helpful to keep in mind that all unconscious memories have a tendency to become re-experienced, or to be re-lived in the transference situation, during any form of therapeutic work. This has been very well-established in psychoanalytic settings (Stern, 1986), and it is also clear for many types of Body Psychotherapy work (see: Levine, 1997; Rothschild, 2000; Ogden *et al.,* 2006). The sensorial basis of this type of embodied transference phenomenon has been clearly established in 'mirror neurone' research (Rizzolati, *et al.,* 1996).

However, in daily Body Psychotherapy practice, it appears like something a miracle, that happens again and again to the therapist during their work, to feel (or resonate to) sensations in his/her body that are related to the sub-conscious processes happening within the client's body. The therapist then just has to decide when it is the right moment (and if it is appropriate) to mention their own sense of awareness to the client.

Summary

In this particular case study, the client was fully aware of her trauma and abuse before entering into this particular Body Psychotherapy process: therefore, the goal (that she wanted) was to make her more somatically aware of how she 'stored' the symptoms of her trauma, and how to help her to reduce the tensions in her torso, without triggering her defence mechanisms. Pat Ogden (2006) talks about staying well within the client's "comfort zone" or "window of tolerance", and the delicate preliminary work with her boundaries and the different experiences of touch demonstrated something of this approach. It was obviously very important for her to re-establish a sense of control; and it would have been very different (and it might have been a bit easier) with a female therapist, but the therapeutic relationship had already been started through the shamanic training work and the client chose to continue with this: the therapy setting had become a relatively 'safe' place, where these memories could now emerge.

Author

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A Body Psychotherapy Case Study about the Release of the Effects from a Pre-natal Traumatization through Enactment Techniques

Bernhard Schlage

Abstract

This case study developed from some unconscious, unrecognised movements to the client's (so-called) 'memories' about some pre-natal experiences that she had had. The study presents a number of Body Psychotherapeutic concepts, which give some analytic insights into the use of the so-called 'somatic transference' within Body Psychotherapy, in order to become more oriented (or empathic) within the therapeutic relationship. Also, the use of "tracking" and "enactment", as central techniques of Body-Oriented Psychotherapy, are indicated. Overall, this case study presents a process where both, the client and the therapist, strengthen their sense of embodied awareness – for a better analytic understanding, and for the release of psychosomatic symptoms.
Key Words: Somatic Transference, Embodiment, Non-verbal bonding.

Introduction

After several sessions of dancing therapy (with a different therapist), the client had discovered some residual movements in her body that she could not understand – which, through the technique of enactments during some of her Body Psychotherapy sessions – these movements had led her to discover some memories

relating to her (so-called) pre- and peri-natal life experiences (Janus, 1991; Jones, 1997).

Case Presentation

The client in this case study was a woman of about 40 years old, and the mother of 3 children. She had a Ph.D. in Linguistic Studies. Socially, she had grown up in East Germany (before the fall of the Berlin Wall). She had had difficulties in her relationship; and she also had difficulties in the self-regulation of her emotions. She could be considered as a "person in transformation". (Boyesen, 2009)

Right from the beginning of the Body Psychotherapy sessions, this client seemed to be really direct and clear – verbally; she said what she wanted, and she was also willing to work on various issues. In contrast to this, the somatic 'bonding' situation that she was in felt completely different: she had a little sense of how to attain things with her body, especially when she felt she needed closer body contact; and, on the other hand, she practised a strict regimen of separation in various potential 'bonding' situations (e.g. dating, or close friendships) (Brisch, 1999; Bowlby & Fry, 1953). There was a frequent fluctuation between these two extremes.

Her posture seemed to be quite rigidly-oriented (Johnson, 1985, 2005); thus, we found strong muscles in the back, around her spine, and, as a counterpart, a weak front part of her body with a tendency to collapse, especially while talking about her emotional situation. There was nearly no eye-contact at all. However, there was a reasonable sense of orientation concerning her own internal needs and impulses. Her breathing pattern was not really regular, nor properly established: she often restricted her breath; and then she would fall into a pattern of hyper-ventilation; or she stopped her breathing completely for about half a minute. Her emotions emerged spontaneously; almost erupting – and she was not able to regulate them, or even to *find* their beginning (origin), or their end (closure).

This was similar to a case of "people with hysterical character structure" (a term more used in the earlier days of psychotherapy) (Marlock *et al.*, 2006, 2015): her symptoms seemed to jump around, from one part of her body to another.

Management and Outcome

She had 91 psychotherapy sessions, over a period of 6 years. In this case, the primary 'bonding' situation (Brisch, 1999; Bowlby & Fry, 1953) presented something of a paradox to myself as the therapist. Even when the client seemed

to be clear about her needs, the transference situation felt unclear, and sometimes quite impulsive: emotions seemed to come up very spontaneously, and were gone again in the same minute, so that any form of self-regulation for the client, but also any regulation or constancy within the therapeutic relationship, was not possible. It was even quite difficult for her to talk about what she was experiencing.

With this client, the sessions often started with a gentle 'body-scan' type of exercise to help her to increase her inner awareness. Immediately after that, she would start to have spontaneous, autonomous movements in her body. Following these movements, often led her into a slide-away, drifting-movement, ending with her lying curled up on the floor of the therapy room, making small hand & leg gestures – like an embryo. The atmosphere in the therapy room by then had changed completely – into almost an empty or wide-open space – as if there was something really "fragmented" in the air. She would remain quite still like this for several minutes. Using the technique of 'somatic transference', I, as the therapist tried to sense what these movements could be about. In the breaks in between her movements, we started to talk about what was happening within her.

One day, at a point in this time-period, I came across a book by Otto Rank (1998) and this offered some good ways for an analytic interpretation, or an understanding of the possible meaning of her movements. So, I searched for more information about pre-natal dynamics in therapy (Verny, 2014), and finally came upon some images about this stage of the foetal life-cycle by Lennart Nielsson (1997). I proposed that she could take this book home with her; and then watch, and sense, and meditate on what was being happening within her.

The next time that she came to a therapy session, she reported that she was quite clear that the so-called "meaning" of these autonomous movements of hers was a replication of the 'search' by the early "morula" (group of fertilized cells), moving down the fallopian tubes to the mother's uterus, and searching for a place to initiate implantation in the lining of the womb.

Up to this time, it had been me, the therapist, who had been trying to make some sense out of these movements of the client's, mainly because of her inability to talk when in a very emotional or somatic state. Now, I as the therapist had to follow these (non-verbal impulses that she was presenting, in order to try to find the unconscious meaning(s) behind this obviously largely somatic process (Janus, 1991). This sort of 'opening up' new areas of exploration is described in the so-called "Johari-window" (Yalom, 2002).

Working with such spontaneous, autonomic movements is one of the Body Psychotherapy techniques that allow clients just to start feeling these sorts of impulses in their bodies, and – usually with some initial therapeutic encouragement – help to discover, or find out, for themselves, what these

movements might signify and – more precisely – where they feel them and what they feel like. These concepts are all part of a relatively new Body Psychotherapeutic approach; that of "embodiment", which is increasingly being supported by recent neuro-physiological scientific results (Storch *et al.*, 2011).

It is also possible that some people, possibly with a more right-side oriented brain, who also seem to have less verbal activity, are able to express themselves more easily through various creative and/or artistic methods.

The difficulty – or the challenge – in this particular therapeutic relationship – with this particular client – was to try to allow, to follow and hopefully to understand and, then later, interpret – all these autonomous movements within a Body Psychotherapeutic theoretical and existential framework.

After her 'realisation' – with this type of 'imagery' work – the client was able to feel more 'empathic' with the embryo that she felt that she had been, and her 'devotion' to (or involvement in) this type of 'role play' became considerably deeper. Throughout the subsequent sessions, in her 'role-playing' of being an embryo, she described how sometimes she "found a place" – to come into contact with the mucous membrane of the mother's womb (i.e. to 'implant' herself), but – to the surprise of both of the therapist and the client – her reaction to this was quite ambivalent: in her 'role-playing' role, in her imagination, "… *she did not have any clear sense of how to get 'there', but – at the same time – there were also feelings of fear when trying to make contact with her mother's uterus"*.

Whilst this type of 'role-play', which involved her coming in towards, then retreating back from, the imagined mucous membrane of her mother's womb, happened over several sessions, both the client and therapist noticed that she was becoming much calmer and having softer feelings during the sessions. She also reported that this calmness was happening more in her daily life, as well. So, it seemed that – her understanding and her experiencing (and/or acting out) – in this process of 'searching' for a place to 'implant' – or to come more into life – had released something very deep in her emotional life – even if it was not being fulfilled more obviously, at that particular time, within the therapeutic process, or within her day-to-day life.

After this particular phase of therapy sessions, she decided to take some time out, and booked into a residential therapeutic clinic, for about two and a half months. There, she used many creative techniques to try to express some of her inner sensations. Amongst these techniques, she was painting big pictures of about 2 square meters in size, all of which expressed some of her sensations and feelings about different stages of her Body Psychotherapy process to date. After this creative period, she organized an exhibition of these paintings, and the process of

presenting these pictures, and the positive feedback that she received from visitors, played a really large part in her growing feelings of self-confidence.

After returning to individual work, something of a landmark occurred in her therapeutic process. This was when she felt that she had now "found" the very place in which to "implant" herself; and then, after some more similar sessions, she said that she now felt a tiny little movement from her navel to "that place" (of implantation). This, in her imagination, was because, 'in utero', the embryo's navel cord starts growing in that direction. [37]

At this point, a complete change in the 'somatic transference' situation took place – deep, heart-felt feelings started emerging – and something like an atmosphere of a respectful silence occurred in the therapy room. This was something that the therapist had never experienced before. The previously hurt and fragmented situation between them had changed completely into an atmosphere of being much more connected, and it felt like relating to someone who was full of love or joy. It felt as if this was something emerging from her unconscious.

Astonishingly, after these sessions, the quality of the therapeutic verbal contact had changed completely, as well. Her language now seemed to be more embodied: – she talked about how she felt, and how she was more 'present'; her eyes were now brighter, looking for contact; and, at the beginning and at the end of the

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[37] **Editor's Note:** The developmental sequence of the fertilised cluster of cells implanting itself into the wall of the mother's uterus (nidation) is described here: *'Implantation', or 'nidation', is the process during which the blastocyst (a growing cluster of fertilised cells) implants into the uterine wall. This occurs approximately six days after conception. Hormones secreted from the mother's ovaries and a chemical secreted by the trophoblasts begin to prepare the uterine wall. The blastocyst first adheres to the wall of the uterus, then moves further into the uterine tissue. This stage of implantation marks the end of the germinal stage, and the beginning of the embryonic stage of foetal development. After the blastocyst (or conceptus) is implanted in the uterine wall, the cells that will come to form the embryo proper divide and organize themselves into a bilaminar (two-layered) disc. This disc is surrounded by an outer ring of cells, called the trophoblast, which does not contribute to the new organism's tissues. The trophoblast cells multiply rapidly and invade the endometrium (uterine wall). Together, the trophoblast and the endometrium go to form the placenta, and through which all the nutrition for the developing embryo will pass. This rich mass of tissue is filled with blood vessels, allowing a rapid exchange of nutrients and waste. Another group of cells separates from the developing embryo about this time, and these cells also do not form part of the new organism. Instead, they develop into the amnion, the membrane that will surround the foetus to form the embryonic sac. This fluid-filled sac helps to cushion the foetus during later stages of development. This phase begins during the second week of development.*

sessions, the ‘normal’ touching rituals of welcoming and parting became much clearer. Her ability to write about her experiences also increased. This had been impossible for her before, but now – using creative methods (like painting, or mind-mapping) – she was able to get into a dialogue about her internal experiences.

Later, she started a Body Psychotherapeutic training and, after her children were grown up and had left home, she found herself entering into a new professional field.

Discussion

In this case study, there was a problem – at the beginning – that occasionally arises in Body Psychotherapy: people do not often choose psychotherapy when (or because} they are unable to talk about their experience.

This problem has been discussed earlier by Rank (1995). If the "ursprüngliche szenario" [“original scenario”] was situated in – or if the traumatic situation had occurred before – the time that children start talking – then any type of therapy that is language-oriented cannot easily work with that period of development and with that particular scenario, but, in association with these experiences, the so-called “here-and-now” techniques also seem to be impossible to use (Greenson, 1967).

By contrast, in a case like this, Body Psychotherapy has a lot of good resources to handle, or to approach this type of challenge, especially when working with largely non-verbal dynamics.

The old therapeutic habit of the therapist interpreting the clients’ unconscious expression is equally quite difficult for clients to integrate, like the related model of clients’ resistance (Greenson, 1967), which often means nothing more than a lack of creativity on the part of the therapist. Instead, using the Body Psychotherapy technique of “tracking” [38],the therapist is brought much closer to the client’s process, and any upcoming sensations do not have to be interpreted,

[38] **Tracking** – in this context – is where the therapist just follows the client’s somatic (largely non-verbal) process – noting the various stages, and/or repetitions, and/or moments of being stuck, etc. – without any judgement. There can sometimes be an ‘observational monologue’ – *“I notice that you are now doing this”* – but this verbal input can also potentially disturb the client’s attention to their inner process. Sometimes, the client wants ‘feedback’ from the therapist about what happened. This should also be given non-judgementally: something like the “feedback” given in Authentic Movement – *“When you did this, I noticed this and/or it felt (for me) as if …”*

because the client himself or herself is experiencing an understanding of what is going on, step-by-step, in their somatic process.

However, the client's unconscious dynamic can be, and should be, understood – as there is a need for the therapist, himself or herself, to be able to create an empathic framework for the therapeutic process, as well, in order to help contain and understand it.

For the therapist, it is also necessary to be able to develop a working hypothesis, during the course of therapeutic process, as well as seeking counsel of a supervisor (who, in this particular case, had just – by chance – had found the prenatal information and photographs, which allowed the therapist to obtain a deeper understanding of the movements in his client. In the beginning, however, it was the method of 'somatic transference', the sensing of the bonding situation, that allowed him to come into a greater contact with the client's experiences. The observer of a situation, also is part of the situation: this is a form of systemic approach. Yalom (2002) calls this: "the body of the therapist (being) the 'Stradivarius' of the psychotherapeutic situation".

From a Body Psychotherapy point-of-view, it is the process of somatic transference, that – whilst enabling a better non-verbal empathic situation with clients to develop – also allows us, Body Psychotherapists, to follow what is going on, and to be prepared for creating a framework, in which the client's process can continue and develop deeply.

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A Body Psychotherapy Case Study about the Release of Pain in the Upper Back using Bioenergetic exercises: 'Defining Personal Boundaries'.

Bernhard Schlage

Abstract: This case study demonstrates some Body Psychotherapy techniques for the release of back pain using exercises from Alexander Lowen's Bioenergetic therapy. Specific problems are discussed; mainly those arising from the parallel use of different therapeutic approaches by the same client, as often is the case with the treatment of psychosomatic disorders. This case study also demonstrates types of resistance against any kind of aggressive expression, in accordance with the client's (Reichian) character type; and the need in a client for healthy 'parental' separation. It also demonstrates how BPT techniques can support clients' resources in helping them to become more self-confident by expressing their personal needs, instead of suppressing them and for example unconsciously 'creating' back pain.

Key Words: Psychosomatics; Back pain; Memory tracking; Conflict resolution; Bioenergetics; Intrapersonal to interpersonal

Introduction

The client in this case study was a 52-year old sports teacher, and a Feldenkrais practitioner[39], married, with one child. She had become aware – during a course of couples' therapy – that the painful bodily sensations in her back were also expressions of (or connected with) her personal need to distance herself from the (sexual) demands of her husband.

Case Presentation

The client had already become aware of some of the psychosomatic implications in her back pain (Lowen, 1975; Lowen *et al.*, 1976) and so she entered into personal Body Psychotherapy, in order to work with this particular issue.

During the previous couples' therapy, it had become clearer that the 'bonding dynamics'[40] between the couple had become increasingly fragile (Brisch, 1999; Bowlby & Fry, 1953). She reported that she had often fallen back into (what she described as) 'regressive' feelings, and sadness, especially when she was in conflict with her husband, instead of acting more like an adult. However, when she was in contact with herself, she could feel a deep sense of fear, as well, but she was not able to connect any further with this.

Physically, she tended to lean forward in her posture, giving the impression of a much older woman than she actually was. Her movements did not seem particularly co-ordinated and – at the beginning, and also at the end of the session – she performed a fixed set of actions that she repeated each time (i.e. like blowing her nose; combing her hair; going to the toilet; looking for a piece of paper; etc.). These actions seemed to be part of a form of a neurotic, or compulsive, habit.

At that time, her breathing pattern was very controlled – and yet was also often interrupted – however, these were not particularly related to any of her movements. Her 'affect' also seemed to be very controlled. On the whole, she gave the impression of what is known in Reichian therapy, as a "masochist character structure" (Johnson, 1985, 2007; Keleman, 1983).

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[39] **Feldenkrais training**: 'Awareness Through Movement': a set of gentle and repetitive therapeutic exercises to help increase body awareness. For more information: www.feldenkrais-training-program.com

40 'Bonding dynamics': These can be thought of as the (psychic) 'bonds' in a relationship: or 'that' which ties two people in a relationship (even if they are apart or have not met for a while); the 'glue' of a relationship is how well or strongly bonded two people are.

As this character pattern is reasonably well-known – at least within Body Psychotherapy – there are nearly always specific somatic expressions carried within a person (and/or a client) that relate to some of the unresolved psychodynamic issues, usually coming from the childhood of that person.

As somatically-oriented therapists, we are also aware of all those non-verbal signals that impinge on the therapeutic dynamic: from the therapeutic relational (bonding) situation with the client; from their different breathing patterns; from the different kinds of muscle tonus and the level of sensation of the skin tissue that we sometimes touch.

All these 'bodily' signals can lead us to suppose various understandings (or constructs) about the person: for example, if a person is fixated more within problems from their early childhood, these can be classified, for instance, as 'schizoid' types; or those clients who have unresolved problems from the psychodynamic field of their familiar Oedipal-situation; these can be classified as 'rigid' types. The combination of the relationships with some clients is much clearer; but, with others, we may have to use the model in a more dynamic way. There can be changes in our diagnostic decision, after new themes emerge in contact with that client.

However, even if it is helpful to become fully impressionable to any changes in any new situation with a client, it is better to be effective, and to choose different therapeutic strategies with different people.

Management and Outcome

Here, we had an interesting beginning of the therapy work: the client (together with her husband) had been with another therapist. It was during the work with him that certain circumstances had arisen that indicated that she needed to add individual therapy into the process. She had always had problems with pain in her back: however, these seem to intensify during her conflicts with her husband. Even when the conflicts with her husband became resolved, the back-pain nevertheless persisted. Medical examinations had not discovered any serious diagnoses (like degenerative spinal problems; or a prolapsed or herniated disc; or spondylolisthesis). So, something else had to be the cause of her quite severe and chronic back pain. She wanted to explore the reasons for this pain – in the therapy.

The first steps were to discover what she wanted from therapy and to (re-)create a good working therapeutic relationship: it transpired that this resembled some of the ideas that she had had about having a 'good' father. Her father was actually a well-known dentist and oral surgeon, but … one who was not able to act warmheartedly towards her, his only child; he was always demanding

achievements from her. So, the client – as his only child – was trying hard to live up to his high expectations.

We discovered, in the first phases of the therapeutic work, that the transference situation to her previous therapist was very similar: she had tried hard to do what she thought was expected of her, in order to make the relationship more secure. In the individual therapy, it became quite a landmark for her to experience that a new kind of achievement was not requested, or required. Instead, what was asked for was some feedback about her feelings, while she was in the therapeutic relationship, and how she could communicate her feelings to the therapist, without feeling judged or (seemingly) being asked to do something more.

In the second phase, we explored her habit of expressing her needs and desires in a way that puts the blame onto other people, like: *"If you love me, you should ... "* or *"When you do 'this' and 'that', you are showing your ignorance of my individual needs"*, instead of saying what she needed, and staying in open contact with what was going on within her husband.

After experiencing this dynamic, we found out that there was a major problem concerning her sexuality, and her sexual activity with her husband: for years, they had practiced "coitus interruptus", because he did not like to use condoms, and she (after giving birth to one child) did not want to use any other kind of birth control, neither mechanical, nor chemical.

In this situation, the sexual practises of the couple had become increasingly unsatisfactory (Christinger & Schröter, 2009) and normal interactions, from sensual touching to erotic interaction and sexual intercourse, had become deeply disturbed, as she had declared several times, when this topic was brought up in their couples' therapy. A lot of frustration – from both sides – had apparently become obvious. However, in that particular therapeutic setting, it was not possible for them to work out all their feelings – in order to become free of them – and to come to appreciate what was actually happening as a result of their unconscious interactions.

Therefore, the frustration had found its way into the individual therapy, and – as a way of helping her to express these strong feelings more openly – we tried various Bioenergetic exercises with stronger movements, louder sounds, or a wider range of movements (Lowen & Lowen, 1977); like that of pushing back with her arms. But, all these things seemed "theatrical" to her. She was capable of 'acting out' some of her feelings, but she always interrupted the process by laughing, or with tears of sadness, instead of bringing more force into her movements.

At this somewhat unsatisfactory point, the client stopped (or interrupted) the therapy for nearly 2 years. She had started a Feldenkrais training (Awareness through Movement)[1] to explore a new direction in her profession, as a sports

teacher, and was very involved in this training, with all the resultant needs and changes of body awareness and movements that come along with the practice of Feldenkrais. Our contact was thus interrupted, yet it did not feel disconnected, as sometimes she had asked for an individual session about a particular issue; or she had responded – in writing – to the half-year practise-information newsletters.

During this period, she also realized that her deep resistance against more aggressive ways of expression persisted, and so did the pain in her back. When she returned to individual therapy in this new phase, we started with some normal grounding exercises (Lowen & Lowen, 1977), to deepen her contact with her body, especially with her feet and legs.

As the therapist I was surprised, because she really was not able to stand up for a while, stamping on the ground, and connecting with her emotions, with the power rising up through her legs. She had nearly always had to look away, or she would talk about something that had happened the day before, or interrupted the exercise by blowing her nose, or expressing a need to relax.

Using types of emotional expression, we started to 'transform' the pain in her shoulders and her back into something like a "bear stomping on the floor". She really enjoyed expressing this newly found power, and she also used it to supplement her professional standing in the world. But, as we continued with the grounding exercises, it became clear to her, that she could not connect with any sensations in the lower part of her body. She would not be able to feel this power, as, subconsciously, she was unable to avoid the increased sexual impact that follows from using these exercises, and so, again, she was able to dissociate from her feelings.

We then had a six-months phase of working on the rejection of her sexual feelings. Using sensori-motor tracking methods, (Ogden *et al.*, 2006, 2010), we concluded that she had (possibly) been sexually abused in her early childhood; and she, therefore, had a strong need to protect her sexuality. In the end, after many sessions, she was able to face up to her painful experiences. Thus, she came to a deeper understanding of her earlier sexual frustration, and why she had always felt tempted to comply to a man's demands and wishes within a sexual relationship.

Survivors of sexual abuse sometimes maintain a deep rejection during their therapeutic work (Bass & Davis, 2008). And, this seemed to be the case here, and the client discovered that she would then have to communicate this need for distance to her husband.

At this point, in the individual therapy, the client took a break, because she wanted to share her resistance against sexual feelings with her partner, within the

forum of couple's therapy. This break – in the individual therapy – lasted several months.

After a while, she returned back to individual therapy, and we then started to work with a validation of what we had already done. The method that was being used now was not a form of Body Psychotherapy, but was more of talking therapy; and we re-visited and reviewed the new kinds of resources that she had developed over time.

Because of her sexual abstinence, some new problems had come up in her partnership, but both partners had coped reasonably well with this. They claimed that their increasing age was one reason for this. To tell the truth, as the therapist, I remained sceptical about a conclusion like this. From this point of view, the rejection of her sexuality went together with her greater problems of expressing aggression. Nevertheless, after their daughter had left home and when (because of the client's bicycle-accident) the necessity arose to stay together more closely, and they each found ways to increase their empathy and to deepen the trust to one another. So, they were capable of softening the (possibly masochistic) border between themselves, and, more and more, they had managed to create a much calmer dialogue within their relationship.

Discussion

In this case study, the most significant fact was the lengthy time of co-operation between therapist and client. Even during the periods of breaks, the contact did not really get lost. The client repeatedly returned, sometimes simply for personal questions, or to participate in one or another of the seminars that the therapist organised in his therapy centre. Therefore, the established relationship could probably grow, and became more of a life-counselling situation in difficult times. It needs to be discussed what the major points in the therapeutic contact are that allow for long-term therapeutic relationships.

The other significant fact was the combination of two different kinds of psychotherapeutic work. In this case, couple's therapy and its influence upon the individual therapy (and vice versa). It was easy to handle because the client had lifted the duty to maintain confidentiality for both therapists, which allowed them to communicate with each other about their therapeutic work. This was done on a regular basis, depending on the kind of work the client had done. Potentially, this type of communication can hold a danger of competition or mistrust between the therapists. This was not the case here: the professional contact was both productive and complementary. Possibly, this is something that needs more exploration: ways to create cooperation like this one for the benefit of clients.

One obstacle in this cooperation was the 'hidden' sexual abuse by the father of the client. It was difficult to verify, because the client was a very young child when this happened, and this happened at an age when children did not yet have words to talk about their experiences. I suggested that the client should try to focus on the 'shadows' of what had happened, while deepening her breath, focusing on her inner visions, and tracking the kind of movement around the scenario (say) of the diaper-changing table, where and when the abuse had possibly happened: thus, she could not speak about it. In this instance, we used some special pre-natal Body Psychotherapeutic tools (Verney, 2014).

Summary

In this work, there were some effects that were caused by the client's change of life circumstances. So, she said that – as she got older – she had grown mellower, and more mutual support between her and her husband became necessary; illnesses had also appeared, and this forced this couple to change their habits. These circumstances enhanced their cooperation and deepened their bonding situation.

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