

Relational Body Psychotherapy

(or Relational Somatic Psychology)

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*We live in a relational matrix
within ourselves, with each other, and with our planet.
Any break in connection within this relational matrix
is experienced as stress or trauma.*

Abstract

This article discusses the history, concepts, and methods that characterize relational body psychotherapy. It reviews its historical origins beginning with the evolution of the role of empathy in the object relations and humanistic movements, continuing with the development of the principles of attachment in the seminal work of John Bowlby and Mary Main, and maturing in relational psychoanalysis as it replaced therapeutic neutrality with the centrality of the therapeutic relationship as an agent for change. It is this shift away from therapeutic neutrality that has played a major role in opening the way for body psychotherapy to embrace relational psychoanalytic principles. The relational approach has created opportunities to introduce embodied clinical applications into the broader field of psychotherapy and psychoanalysis. Relational body psychotherapy is explored from the perspectives of (1) transference dynamics and the importance of therapeutic resonance; (2) a theory of bodymind organization that views the body as engaged in an ongoing dialogue that includes somatic flow and pulsation, cognitive organization, and relational interdependence; and (3) an attuned and collaborative relational matrix that supports the importance of the body in restoring the capacity to love and in activating the conditions that facilitate the emergence of Self. This article is inspired by four publications I found most helpful in understanding the origin, depth, and breath of relational body psychotherapy, or, as it is called in the United States, *relational somatic psychology*:

- *From Broken Attachment to Earned Security: The Role of Empathy in Therapeutic Change*. The John Bowlby Memorial Conference Monograph Series (2014), edited by Andrew Odgers.
- *Talking Bodies: How Do We Integrate Working with the Body in Psychotherapy from an Attachment and Relational Perspective?* The John Bowlby Memorial Conference Monograph Series (2014), edited by Kate White.

- *Touching the Relational Edge* (2014) by Asaf Rolef Ben-Shahar.
 - *About Relational Body Psychotherapy* (2012), edited by Courtenay Young.
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Over the past two decades, relational psychoanalysis has emerged as a new tradition of thought and clinical practice. It has become an influential force within psychoanalysis, leading the movement away from classical Freudian drive theory towards a developmental model grounded in a wide-ranging mix of influences. Primary among them are attachment and object relations theories, and self-psychology. This change has been accompanied by a corresponding shift in clinical practice away from neutrality, abstinence, and anonymity and towards an interactive vision that places the relationship between the therapist and patient at the center of the therapeutic work.

Relational psychoanalysts believe that the desire to be in relationship is the primary human motivation. They argue that personality emerges from the matrix of early formative relationships with parents and caregivers and that, consequently, our desires and urges cannot be separated from the relational contexts from which they arise; our early relationships shape our expectations about how our needs and desires can be met. As a result, relational theorists have come to the conclusion that the formation of identity is largely organized in relation to others. Throughout the lifespan, we attempt to recreate our relational patterns in a way that conforms to what we learned as infants.

Although there is a contemporary tendency to minimize the contributions of psychoanalysis, most of the significant theoretical advances in the field of psychology have had their beginnings in its rich and controversial tradition. In the case of relational body psychotherapy, the path begins in the humanistic movement and in the now-historic revolution set in motion by the cooperative work of psychoanalyst and psychiatrist John Bowlby and psychologist Mary Main. In addition to this deep connection to the principles of attachment theory, relational body psychotherapy was also strongly influenced by relational psychoanalysis. In his important book *Touching the Relational Edge*, Dr. Asaf Rolef Ben-Shahar notes:

One of the reasons for the current blossoming of body psychotherapy within the general field of psychotherapy concerns the conceptual and clinical openness brought by the relational turn in psychoanalysis. Relational psychoanalysis shattered the sterile fantasy which typified the first decades of psychological treatment. (2014, p. 10)

In her preface to Rolef Ben-Shahar's book, Jacqueline Carleton points out how the links between relational body psychotherapy and psychoanalysis connect two worlds that have traditionally been estranged:

Psychoanalysts reading interpersonal neurobiology began to realize that the body held information inaccessible by words alone. In the meantime, body psychotherapists, tired of their own small world, had begun to explore and incorporate ideas and techniques from psychoanalysis, especially and most fruitfully, relational psychoanalysis. (2014, p. xvi)

Rolef Ben-Shahar observes that the rise of relationality in psychoanalysis has brought about a cross-fertilization with contemporary body psychotherapy, resulting in a new generation of body psychotherapists interested in and able to use psychodynamic terminology. The 2012 John Bowlby Memorial Conference “Talking Bodies: How Do We Integrate Working with the Body in Psychotherapy from an Attachment and Relational Perspective?” is an illustration of the growing movement toward greater integration between therapists trained in a relational psychodynamic tradition and those who come from a body psychotherapy tradition.

Relational psychoanalysis and relational body psychotherapy mutually enrich one another: whereas relational psychoanalytic thinking provides a fertile theoretical foundation to the interested body psychotherapist, relational body psychotherapy offers practices that translate relational concepts into embodied clinical application. Relational psychoanalysts are faced with the fact that including the body and bodily interventions in the therapeutic dialogue challenges traditional clinical practices. Relational body psychotherapists who no longer want their work marginalized are challenged to base their clinical interventions on well-founded theory. Rolef Ben-Shahar cautions:

To reintegrate their position in the psychotherapeutic community, body psychotherapists can no longer resort to the naive and spontaneous stance which has characterized the first few decades of body psychotherapy; as do psychoanalysts and psychotherapists of all schools, they need to position themselves authentically and responsively with their clients, and take responsibility for their clinical interventions. (2014, p. 59)

The Role of Empathy in Relational Psychotherapy

*If it is bad human relations that created the problem,
then it must be good human relations that can provide the cure.*
—Harry Guntrip

Research into the primary parent–infant relationship shows that the development of empathy in children is essential to their capacity to form satisfying relationships as adults. In

response to this finding, the 2011 John Bowlby Memorial Conference monograph addresses the theme of empathy in clinical practice. The conference examined the proposition that just as empathy is essential to a child's capacity for secure attachment, empathy is also an essential relational skill needed by a therapist to help a client move from an insecure attachment to the achievement of earned security.

Historical Background

John Bowlby began to develop his attachment theory during his early work with children who were displaced through war or institutionalization. In his 1952 landmark report for the World Health Organization, *Maternal Care and Mental Health*, he established that prolonged separation from their parents was the primary trauma at the heart of children's disturbed development.

Initially the psychoanalytic establishment was hostile to Bowlby's ideas. However, in the last few decades, dramatic advances in infant research, neuroscience, and relational psychoanalysis have solidly established the pivotal significance of Bowlby's work. In 1976, as a result of the expanding influence of Bowlby's work, the Bowlby Centre was founded as an attachment-based psychoanalytic center. The Bowlby Centre, in its mission statement, states that it operates on the belief that "mental distress has its origin in failed and inadequate attachment relationships in early life and is best treated in the context of a long-term human relationship" (2014, p. 148). Empathy is seen as the essential element of relational communication, contributing to the creation of a secure context within which traumatic and disavowed experiences can be explored. The Bowlby Centre's approach validates and builds on the work of Sándor Ferenczi, Carl Rogers, and Heinz Kohut. These analysts developed approaches based on the concept that empathy is central to the healthy development of the self, and brought them into clinical practice long before research had established empathy's importance as an essential ingredient of relational therapeutic communication and treatment.

Ferenczi and the Absence of Pretense

Sándor Ferenczi, a protégé, close colleague, and friend of Freud, was an early developer of analytic technique. His belief that empathy, warmth, kindness, and acceptance are key aspects of psychoanalytic treatment is among his important theoretical contributions. Emotionally present, intuitive, and innovative himself, Ferenczi believed that special emotional and intellectual capacities were required to be an empathic analyst. He wrote:

One gradually becomes aware of how immensely complicated the mental work demanded from the analyst is. . . . One might say that his mind swings continuously between empathy, self-observation, and making judgments. (1928, p. 96)

Ferenczi understood that the analyst–patient relationship was not only transference—that is, that the patient projected past experiences onto the analyst—but also that the analyst's personal history and experiences were part of the therapeutic field. Ferenczi advocated the absence of all pretense, challenged the idea of the analyst as authority, and viewed the therapeutic process as a collaboration. He was the first analyst to make use of nonverbal cues to interpret unconscious process. Ferenczi's thinking anticipated by many decades the work of relational and intersubjective psychoanalysis and relational body psychotherapy.

Carl Rogers and Congruence

Carl Rogers, one of the founders of the humanistic approach, described the empathic process in the following way:

An empathic way of being with another person has several facets. It means entering the private perceptual world of the other and becoming thoroughly at home in it. It involves being sensitive, moment by moment, to the changing felt meanings which flow in this other person, to the fear or rage or tenderness or confusion or whatever he or she is experiencing. It means temporarily living in the other's life, moving about in it, delicately without making judgments; it means sensing meanings of which he or she is scarcely aware. (1980, p. 142)

Rogers considered empathy to be a *way of being* rather than a reflective technique. He recognized that holding a genuine empathic stance is an incredibly delicate and complex process that develops through experiential training in the following three areas:

1. *Empathic listening and communication.* Therapists learn to accurately sense the thoughts, feelings, and personal meaning of a client's experience and communicate this understanding back to the client in an accepting way. In their most empathic states, therapists become so immersed in their client's world that not only can they identify meanings of which their clients are aware, but also meanings that are below their conscious awareness.
2. *Congruence.* Rogers believed that growth is facilitated when therapists are genuinely themselves with their clients. He did not believe in presenting a professionally neutral or veiled façade. Only when therapists embody the feelings and attitudes flowing in the intersubjective space can there be congruence between (1) the client's felt experience as empathically perceived by the therapist; (2) the

therapist's own internal experience and awareness; (3) what the therapist expresses to the client; and, I would add, (4) what the client can safely express to the therapist.

3. *Unconditional positive regard*. A primary aim in therapy is to counteract a client's struggle to fulfill the expectations of others. To lessen or neutralize the pressures of these expectations, therapists need to communicate to clients that there are no conditions to their acceptance of them; that they, the therapists, have no expectations. Rogers admits that the phrase *unconditional positive regard* was an unfortunate choice of words for this empathic state because it seems achievable only in theory. In reality, in addition to moments of unconditional positive regard, therapists may experience *conditional* positive regard or even *negative* regard. Whether unconditional, conditional, or negative, these experiences can be appropriately addressed with a client in a way that is helpful and congruent with the therapeutic relationship. The attuned therapist can model ways of exploring all types of internal and intersubjective responses in a caring and stabilizing way by keeping the dialogue transparent and the relationship with the client honest and open. This level of therapeutic skill does, however, require that therapists develop their own relational capacities.

Kohut and the Selfobject

Heinz Kohut believed that parental empathic failure caused narcissistic injuries that impaired the child's capacity to develop an integrated sense of self; hence his conclusion that the therapist's relational responsiveness was crucial for building the cohesiveness of the patient's self. He found that the psychoanalytic approach did not help patients who suffered from developmental trauma. Rather, Kohut observed that his patients responded to their analyst's empathic attunement and accurate reflection of their internal experience—not to their interpretations—with an increased sense of well-being and mental functioning and that the opposite was true when there were lapses in empathy. From Kohut's relational perspective, the analyst corrects a patient's earlier deficits by providing a reparative selfobject experience.

Kohut realized that empathy not only fosters a warm nurturing environment, but that when patients feel understood, access to their inner life is facilitated; he called this access *vicarious introspection* or *feeling oneself into the life of another*. Each patient's sense of reality is unique and it is the therapist's task to look at reality from the patient's perspective. Like Bowlby, Kohut's findings were met with outrage and resistance from the analytic community; it was not until 1971, with the publication of *The Analysis of the Self*, that Kohut was able to give a full account of his personality theory.

Relational Psychoanalysis

The importance of an empathic therapeutic context was further strengthened by the work of relational psychoanalysts such as Stephen Mitchell, Robert Stolorow, Bernard Brandcraft, and George Atwood, all of whom also questioned whether the analytic stance of the therapist as a detached observer was justifiable. They emphasized the importance of the patient–analyst engagement as central to the therapeutic work, making a clear distinction between a *one-person psychology*, which positions problems within the analysand, and a *two-person psychology*, which explores the system formed by analyst and analysand together. The relational two-person approach challenged the psychoanalytic assumption that the analyst could remain unaffected by the patient’s innermost revelations. Relational analysts firmly placed the therapeutic relationship within a *two-person co-created framework*, believing that the patient’s genuine self cannot emerge without a supportive and empathic connection modeled by the analyst.

Relationalists base their understanding of the therapeutic relationship on the caregiver–infant relationship. They draw on the work of Daniel Stern (1985, 1991) and Beatrice Beebe (2002, 2004), who describe how the attunement within the mother–infant dyad is instrumental in co-creating the relationship on which the infant depends for optimal development and growth. Infants are born seeking connection, and attuned connection with their primary caregiver leads to secure attachment. In particular, Beebe’s research (2004) demonstrates how the parent–infant interaction creates a shared system of mutual influence and regulation that is reproduced in the therapeutic relationship. Consequently, relational psychoanalysts monitor the intrapsychic and interpersonal states within the analyst–patient dyad, consistently tracking these complementary aspects as they create a new attachment relationship. Likewise, the relational body psychotherapist offers authentic presence and mutual partnership. Positioned in a two-person psychology, relational body psychotherapists closely monitor the body and mind relationship within themselves and their clients.

Active Empathic Inquiry

Although Robert Stolorow (1992) valued empathy as a crucial factor in the interplay between the mother–infant and therapist–patient connection, he observed that an empathic stance, in itself, is not enough to foster growth. He added an important refinement to the clinical use of empathy by proposing that the analyst provide an *active empathic inquiry* into the subjective life of the client. Stolorow aimed to help clients reexamine how they organize their inner experience—their *internal working models*—in order to bring about reflective awareness. Using empathic attunement as a starting point, in the way Rogers (1980) had

proposed, relational psychoanalysts add appropriate and attuned suggestions and timely interpretations to help shed light on their clients' prereflective unconscious and to support their internal restructuring.

Rogers maintained a deep empathic listening process and saw himself as a *companion* to his patients, whom he supported to come to their own realizations. Relational psychoanalysts see themselves as *active facilitators* and propose a more dynamic involvement with the patient's conscious/unconscious and verbal/nonverbal communications. No longer seeing themselves solely as companions, relational psychoanalysts affirm that their patients' inner states, as well as their own, are mutually affecting both parties and therefore need to be understood collaboratively and processed experientially, moment to moment, within the therapeutic relationship. At the same time as they hold the awareness of an internal world, relational psychoanalysts acknowledge an interpersonal world. Who we are is seen as an ongoing process emerging at the interface between the intrapsychic and the interpersonal—an awareness of two complementary aspects of existence out of which self is created and defined.

Cultivating Empathy

Before going any further, let's look a little closer at what empathy is and is not. Sue Gerhardt writes:

Many people think of empathy as some sort of cosy . . . ideal of mothering, and perfect attunement, and being nice. Some people have argued that therapy based on empathy is a kind of "safe analysis" where there are no ethical dilemmas, no sexuality, no challenges. The analytic therapist Andrew Samuels is one such, who calls it, rather evocatively, "a 'milky' worldview." (2011, p. 11)

Empathy has been misunderstood: it has been seen as coddling patients and meeting their demands by colluding with them. A more sophisticated understanding of the term may help to counter these misconceptions. Gerhardt describes three levels of empathic relating, showing that it is both a natural response and a capacity that we need to cultivate.

- *Emotional contagion*. At its basic level, empathy is described as a bodily resonance that happens naturally when people share feelings with each other. This bodily resonance is widely believed to be generated, at least in part, by mirror neurons. By activating the areas of our brains that respond to the body language of others, mirror neurons give us a sense of how others feel and generate similar behaviors in us. This type of empathy is an evolutionary development that requires no effort on our part.

- *Affect attunement.* This level of empathic responding is also mostly automatic and unconscious. When affectively attuned, an individual instinctively adjusts his or her response to mirror how another feels. For example, if a client comes into a session conveying sadness, a therapist might adjust her voice to a gentle, low tone, thereby letting the client know that his inner state has been recognized. For the most part, affect attunement happens unconsciously, but therapists can also choose to consciously use it to give clients nonverbal feedback that lets them know they understand their inner state.
- *Empathy.* Using both bodily resonance and affect attunement as a base, empathy proper is more complex and includes a cognitive element. When we empathize, we consciously draw on our own experiences and self-awareness to imagine what someone else may be feeling. We give priority to feeling along with the other person, while at the same time remaining aware of our own feelings.

Empathy is deeper and broader than attunement. Attunement happens moment-to-moment as a sensitive caregiver regulates a child's current emotions and responds to his or her immediate needs, whereas empathy is a response to the uniqueness of a whole individual and his or her personal history. Empathy takes time and effort to develop because we need to have acquired a memory bank of encounters with people and have enough self-awareness to draw on those memories. To be capable of empathy, children require empathic caregivers who can consistently help them identify and name their emotions, accurately read their inner states, and translate their inner experiences into a coherent narrative.

When babies and young children do not experience empathy from their caregivers, it is difficult for them to respond empathically. Instead, they react without awareness of their own feelings and without thinking about the impact of their behavior on others. The psychology of the parent becomes the psychology of the developing child. Adults who were on the receiving end of non-empathic parenting as children in turn believe that punitive parenting will teach their children to behave and know their place in a hierarchical society. In this way, lack of empathy contributes to the generational transmission of developmental and relational trauma.

Gerhardt points out that psychoanalysts who were themselves parented without empathy set the tone for decades of analytic assumptions: "Analysts regularly referred to their clients as 'babies' who needed to grow up or 'victims' who needed to take responsibility for themselves" (2014, kindle location 402). Empathy and identification with others were seen as unsuitable behaviors for professionals. In Gerhardt's words:

This more relational perspective makes it clear that the twentieth century style of psychotherapy, as a power relationship where the superior therapist tries to force the patient to grow up, is as outdated and unhelpful as parenting which insists on deference to authority and overly strict disciplinary practices. (2014, kindle location 592)

Because empathy is not a symbiotic merging with another, it requires that a therapist have a well-defined separate self. Being empathic requires clarity, good boundaries, maturity, trust, confidence, and compassion. Empathy does not develop without appropriate modeling, and its presence cannot be taken for granted; it is a quality of being that psychotherapists can offer only once they have experienced it themselves. A psychotherapist's own attachment history affects his or her ability to generate the experience of a secure base for a client.

Relational psychotherapy involves the creation of a relationship that provides a secure base for the client. The following qualities are at the heart of secure attachment and equally at the heart of a psychotherapy that is relational:

- *Sensitivity.* Sensitive therapists tune in and are able to understand what clients are feeling, joining them in their pain as well as their joy.
- *Self-regulation.* Therapists generate confidence when they are available to support the regulation of their clients' emotions, particularly in times of distress. One of the main obstacles to the development of empathy is the caregiver's own difficulty with self-regulation; hence the importance of the therapist's personal development and capacity for self-regulation.
- *Responsiveness and mutual feedback.* Therapists must be willing to own their empathic failures and repair misunderstandings. Clients can be retraumatized by being seen in a negative light and judged, by being held at arm's length or when feeling unsafe to express their needs. Again, quoting Gerhardt:

In particular, an empathic narrative recognizes that it is not the client who is negative, but the relationships that the client has experienced in the past, and the relational patterns that he or she has internalized. Therapy based on modern developmental understanding recognizes that our selves are really the emergent properties of actual relationships. (2014, kindle location 587)

Working with the Body from an Attachment and Relational Perspective

*. . . therapists need a model of non-verbal communication
based upon acceptance of intrinsic affective states and their communication
by active contact between bodies in all degrees of intimacy.
—Colwyn Trevarthen*

The presentations of the 2012 John Bowlby Memorial Conference center on the importance of the body in the relational perspective. As stated by Kate White, the monograph's editor, the aims of the 2012 conference were three-fold: (1) to explore the growing role of the body in relational psychoanalysis and psychotherapy over the last decade; (2) to update our thinking about the relationship between the body, attachment, and trauma; and (3) to support a greater integration between therapists who come from a body-oriented psychotherapy tradition and those who have been trained in a relational and psychodynamic tradition. White notes in her introduction:

Perhaps relational approaches to psychoanalytic psychotherapy have underplayed the central role of the body in constructing experience and the shaping of our internal worlds. The child's longing for the body of the mother has always been implicit in attachment theory. Yet perhaps in reaction to the excesses of certain classical theories, and because of its need to achieve scientific respectability, the body and by implication touch, the sexual and the erotic have been under theorized. (2004, p. xxiv)

Questions addressed during the conference included:

- How do we anchor the new understandings we are gaining within the framework of attachment theory?
- How might the integration of these ideas about the body change what we do in the consulting room?
- What impact might this focus on the body have on the therapy relationship?
- Can we maintain and respect the place of a secure, attuned attachment between therapist and client, and its healing potential, at the center of our therapeutic work?

In support of bringing the importance of the body to the foreground, key contributors from the somatic field were invited, among them were Roz Carroll, who presented the opening address; Pat Ogden, who gave the conference's John Bowlby Memorial Lecture; and Nick Totton, who gave a paper on the theory and practice of relational body psychotherapy. *Talking Bodies* (White, 2014) contributes to the interdisciplinary dialogue on the role of the body from a relational perspective. The 2012 conference builds on the 2003 conference, titled "Touch: Attachment and the Body," in which Susie Orbach reminded us, "Our personal body unfolds and develops its individuality in the context of its relationship to and with an other and other bodies" (2004, p.23). Orbach emphasized that the body, just as the psyche,

struggles to come into being, and put out a call to retheorize the relationship between body and mind.

More Historical Background

Bowlby joined the British Psychoanalytical Society in the 1930s. At that time, the Society was influenced by the views of Joan Riviere and Melanie Klein, with whom Bowlby trained, and who believed that an infant's and toddler's life was primarily influenced by his or her inner world of drives and fantasies. Bowlby, on the other hand, was interested in real life and was consequently not convinced of the value of Riviere and Klein's emphasis on inner fantasy. Searching for a theory that would explain young children's protest, detachment, and despair when separated from their parents, he became convinced that animal behavior, particularly primate behavior, could shed light on that despair. The fact that young animals stay in close physical proximity to their caregiving adult suggested to him that attachment behavior has a survival value that most likely serves the need of the young for protection from predators and care and nourishment from the mother. Bowlby observed that in young children, the threat of loss leads to anxiety and anger, and actual loss leads to anger and sorrow, suggesting that from the beginning of life, human babies, like other animals, have a *primary* need to establish a bond with a caregiving adult.

American psychologist Mary Ainsworth joined Bowlby in the development of this work. She created the Strange Situation procedure to study the differences in young children's attachment patterns. Observing babies and toddlers with their mothers, Ainsworth (Garhart Mooney, 2010) noticed that, following separation and reunification with their attachment figure, children expressed clear patterns of behavior: they were either (1) securely attached—that is, when the mother returned after an absence, they could calm down and reconnect with her; or (2) insecurely attached, with anxiously avoidant, resistant, or disorganized behavior—that is, they had difficulty regulating their arousal and reestablishing connection with the mother when she returned. Ainsworth called these patterns of interaction *attachment styles*. Further research showed a correlation between secure attachment and positive identity formation. Ainsworth provided attachment theory and psychoanalysis with evidence-based data that supported the need to introduce into clinical practice the knowledge of how attachment styles are formed and how they continue to influence a person throughout his or her life. As a result, the need for secure attachment is now seen to be as fundamental as the need for food and the adult need for sex.

Ainsworth also demonstrated that the link between the quality of parenting and children's resulting attachment patterns influence their capacity to explore and adapt to their environment. Although children's need for secure connection and for exploration might

seem contradictory, Ainsworth found that they are, in fact, complementary: a mother's capacity to provide a secure base of availability and responsiveness to which the child can return after exploration enables that child to develop self-reliance and autonomy during his or her exploration.

The links between attachment theory and various developmental and relational approaches are continually evolving. For readers interested in further researching the roots of relational psychotherapy and exploring how these inform the theory and practice of relational body psychotherapy, the following are some of the significant contributors mentioned in this Bowlby monograph:

- **Mary Main** created the Adult Attachment Interview to study the unconscious processes that underlie the attachment styles identified by Mary Ainsworth in her Strange Situation procedure.
- **Daniel Stern** brought support from the perspective of infant observation and developmental psychology.
- **Beatrice Beebe** demonstrated that each parent–infant dyad creates a distinct system of mutual influence and regulation, which is reproduced in the narrative between adult clients and their therapists.
- **Susie Orbach** studied the body in its social context and considered the construction of bodily experience and sexuality in the therapeutic relationship.
- **Stephen Mitchell** proposed a *relational matrix* that links attachment theory to other relational psychoanalytic theories.
- **Allan Schore** presented important developments in the new field of neuropsychanalysis, describing the emerging theories of how in early life, the developing brain is shaped by attachment experiences.
- **Bessel van der Kolk** showed that posttraumatic stress is a developmental trauma disorder as well as a single-incident shock experience. He was the first to consider the impact of trauma on the entire person, integrating neurobiological, interpersonal, and social perspectives.
- **Arietta Slade** pioneered attachment-based approaches to clinical work with both adults and children, which include the development of parental reflective functioning, the relational contexts of play and early symbolization, and how the attachment system functions to regulate fear and distress within the therapeutic process.

The Hardwired Desire for Connection

In his presentation, Nick Totton defines what a grounded understanding of *embodied relationship* involves. We are born, writes Totton, with a hardwired imperative to form

relationships. Totton's *Embodied-Relational Therapy* (ERT) is an approach based on the perception that we are all embodied and relational beings and that to survive and thrive physically and emotionally, we need relationships with others in *all* stages of life. Bowlby had postulated: "While especially evident during early childhood, attachment behavior is held to characterize human beings from the cradle to the grave" (1979, p. 129). In line with Bowlby's thinking, Totton aims to move our understanding of embodied relationship beyond infant-focused early attachment to consider the nature of social bonding throughout the lifespan.

As do attachment-centered and relational psychoanalysts, Totton anchors his work in the fact that anyone who closely observes infants can witness their huge capacity and desire for connection. Anyone who has taken care of a baby has experienced the storms of grief and despair with which they respond to disturbances in relationship. Babies, writes Totton, arrive in this world eager and expectant to form relationships, expressing their eagerness through their gaze, facial expressions, voice, and movements. This eagerness is implicitly present in our bodies:

Our bodies tremble and vibrate with urgency to connect, soaring and swooping between peaks of bliss and troughs of agony and despair, visibly expanding and contracting with the responses we receive. These earliest relationships literally form and shape us and all our future relationships; throughout our lives we can experience the deepest wounding and the deepest healing in relationship. (2014, p. 43)

Our adult capacity for connection and attunement carries the imprint of our early attachment experiences. This is as true for psychotherapists as it is for their clients. The capacity for connection and attunement within a therapist–client dyad depends on each member's early attachment experiences; each dyad is unique. Consequently, it is important that relational body psychotherapists bring to conscious awareness their own early attachment and developmental experiences and the effect those experiences have on their adult capacity for empathy, connection, and bodily presence. It is essential for relational body psychotherapists to have an awareness of and openness to their own bodily experiences. Body psychotherapists, writes Totton, have hopefully worked through their own relationship with embodiment to the extent that they can regularly find comfort in it and communicate this comfort to their clients. Totton sees a therapist's capacity to track and use his or her embodied experience as the central competence to successful body psychotherapy:

. . . as practitioners we *commit* to our embodied response in order to form a living, two-way relationship, which becomes the crucible of change and growth. Our body bathes in

and soaks up the embodied presence of the client; we catch fire from them; we breathe them in and metabolize them; we reverberate to their rhythms, and our own rhythms shift to meet them. (2014, p. 44)

For Totton, embodiment and the relationship between client and therapist are inseparable and are vital elements of the therapeutic process. It is this state of "mutual co-arising where each continuously affects and conditions the experience of the other" that reveals the history, patterns, and belief systems at work. We need bodies to relate, and we need to relate to become embodied: relationships are first and foremost bodily events. Relationship requires a dance between two feeling bodies and two embodied psyches that create and condition one another.

Embodied Transference and Countertransference

Totton notes that transference and countertransference are bodily phenomena based on the implicit—that is, out of awareness—activation that allow us to create "an echo in ourselves of what we perceive happening in the other" (2014, p. 49). We are all familiar with the concepts of transference and countertransference. However, its *somatic* aspects are not as frequently discussed. *Embodied* transference and countertransference refer to the way clinicians and clients experience each other's physical states within their own bodies. Totton and Priestman write that:

Transference is thus not only a psychological, but also a bodily process, a function of implicit procedural memories of childhood relationships, learnt complexes of physical response held outside consciousness and in part repressed from consciousness. (2012, p. 39)

For example, beyond natural empathy, body psychotherapists develop their capacity to consciously track shifts in gut feelings, breath, heart rate, and bracing patterns both in their clients and in themselves. In conjunction with supporting their clients' ongoing emotional and cognitive reflective processes, relational body psychotherapists allow themselves to be guided by their own interoceptive body-based responses. Irish psychologists at the National University of Ireland (NUI) Galway and University College Dublin measured body-centered countertransference in female trauma therapists. Their research was based on the theory that to understand their clients' internal experience, therapists use their bodies somewhat as empathic tuning forks. Using the Egan and Carr Body-Centered Countertransference Scale (2008), they found high levels of the following body-centered countertransference experiences:

- Sleepiness

- Muscle tension, shakiness
- Yawning
- Unexpected shift in body, heart palpitations, sexual excitement
- Tearfulness
- Headache
- Stomach disturbance, nausea, churning stomach
- Throat constriction

Embodiment 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.

The Multidimensionality of Relational Body Psychotherapy

All human beings are impacted on a bodily level by the feeling states of others, whether they recognize them or not, whether they welcome them or not. How can relational body psychotherapists make a clear distinction between an upsurge of their own material for which they must acknowledge ownership and their internal experiences as a reflection of the client's material? What allows clinicians to assert with certainty that they are responding to their clients' arousal levels? For the relational body psychotherapist, making this distinction involves complex terrain.

Roz Carroll (2014) tells a story about neuroscientists Chiel and Beer who compared the feedback loops between the brain, the body, and the environment to the relationship between improvising jazz musicians. Brain and body, self and other, nervous system and environment riff off each other as do jazz musicians, influencing and responding to each other in a complex weaving of interrelated responses.

The jazz ensemble metaphor illustrates the understanding that a psychotherapy that would be relational and inclusive of the body is *multidimensional*. Relationality involves the capacity to think and hold multiple perspectives: to perceive the other's body and to feel one's own body as sources of emotional engagement without falling into the oversimplified view that the brain is the conductor of the orchestra or that it controls the actions of the body. Relational body psychotherapy must take into account the many dimensions of relationship:

- The internal relationship clients have within their own bodies and minds.
- The internal relationship therapists have within their own bodies and minds.
- The capacity for secure attachment and the quality of the relationships clients have with their loved ones, their environment, and the people they come in contact with, including their therapist.

- Therapists' own capacities for attachment and relationship in their own lives and with their clients.
- The dynamic interactions among all of the above.

From our perspective as clinicians, it is a complex and challenging task to listen simultaneously to the client's words, gestures, prosody, pulsations, movements, etc., while monitoring our own physiological and feeling responses, all the while formulating our thoughts within the context of an empathic understanding and developmental–relational framework. In addition, this multifaceted process, much of which happens outside of our consciousness, requires spontaneity and discipline, and involves sensitive timing skills that range from recognizing split-second perceptions to incubating slower reflective responses.

Touching the Relational Edge

*The road between vital experiencing and dying inwardly
is paved with disappointments in love.*

—Wilhelm Reich

Asaf Rolef Ben-Shahar, in his book *Touching the Relational Edge*, asks a simple but key question: "What is it that makes relational body psychotherapy different from other bodywork or body psychotherapy modalities?" (2014, p. 61). In the process of formulating an answer, Rolef Ben-Shahar gives us an in-depth understanding of the history, concepts, and methods of body psychotherapy. For this reason alone his book is a valuable contribution to the theory and practice of body psychotherapy: a gem for psychotherapists and psychoanalysts who want to orient themselves to the field of body psychotherapy, as well as for body psychotherapists who wish to have a clear overview of their field. As a result of integrating the features that link relational body psychotherapy and relational psychoanalysis, Rolef Ben-Shahar has developed a complex understanding of both fields; this allows him to raise important questions about the sometimes heightened, emotional charge that takes place in an embodied body psychotherapy practice:

- How important is the therapeutic relationship in body psychotherapy?
- How weighty are transference dynamics in the work?
- What is the role of the therapist in the therapeutic relationship?
- What complexities enter therapy when clients lie down on a massage table or a mattress, and may take off some of their clothes?
- What happens to the therapeutic relationship when touch is a possibility?

We have already considered some of the influences that connect relational psychoanalysis with body psychotherapy. However, before going deeper into Rolef Ben-Shahar's complex relational model, I want to briefly review some of these influences from his perspective:

- *The use of psychotherapeutic terminology.* Body psychotherapy was exiled from psychoanalytic practice because it did not fit the orthodox analytic principles of earlier times. Today, following the emergence of relational psychoanalysis, it can rejoin the analytic discourse and contribute valuable somatic skills and conceptualizations that support a greater integration of developmental psychology and neuroscience into clinical practice. Relational body psychotherapists use a terminology that is understood by the broader psychotherapeutic community and work to bridge the divide created by their distinctive embodied view of clinical interventions. They extend the expression of their professional expertise beyond what, in the past, has been the marginalized world of body psychotherapy and bodywork.
- *The centrality of the therapeutic relationship.* The therapist–client relationship is held as central to the therapeutic process. Therapeutic interventions stem from the client's needs, are mindful of the internal state of both therapist and client, and tend to the growing therapeutic relationship. It is the client's process within the therapeutic relationship that governs the use of bodywork techniques.
- *A two-person psychology.* Relational body psychotherapists work with transference and countertransference from a psychological as well as from a somatic perspective.

To quote Rolef Ben-Shahar:

The therapist is not perceived as an external spectator assisting the client's change, but an active participant in a process of change that takes place in the therapist as well. By recognizing that her presence impacts and creates change, the psychotherapist converses with her clients and discusses issues of influence and power between them rather than ignoring or avoiding such important matters. (2014, p. 61)

The Relational Matrix

Rolef Ben-Shahar (2014) proposes that meaningful relationships operate on four dimensions: a basic functional dimension, a more complex transference dimension, an empathic humanistic dimension, and a fourth dimension created by the interactions of the first three: *a relational matrix*. The following takes a closer look at these four dimensions of meaningful relationship within the therapeutic setting:

1. *A functional dimension.* Every relationship fulfills a need: we need to discover ourselves, we need to feel worthy, we need connection with each other, and we need to belong to a social structure. When two people enter a relationship, however simple or complex, the functional dimension is usually the first filter. The therapeutic question in the functional dimension is that of a service provider to a consumer: “*What can I do for you?*” In all relationships, the functional dimension requires some degree of mutuality in which service, interdependence, mutual needs, and utilitarian gain are exchanged so that both parties benefit from the interaction. In the same way, in the therapeutic relationship, the functional dimension requires mutuality: clients pay their therapist in exchange for attending to their needs, and in return therapists receive worth for their expert service. Therapists specify their functional rules: fixed time, set fee, cancellation policy. In turn, clients expect a positive outcome for their investment.
2. *A transferential dimension.* The psychotherapeutic relationship is an intimate connection in which clients talk about their deepest issues. They bring to sessions their past relationship history, in particular, the way they have internalized their attachment figures. In the transferential dimension the therapeutic issue is: “*Who are we to one another, and how did we come to be so?*” Therapist and client explore who they are to each other: parent–child, siblings, lovers, friends, abuser–victim, etc. What characterizes the transferential dimension is the willingness and commitment to name these influences and work with them consciously. The transference relationship is not symmetrical in that it has some power inequality; it is nonetheless a two-person mutual encounter that demands the full presence of both therapist and client. Within the transferential dimension, clients can revisit and reframe formative experiences by which their personality developed.
3. *A humanistic dimension.* In this dimension, there exist genuine moments of connection that take place beyond function, role, history, or transference. From a humanistic perspective, the therapist affirms: “*I am here with you.*” Whereas the previous two dimensions are asymmetrical and involve power differences, the humanistic dimension is a place of equality embracing and going beyond asymmetrical continuums. It is an invitation to relationship that demonstrates a longing within *all* human beings for connection. It touches into what Rolf Ben-Shahar (2014) describes as “surrender to a wider mind” within which it is meaningless to speak of me and you as separate.
4. *A relational matrix.* The surrender to a wider mind creates yet another order of connection: one in which relationships are, again quoting Rolf Ben-Shahar, “. . .

reciprocal and asymmetrical, saturated with transferential projections yet holding potential for true meeting of souls, full of implicit unspoken agendas yet embedding transcendence of ego-centered utility” (2014, p. 327). At its most profound, the therapists–client connection transcends the functional, transferential, and humanistic dimensions. These three dimensions, embedded in the heart of relational body psychotherapy and of relationships in general, form a matrix that is more than the sum of its parts. This matrix is multifaceted and inclusive of the therapist’s and client’s capacity for attachment, self-organization, mutual regulation, and agency as they engage their growing awareness and the re-creation of their world.

Mirror Neurons

Recognizing that observing the activity within one individual influences another’s nervous system was a startling finding that captured the relational imagination. Mirror neurons were discovered in the 1980s and 1990s by neurophysiologist Giacomo Rizzolatti (1996) and his research team at the University of Parma, Italy. Rizzolatti and his team studied the neurons that control the hand and mouth actions in the macaque monkey. They noticed that the same neurons that were active during grasping were also active when a monkey simply observed a researcher reaching for food. It was further observed that an emotionally meaningful stimuli was required for the mirror neurons to become active. A mirror neuron therefore, is a neuron that fires both during a subjective action, and when that same action is observed performed by another and has emotional meaning.

The existence of the mirror system has generated a great deal of excitement, research, and speculation. Functional magnetic resonance imaging (fMRI) research has not only shown that humans have a mirror neuron system but also suggests that they have a much wider network of brain areas with mirroring properties than was previously thought. This wider network includes the somatosensory cortex and is thought to allow an individual to feel an observed movement. Before venturing too far in conjecture, it is important to remember that mirror neuron research is still the subject of speculation and that widely accepted neural or computational models are, even now, in development in the scientific community. Nonetheless, this research is fascinating and the following list summarizes the hypotheses under investigation:

- Having identified brain regions that respond both to an action and to the observation of an action, researchers believe that the mirror system could be the physiological mechanism that couples action and perception.
- Mirror neurons allow us to understand other people’s actions and to learn new skills by imitation.

- By stimulating our observation of other people's actions, mirror neurons contribute to theory of mind and to the development of language abilities.
- The mirror neuron system helps us understand not only other people's actions but also their *intentions*: for example, discerning if someone picks up a cup of tea planning to drink from it or clear it from a table.
- Mirror neurons may be the neural basis of the human capacity for empathy, resonance, and even transference. Mirror neurons appear to be the physiological mechanism that allows us to identify with one another and to feel what the other is feeling in our own bodies.

The question as to whether we feel empathy, resonate, imitate, or simulate one another's behaviors is because of mirror neurons remains open. Nonetheless, empathy and resonance, independently of their connection to the mirror neuron system, are essential skills central to relational body psychotherapy.

Resonance

Empathy goes by many names: resonance, somatic resonance, attunement, entrainment, and vicarious introspection. Even though each of these states has distinctive attributes, they have enough similarities that they are frequently used interchangeably. They all refer to a natural transmission of sensations, visceral reactions, emotions, images, and thoughts from one person to another. Seemingly, the term resonance is widely used in body-centered therapy whereas empathy is preferred in psychotherapy.

The definition of resonance closely corresponds to Carl Rogers' definition of empathy: a primarily nonverbal and emotional experience during which the internal states of one person are sensed in another's body. Resonance is not only the domain of therapy: we all experience resonance in daily life. Loewald describes the process of therapeutic resonance:

The resonance between the patient's and the analyst's unconscious underlies any genuine psychoanalytic understanding and forms the point of departure for eventually arriving at verbal interpretations of the material heard or otherwise perceived. The analyst, during that internal journey, in his effort to stay sane and rational is often apt to repress the very transference-countertransference resonances and responses, induced by the patient, that would give him the deepest but also most unsettling understanding of himself and the patient. (1986, p. 283)

In the spirit of psychologist Edward Tronick and his colleagues (1998), who differentiated between individual and dyadic states of consciousness, Rolef Ben-Shahar (2014) further defines our understanding of resonance by proposing that we have two types of bodies:

- The first body is our skin-bound physical body: it is a closed system that does not require contact with another for us to experience it.
- The second body is an open system that only comes into awareness when we are in relationship with another. It comes to life—is switched on—by experiences of attachment and connection. This second body resonates when in dyadic states and is an aspect of the humanistic dimension of the wider mind. It is complementary and in dialogue with the skin-bound first body. (2014, p. 96)

Resonance is an excellent diagnostic tool that therapist and client can use to experience the relational field, particularly to bring to awareness nonverbal and unspoken communications. A useful working premise for the therapeutic use of resonance is to consider that as soon as we enter a mutual field with another, nothing purely belongs to us any more; when we are engaged in a relational field, thoughts, feelings, images, and sensations no longer arise in isolation.

According to Regina Pally (1998), mirror neuron and neuroscience research suggest a link between resonance and emotion. Not only does emotion coordinate an individual's relationship within themselves, it also helps to connect minds and bodies between individuals. Thus, as a biological regulating function within and between individuals, emotion is an important component of the resonance that facilitates social interaction. An authentic emotional engagement between client and therapist organizes their attachment experience and allows previously unformulated inner states to come into awareness. Healing takes place in shared and emotionally alive moments of meaning.

Cultivating Therapeutic Resonance

Using resonance therapeutically is a complex skill. Rolef Ben-Shahar suggests that resonance cannot be perceived cognitively but requires somatic attention: intellectual means alone do not give access to the capacity to be aware of the subtle currents of resonance. He writes:

. . . the main way to feel into the intersubjective space (and intersubjective body) is through body sensations. We feel our wider bodymind through our six senses (the familiar five senses and proprioception), through our own body. To simplify the argument: when we are attentive to our own bodies, we can feel the other alive and moving through us. This implicit knowing . . . is, so I believe, resonance—our connection to the other through the interface of our own body. (2014, p. 153)

Even though resonance is a natural phenomenon, body psychotherapists must consciously cultivate their relationship to their body in order to insure their safe use of resonance as a therapeutic tool. Courtenay Young explains:

The quality of this relationship to our body also determines how “embodied” we are; whether we truly inhabit our body, live in it fully and operate from the center of its being; whether we are aware of its subtle nuances and thus whether we use our body as a finely tuned instrument—and take care of it; or instead, whether we “use” it purely as a physical shell, an organic vehicle, to carry our head around, so that it is something that just needs to be fed, watered and maintained occasionally. . . . (2012, p. xi–xii)

Given that the greater portion of bodily communication is nonverbal, relational body psychotherapists rely on their personal relationship to their bodies to sense and feel their clients’ inner experience and receive their unspoken communications. Therefore, just as psychotherapists are required to undergo their own psychotherapy and analysts their own analysis to explore their patterns of thought and feeling, likewise body-centered psychotherapists must develop a carefully honed relationship to their bodies. In order to accurately observe a client’s body, to be aware of the somatic transference and countertransference, and to be present in the here and now with fitting somatic interventions, they must be attentive to and aware of their own sensory and energetic channels both interpersonally and intrapsychically. To meet the responsibility of working directly with a client’s body, body psychotherapists must know their own.

Compassion Fatigue

Therapeutic resonance does have its risks and when used unconsciously, can pose serious problems to a therapist’s well-being. Relational body psychotherapists, drawing heavily on neurologically based empathy and resonance, must be aware of the possibility of mental and physical exhaustion: They must pay attention to their level of compassion fatigue, to the exhaustion of burnout that can affect their quality of life, and to the more serious vicarious traumatization, that is, becoming infected by another person’s trauma. In her book *Help for the Helper* (2006), Babette Rothschild has laid out a sound program for concrete self-care strategies that help psychotherapists avoid the very real dangers of compassion fatigue and maintain their capacity to remain open to their clients without suffering the effects of vicarious exhaustion and traumatization.

Transference, Countertransference, and Body Psychotherapy

Following the realization that there is no such thing as an objective observer and a subject unaffected by the observation, modern physics has undergone a paradigm shift. The fact that it is not possible for an observer to observe a system without changing that very system brought into question the belief in rigorous neutrality, abstinence, and anonymity. As a

result, the approach of traditional psychoanalysts who see themselves as scientific observers of patients who are their subjects has come into question, as has the self-assured presentation of interpretations delivered in a manner seemingly without personal emotional response—as though the analyst were free of countertransference.

The need for a paradigm shift also applies to body psychotherapists who see the body as something to be "done to" and, working under the assumption that they know what their client's body needs, impose somatic interventions that are intended to break through body armor or somatic resistance. According to Michael Soth (2012), transference issues have not been sufficiently recognized in body psychotherapy. Soth believes that the traditional body psychotherapeutic agenda of breaking through body armor leads clients to experience their therapist as being like the very person against whom their armor was first developed; in psychoanalytic terms, the therapist is experienced as a "bad object." Robert Hilton (2012), co-founder of the Southern California Institute for Bioenergetic Analysis (SCIBA), notes that in many bodywork modalities, the presence of the therapist is not acknowledged since it is assumed that healing occurs by release of body tension and does not involve a relationship with the person facilitating the release. The early Bioenergetic model for example, did not allow for the mutuality of shared experience between therapist and client. The assumption that the body heals itself ignores issues of attachment. Working to awaken sensory-motor amnesia or facilitating the expression of blocked emotion does not replace a client's relational need for a "good object" with whom early loss can be repaired. From a relational perspective, the therapist is an integral part of the work. In the words of relational psychoanalyst Stephen Mitchell, "The emphasis is now on interaction, enactment, spontaneity, mutuality, and authenticity" (2005, p. ix).

Courtenay Young states what is perhaps obvious when he writes in the preface to his edited book *About Relational Body Psychotherapy* (2012) that in body psychotherapy, the relationship to the human body is not just a relationship to the client's body; the therapist also has a body. Young reminds us that including the therapist's body and how therapist and client relate to each other's bodies, is a relatively new focus. Transference dynamics between psychotherapist and client can no longer be discussed solely within an impersonal conceptual framework; there is an undeniable relational flow within the therapeutic interaction.

The complexity of the sensitive relational matrix has not been well understood by either psychoanalysts or body psychotherapists. The relational approach invites all 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. Hilton emphasizes that the therapist's authenticity is a key healing agent:

The countertransference of the therapist—how he or she influences the client or patient—is critical in this process of becoming. When the therapist experiences what he is trying to get the patient to experience, the patient gets better. This happens when the therapist can ask himself, “What feelings does this client create in me that I am resisting acknowledging? Is it fear, anger, sadness, longing?” And almost always that is the feeling that the patient is resisting experiencing with you. (2012, p. 2)

We all live within an energy matrix that is impossible to avoid and from a relational perspective, transference relationships are co-constructed. Everything we have experienced in our past relationships is present with us from the onset of any new relationship: we all carry our mothers, fathers, siblings, friends, teachers, heartbreaks, and expectations. Because psychotherapists and clients alike bring their past histories into sessions, the dynamics of transference and countertransference are inevitably present regardless of the therapeutic model used. Sharing, identifying, and disentangling past from present—clarifying the biographical matrix—becomes a process of collaboration to uncover the meaning that underlies transference patterns. It is ill-advised, indeed impossible, to treat transference and countertransference as separate issues. They are like the two faces of the same coin, inextricably bound to each other.

In the initial phase of therapy, clients learn to trust that their therapist will reliably hold their inner process. To heal their childhood wounds, clients seek a particular kind of relationship with their therapist; if the nature of the relationship is not addressed in ways that clients can use for self-recovery, they will find ways to adapt to the therapist's model just as they adapted to the dysfunction of their family system. They become the "good" client who does what is expected. A relational psychotherapist who is sensitive to the transference will sense clients' unmet needs, bring their internal working model to awareness, and challenge their misperceptions in the here and now. Relational therapists gently stretch their clients' ability to trust; they encourage them to explore the transference responses that are based on attachment and relational traumas—their expectations that the therapist will be critical, uncaring, and punitive, as well as their idealizations.

From the therapist's perspective, countertransference responses are no longer kept hidden. In the hope that new ways of being may be modeled, psychotherapists and body psychotherapists who practice from a relational stance are willing to be seen—to be examined and analyzed by their clients. Revising internal working models within the transference and countertransference dynamics helps both therapist and client expand their relational options. *The emphasis is on creating new relational patterns rather than on presenting interpretations intended to bring insight.*

Self-Disclosure

Relationality does not mean that self-disclosure is done without professional discernment, that therapeutic goals are neglected, or that it becomes a central focus in the therapeutic work. When to share, what should be disclosed, how much to share, and when to hold back are questions that need serious consideration. Hans Loewald (1986) wrote that freeing ourselves from the fantasy of noninfluence does not grant thoughtless sharing. A strong yet flexible therapeutic frame must remain along with the freedom to connect from the center of one's being. For example, how does a relational therapist respond when a client asks a personal question? There was a time when personal questions were reflexively turned back onto clients with comments about what these questions might mean to them. No longer a blank slate, relational therapists may choose to reveal some aspect of their lives, perhaps an arduous lesson learned through personal pain that can serve as a point of reflection or inspiration.

Google and the End of Anonymity

In this discussion on transference and countertransference, we cannot ignore the fact that Google, YouTube, Facebook, and all other forms of electronic connectivity have all but swept away the therapist's anonymity and attendant mystery and power. That clients now have access to Internet information about their therapists blurs the boundaries between the personal and professional and changes the nature of the transference relationship by putting therapist and client on a more even playing field. Googling, of course, goes both ways. Clients' electronic histories are also available to therapists, so the experience of evaluating a client with fresh eyes is coming to an end—further support for establishing a more mutual and relational basis for treatment.

The transparency of information now available serves as an antidote to authoritarian therapies and humanizes the therapeutic relationship. For many clients, having access to information about a therapist is liberating—rather like Dorothy in *The Wizard of Oz*, pulling back the curtain to discover that the therapist/wizard is a mere mortal.

On a different note, the ever-present electronic connectivity brings new appreciation for the privacy of the dialogue that is the heart of relational psychotherapy. The therapist's office offers a quiet place for intimate conversation, a place where secrets, reflections, fears, or confusion never leave the room and are never subject to a possible hacker's violation.

A Relational Bodymind Theory

To function in our ever-changing world, we work to create order out of seeming chaos; to reconcile our internal needs against the all-too-often-indifferent outer world, we impose our personal preferences on reality. In our attempts to create a safe life in which our needs are met, we set limits and we create personal boundaries; however, at the same time as these limits and boundaries protect us, they also limit our lives.

Informed by the philosophies of several major thinkers, in particular, by the formative psychology of Stanley Keleman (1985, 1987, 2012), Rolef Ben-Shahar proposes three major channels of organization through which human beings, for better or for worse, organize their lives: (1) somatic, (2) linguistic–cognitive, and (3) relational:

1. *Somatic organizations.* Somatic organizations—such as how we breathe, digest, think, and act—shape our very existence. Ideally, when we are somatically organized—when we are regulated and feel a sense of mastery in our body—we are flexible enough to respond and successfully adapt to the changing conditions of our inner and outer worlds. We are in harmony with our environment. Maladaptive somatic organizations create barriers that separate us from our experience, from relationships, and from our environment; they can become rigid character armor or they can cause retreat and collapse, further diminishing our responsivity and our aliveness. Rolef Ben-Shahar points out that working with somatic organizations and the knowledge of how to reorganize maladaptive somatic patterns are probably two of the most important contributions body psychotherapy has brought to the broader field of psychotherapy.
2. *Linguistic and cognitive organizations.* Language is another way we organize our world. The ability to organize the narrative of our personal story is a marker of successful development. For example, individuals who enter therapy with a disorganized, difficult-to-follow narrative also usually struggle with an associated fragile sense of self and inability to differentiate feelings from thoughts. Our sense of reality and our cognitions are interactively informed by our linguistic development and allow us to (a) make distinctions between what is real or illusive; (b) continually reorganize what is meaningful to us; (c) orient ourselves to the past, present, and future as well as to self and other; and (d) mediate between the flux of reality and our capacity to contain and tolerate its flow.
3. *Relational organizations.* The success or failure of our early attachment process becomes the relational matrix that continues to influence our adult reality. Throughout life, notes Rolef Ben-Shahar, engaging in relational shifts, that is, participating in and leaving relationships, is an important means of developing our identities:

The qualities of our identity-formation and our ego-strength are dependent on our capacity to open to different orders of relationships, to surrender our individual self to the creation of a dyadic self, a familial or organizational self, and a social self. Our character, personality and identity are therefore in ongoing dialogue with our real and internalized attachment figures. (2014, p. 83)

Unless we learn to consciously open to the wealth of relational possibilities available to us, we remain encased within the limitations of our childhood attachments. Expanded forms of relationship are challenging to those who exist within rigid skin boundaries that sharply separate them from the world around them and do not give them access to the wider relational mind.

Thus, relational body psychotherapy presents a theory of bodymind organization that sees the body as engaged in an ongoing dialogue that includes somatic flow and pulsation, cognitive organization, and relational interdependence. It neither attempts to reduce therapeutic work to cognitive insight in the hope that new awareness will somehow materialize into connection, nor does it impose somatic interventions in the hope they will transform into consciousness.

Emergence

Emergence phenomena are at the heart of relational therapeutic approaches. The concept of emergence is used in various sciences, but the focus here is on its significance as it manifests in the therapeutic relationship.

The principle of emergence refers to something new and unexpected that arises out of a collaboration. An emergent structure arises as a result of *the combined focus of individuals working together*. Emergence requires interactive cooperation; it does not appear when individuals act independently of one another. Relational interactions set in motion a complex chain of processes leading to the appearance of a new order that is more than the sum of its parts. Physician Fritjof Capra explains: “Emergence results in the creation of novelty, and this novelty is often qualitatively different from the phenomena out of which it emerged.” (2002, p. 36)

The Emergent Self

When an organic process such as a relationship reaches a high level of attuned interaction, new, original, and unpredictable characteristics, that were not present before the interaction began, appear as emergent qualities of Self. Emergence is neither causal nor linear; for

example, a mind that emerges from a body cannot be explained only in physiological or neurological terms—it requires more complex circumstances that include, among others, secure attachment, supportive education, creative dynamic interaction within attuned connection.

Broken, betrayed, abused, or neglected attachments trigger conditions that preclude emergence; instead, they foster an absence of connection, the disappearance of self, and the withdrawal from embodiment. This departure from connection is the very opposite of creative emergence.

Facilitating healing change involves being present with clients as they explore and engage in loosening their rigid states and awaken to their own capacity to open to unpredictable new ways of being. Emergence arises out of a necessary suspension of belief in one's old ways, along with the faith that inviting attuned relationship and opening oneself to bodily experience will bring a positive outcome. It necessitates letting go of fear, control, or vigilance to allow the emergence of new experiences that can potentially bring gratifying expansion. Rolef Ben-Shahar (2014) describes this process as a *surrender to flow*, a process in which client and therapist together safely deconstruct rigidities, learn to tolerate unknown factors, and invite new organization, thereby opening to emergent dimensions of self. Because the surrender to flow is potentially risky, frightening, and disorienting, the guiding presence of an attuned therapist is a key factor. No one changes in isolation; a relational therapeutic setting offers a context wherein clients no longer do it all by themselves.

Healing the Capacity to Love

In an interview with Nancy Eichhorn (2012), Robert Hilton spoke about the relational needs that accompany the development of the Self:

I find that, when my clients are facing the breakdown of their usual patterns of self-organization, they need me to hold the experience for them. They need to feel that I am present, *in just the way they need me to be*. They then have the freedom to find a new form of grounding and integration. (p. 31, emphasis added)

Relational psychotherapists engage their clients' desire to recover their capacity to love and be loved by modeling for them, in real time, the experience of empathic and attuned connection. Therapy, said Hilton, is not about technique, it is about relationship:

I knew, in some profound way, that I was to be a model for how she could be with her own pain. She was asking me to bear this pain of love and helplessness that she could not bear herself. I was now willing to be with her in her pain and not try to "fix" her. (2012, p. 29)

Hilton (2012) explained that early bodywork modalities did not provide a bonding experience because it was believed that the body healed itself through releasing tension; therefore, working with the therapeutic relationship was not considered essential to the healing process. For example, although the Bioenergetic model acknowledged that our original pain was due to a loss of love, it did not address the client's need for loving contact in the processing of that early loss. Hilton admitted that in his early years of practice, he repeated what he had learned from his trainers; he turned his clients' needs back on them and reinterpreted their needs through their character structure. Over time, he realized that he was using his training to conceal his feelings of inadequacy as a person, in fear that he would be found wanting. In this process, Hilton learned the following:

All of our interactions with each other are relational and somatic but not all of our interactions are therapeutic. They become therapeutic when we are able to incorporate the experience of love within them. To get there we must constantly open ourselves to the expression of our anger, grief and longing. We can only do that if in fact someone cares deeply enough about us to join us in that journey. (2012, p. 5)

When relational body psychotherapists look at a body, they see the vestiges of the struggles to love and to be loved that implicitly remain in the tissues, organs, postures, sounds, and movements. With open heart, they share in the client's loss, realizing that it is when two people are attuned that they experience positive emotions, whereas it is their misattunement that gives rise to feelings of distress. Relational models, writes Hilton, "at their best, represent our meager, human but heart-felt attempts to reunite mind, body and soul and, in so doing, recover what we once had, or longed for and lost" (2012, p. 34). He writes poignantly of his first-person perspective of this work:

I am a privileged partner in another person's journey of life. My task is to wait, watch and wonder at the mystery of another being, like myself, in their struggles to be who they are or want to be. From this perspective, I have a deep felt body compassion for my fellow sojourner, which I describe as love. (2012, p. 5)

Hilton has found that far from fostering dependency, clients who no longer panic about abandonment or fear interpersonal engagement inevitably move into the next phase of their individuation: They want to explore and test themselves in the world. When the therapist is present to somatically and emotionally "authenticate and hold the ground of their experience" (p. 31), they can tolerate the feeling of being on shaky legs and shaky ground as they explore the unknown.

In Conclusion

The Dalai Lama, in his book *From Here to Enlightenment* (2012), weaves his teachings around the theme of *dependent arising*, the belief that all things arise and exist only through deep interconnections; everything exists through its connection to and dependence upon other things. Love, compassion, and kindness all depend upon the experience of our interdependent relationships with one another. In this vein, Rolef Ben-Shahar offers the following moving passage that speaks to the healing potential of relational body psychotherapy:

The rupture of life occurring when the hand that feeds us is the same hand that deeply harms us, and threatens to destroy us, is irreparable for the child. The very core of organization, of identity, of self-sense, is torn apart. . . . It leads to a chaotic life of isolation and fragmentation, when life and love themselves are associated with fear and death. . . . The way back home, through the slow recreation of secure attachment, through the gradual separation of love from hate, from harm, goes through the body. Two people touching; two people are reminded of life, and hopefully, choosing to say yes, to allow it in, to embody it fully, to connect. . . . I am hopeful in witnessing how love can penetrate the most painful and damaged of places, and remind it of life; that attachment and connection can reach beyond psychobabble and diagnoses, beyond pathologies, and through defenses, and touch it. (2012, pp. 261-263)

We hunger for the symbiotic connection that offers a place we can call home; we long for the heart-centered surrender that gives us relief from isolation. Yet, at the same time, we value our distinct individuality and we brace against surrender for fear that we might lose control of ourselves and our environment as an extension of ourselves. Our identity is therefore poised between the pulsation of expansion, by which we turn toward a loving other, and the contraction or retraction into isolation, by which we move away from a hurtful other. We must bring to consciousness how we live within the continuum of these two relational opposites.

The art of relational body psychotherapy is steeped in loving-kindness and compassion. Anchored in attachment and object relations theory—in the generation of a secure base—relational body psychotherapy brings knowledge of body-centered maturation that offers reparative experiences on verbal and nonverbal levels for *all* stages of development, at *all* stages of life. The therapeutic commitment is to the relationship; to the capacity of the

therapist and client, together, to deconstruct the traumatized attachment patterns of the past; to the ability to construct new attachments in the present that can stabilize the disappointments, protests, and rage that arise as clients contact early abandonment, abuse, and/or neglect; to the trust that this therapeutic relationship will be strong enough to recognize and repair whatever arises. The therapeutic work takes place in two languages: the explicit language of words and the implicit wordless language of the body, in which preverbal and nonverbal experience are embedded and to which the therapist and client listen to hear what the body knows that the mind cannot say. Thus relational body psychotherapy is not a set of somatic techniques "done to" clients, but an alive, pulsing, and breathing interplay of moment-to-moment presence and mutual emergence active on somatic, cognitive, and relational levels.

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