

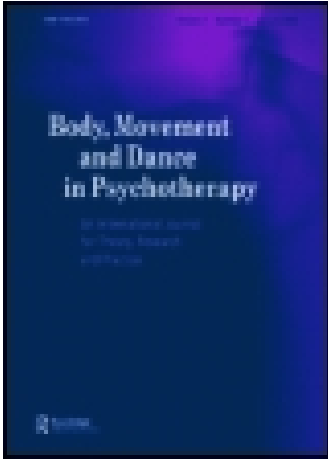
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Body psychotherapy for the treatment of severe mental disorders – an overview

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The evidence base for the effectiveness of body psychotherapy (BPT) in the treatment of severe mental disorders has improved much over the last decade; both methodologically robust randomised controlled trials and also qualitative studies demonstrated how BPT can contribute substantially to the treatment portfolio and help address chronic conditions and disorder-specific psychopathology. This paper summarises how BPT is utilised for the treating a range of severe mental disorders including mania and schizophreniform psychosis, personality disorder and severe anxiety as well as depressive disorders. The intervention strategies are related to specific body-oriented phenomena, i.e. disturbances of body experience and body-mind regulation disorders; the approaches are described in the context of a new theoretical paradigm of BPT as embodied and embedded relational psychotherapy, aiming to facilitate improved self/affect regulation. For each specific illness, a short sketch of the cardinal symptoms and body image phenomenology is followed by a summary of disorder-specific intervention strategies of BPT for severe mental illness.

Keywords: body psychotherapy; mental illness; psychosis; depression; anxiety; personality disorder

Introduction

The body-oriented psychotherapeutic treatment of severe mental illness (SMI) has a long and controversial tradition with regard to scientific theory and practice orientation (e.g. Geuter, *in press*; Heller 2012). At the beginning of the last century, 50 years before the introduction of the first psychotropic drugs, and particularly inspired by the increasing popularity of psychoanalytic theory, there was a lively and creative struggle for psychological treatment strategies for severe mental disorders. The advent of the ‘neuroleptic era’ with subsequent discoveries of other psychotropic treatments and, in consequence, the relatively speedy remission of florid psychotic symptoms heralded the age of biological psychiatry, later referred to

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as ‘the decade of the brain’. Consequently, interest in novel psychological therapies declined. Following the introduction of cognitive-behaviour therapy and family therapy into the portfolio of mental health care for SMI patients and because of ongoing problems with lack of response to somatic treatments, the last decade saw renewed and growing efforts to evaluate alternative psychotherapeutic approaches, particularly with respect to the therapy of psychosis, chronic conditions and personality disorders.

The theoretical underpinning of body psychotherapy (BPT) shifted away from a drives and energy model of (Neo-) Reichian therapy towards a model of embodied and enacted relational psychotherapy (e.g. Röhricht, Gallagher, Geuter, & Hutto, 2014), hereby moving the focus of attention in therapy towards both the experiencing of the self and the relevant interactions with others (and corresponding regulation dynamics). Bower and Gallagher (2013) refer to processes of ‘sensory-motor coupling’ between organism and environment.

Disorder-specific intervention strategies are based upon a novel paradigm with respect to the nosological categories used to distinguish between types of SMI: Fuchs and Schlimme (2009) and Röhricht (2011) describe mental illness as disorders of embodied self-regulation with distinct consequences for intercorporeity (being with others). Applying a basic phenomenological approach of functional psychopathology, I distinguish three main groups of disorders:

- Embodied disorders (the body as source of suffering: e.g. severe Neurosis).
- Alternating and instrumentalised body-mind regulation: PD, Eating Disorder.
- Disembodied disorders (the body in passing, the dissociated body: Psychosis).

BPT employs different, syndrome-specific approaches for the treatment of those three main groups, aiming to facilitate improved body-mind self/affect regulation.

According to most recent reviews of the literature (Loew, Tritt, Lahmann, & Röhricht, 2006; Röhricht, 2009), the current evidence base for body psychotherapy in the treatment of SMI can be summarised as follows: BPT seems to have generally good effects on depressive and anxiety symptoms, somatisation and social insecurity. Patients who are treated with BPT appear to benefit in terms of improved general well-being, reduced motor tension and enhanced activity levels. There is substantial evidence for the efficacy of Functional Relaxation on psychosomatic disorders (asthma, tension headache, irritable bowel syndrome) and evidence from one randomised controlled trial (RCT), that Bioenergetic Analysis may be specifically effective for somatoform disorder patients (Nickel et al., 2006). At least three RCTs have demonstrated that chronic schizophrenia patients with predominant negative symptoms respond to manualised BPT (or body-oriented psychological intervention strategies such as movement therapy), improving patients’ psychomotor behaviour and social as well as emotional interaction; a multicentre trial across the UK will be completed in 2014 (Nitsun, Stapleton, & Bender, 1974; Priebe et al., 2013; Röhricht & Priebe, 2006). The most recent pilot RCT of body psychotherapy in chronic depression demonstrated good effects in comparison with a waiting group receiving treatment as usual only, despite the fact that the participating patients had more than 10 years of ongoing severe symptoms and even though both pharmaceutical and other psychotherapeutic treatments failed

to improve their conditions (Papadopoulos & Röhricht, 2013; Röhricht, Papadopoulos, & Priebe, 2013).

Treatment concepts for specific disorders

Principles for BPT interventions of specific disorders have been identified in recent publications, both on the basis of distinct body psychotherapy schools and corresponding practice variation (see book edited by Röhricht (2012): 'Disorder specific concepts in Body Psychotherapy', in German) and integrated overarching perspectives across schools (EABP science and research committee; e.g. Röhricht, Gerken, Stupiggia, & Valstar, 2013; Röhricht, Butler, et al., 2014).

In the following, the disorders are introduced in relation to their distinctive, disease-related characteristics. A short sketch of the cardinal symptoms and body image phenomenology is followed by a summary of disorder-specific intervention strategies of BPT for SMI conditions.

I would like to point out that reference to the confusing diversity of body psychotherapy schools seems quite irrelevant for the purpose of this article, especially as much of the available literature on BPT in SMI is integrative in concept and with regard to the therapeutic practice. Body psychotherapy interventions for SMIs operate across the aspects of perception, affect/emotion, cognition and movement; they are specific to the disorder, developed based upon the clinical phenomena and the subjective experiences of the patients. The interventions aim primarily for symptom reduction, improvements in patient's subjective quality of life and reconsolidation of functional capacities. At the same time, BPT works in the context of individual narratives and, in the case of individual therapy, is centred on biographic and functional self-exploration. Geuter (in press) emphasised the central importance of exploration of body experiences in BPT for self-experiences. BPT is hereby oriented towards the patient's ability to foster, enhance and improve affective self-regulation processes. With respect to the phenomenological focus, I will refer to those specific psychopathological symptoms for which a body psychotherapy strategy can be developed, i.e. disturbances of body experience (see Priebe & Röhricht, 2001; Röhricht, 2011; Röhricht, Beyer, & Priebe, 2002; Röhricht & Priebe, 1996, 1997). BPT interventions are also used increasingly integrated with and provided as part of mainstream modalities (especially in analytical or in depth psychology methods – e.g. Geissler, 1998; Moser, 1989 – but more recently also in the context of cognitive behaviour therapy approaches – e.g. Klinkenberg, 2000), but that cannot and should not be the issue here.

Disorder specific intervention strategies of BPT for SMI

Disembodied disorders (the body in passing, the dissociated body: Psychosis)

Mania (and bipolar disorder)

These affective illnesses have been practically disregarded in the development of psychotherapeutic techniques; non-pharmaceutical interventions are therefore mostly limited to supportive therapy and psychoeducation. Paykel and Scott (2009) summarised the evidence as follows: 'Psychotherapy has not been evaluated in manic patients and the benefit in bipolar disorder is for relapse reduction when

delivered during euthymia' (p. 677). Also, there are no identifiable publications in the body psychotherapy field that explicitly address this type of condition, even though body therapies such as movement and sport therapy and relaxation techniques are recommended for Bipolar Disorders in the German 'S-3 guidelines [Leitlinien]', an official body comparable to the UK National Institute for Clinical Excellence.

From a clinical perspective, and on the basis of theoretical considerations, e.g. the psychodynamic connection between depression and mania (keyword: manic defences), we can identify potentially useful body-oriented intervention strategies, directly aimed at core symptoms such as psychomotor hyperactivity. This is not – as is psycho-pharmacologically customary – primarily directed at suppressing the agitation and tension, but tries to help patients facilitate the expression of motor impulses related to underlying needs/motivational drives and exploring meaningful and more effectively regulated alternatives. Manic impulses/behavioural tendencies are often reinforced by the ever-increasing level of psycho-pharmacological suppression in a kind of vicious circle. This can result in rather bizarre conditions, in which the patient is 'numbed' or 'frozen', but at the same time is mentally fighting against being quieted down. One could also deploy psycho(bio)-dramatic role playing, which enables manically-ill patients to confront themselves with the various aspects of their dys-regulated body-self, aiming to develop gradually a range of alternative and corrective body experiences. As for symptoms such as excessive speech and thought disorders, focusing techniques (Gendlin, 1996) and/or exercise sequences from Concentrative Movement Therapy¹ (e.g. Schreiber-Willnow & Seidler, 2013) can be utilised with a view to supporting the rebalancing of impulsive and restrictive tendencies.

Schizophrenia spectrum disorders

This very heterogenic group of mental illnesses is characterised by a disorder of identity, a dissociation of psychic processes, such as hallucinations, delusions, depersonalisation, affective symptoms such as parathymia and blunted affect, formal thought disorder and psycho-motor disturbances. Although descriptive psychopathology pays little attention to it, the phenomenon of disturbed body experiences in schizophrenia is clinically significant to the point of describing schizophrenia essentially as a 'disembodiment disorder' (e.g. Fuchs & Schlimme, 2009; Röhricht, 2011). This is especially important in the light of theories that regard schizophrenia as a severe disorder of the ego/self, e.g. Sass and Parnas (2003) 'a self-disorder or ipseity disturbance ... that is characterized by ... hyperreflexivity and diminished self-affection' (p. 427).

Specific disorders of the experience of the body have been identified empirically in schizophrenia: centralised body schema with underestimation of the lower extremities and a corresponding disturbance of the body image, cenesthopathy (qualitatively abnormal body feelings) and – less specifically – loss of the boundaries of the body and desomatization (Fisher, 1986; Priebe & Röhricht, 2001; Röhricht & Priebe, 1997).

The principles of body-oriented psychotherapy for schizophrenia are related to the concept of 'ego consciousness' with an emphasis on disintegrative tendencies as

described by Scharfetter (1981, 2003) and the essential phenomenological features of disembodiment as described above. The intervention strategy is primarily focusing on ego-reconstructive measures, assuming that an integrated, basic embodied self serves as a prerequisite for further self-development and adequate (functional) self-management. In a next step, the patient's body can be utilised as a medium for reality checking and as an anchor point for connection to the world. It is important to bear in mind that the direct reference to the body always constitutes a balancing act for schizophrenia patients; the body as the location of perceptive and affective experience serves as not only the basis of the relationship with the world, but also the experiential site of the conflictual or traumatic and threatening aspects of embodied connectedness.

On a subjective level, the disintegration process (disconnectivity syndrome) tends to be experienced in the form of intense existential fear (of annihilation); patients perceive a lack of ego-coherence with weakened self-boundaries as well as feelings as if the self can be controlled from the outside or invaded by external forces. This is one of the main reasons why these patients suffer from severe ambivalence conflicts when it comes to social contact, which is all the more significant when the contact is physical. Often patients are withdrawing from social contexts in an attempt to preserve the most fundamental aspects of a core self. This withdrawal response involves also aspects of the bodily self, resulting in centralised body schema with neglect of the body periphery (constituting dissociation on a bodily level). So, in BPT we must modify our treatment techniques considerably to suit these special requirements for this patient group. Essentially, the strategy of body-oriented therapy is based in the initial phase on the principles of sensory self-awareness, grounding and mirroring or of moving supportively with the patient, which means to follow the postures and movements of the patient directly and creatively in the sense of providing an auxiliary or supportive ego function, supported by the use of various objects. This is mainly work on the surface of the body to improve the awareness of boundaries and also work on the joints or the transitions between the segments to encourage the experience of inner coherence.

As for the disorders of body experience mentioned above, BPT employs strategies of guided perception, sometimes including external stimulation with balls or natural materials, introducing a range of tactile sensations with which patients can compare the experience of induced actual bodily sensations, serving as a real counterbalance to the predominance of abnormal body experiences. This can be differentiated further individually in therapy, for example with regard to the delusory significance connected to the bodily experiences. For instance, hallucinations can be transformed into movement or specific dance segments, thus substantiating and materialising them, whereby they become more of an integrated aspect of the self, losing influence and power and/or the patient becomes less afraid of them. Many movement exercises help patients to strengthen their autonomy in action. BPT works on issues related to the centralised body schema, both through exercises stimulating the surface of the body, and through cycles of expansive movements (stretching and extending laterally and vertically), whilst working with external objects as a comparison. Also, modelling body-image sculptures from clay creates a visible and tangible corrective; it allows psychotically-ill patients virtually

to materialise their most personal self-experiences, to confront in reality their way of relating to the body and then to question and correcting it gradually over time.

The central principle of BPT treatment of disorders of ego-vitality is to focus on body rhythms (breathing, circulation, etc.). Also non-specific physical activity promotes the perception of liveliness and an improved ego-vitality. Tactile self-exploration, guided and commented by the therapist, addresses aspects of not only ego-vitality but also ego-demarcation. Disturbances in ego-coherence or ego-consistence can be treated in BPT with guided whole-body movements (e.g. various balancing exercises, balancing a sand sack on the head whilst moving about the room or balancing the body weight in a circle with ropes, working with large parachutes). The experience of an integrated and functioning body 'gestalt' can hereby be used as a centre of experience, around which the ego/self can organise itself. Dance movement psychotherapy interventions are likewise especially suitable, as the focus is often on coordination and the flow of movement (e.g. Karkou & Sanderson, 2006). Ego identity disorders respond well to visual exposure with whole-body mirroring. Here too, recognising parts of the body as belonging to oneself can be utilised with graded exposure.

A clinically significant syndrome, which has a decisive influence on the prognosis of schizophrenic illness, comprises the phenomena summarised under 'negative symptoms': emotional and social withdrawal, psychomotor retardation, blunted reduced affectivity. These behaviours may well be regarded as a dysfunctional coping strategy in relation to an otherwise overwhelming, unbearable range of external (social/environmental) and internal (unpleasant bodily sensation/cenesthesias) stressors/stimuli (see Röhricht, Papadopoulos, Holden, Clarke, & Priebe, 2011). The main goals of BPT in chronic negative schizophrenia are (1) body-oriented interventions which aim to reconstruct a basic and coherent ego-structure through grounding and body self-awareness, strengthening self-referential processes and hence ipseity ('mine-ness') as a prerequisite for safe social interaction; (2) to widen and deepen the range of emotional responses to environmental stimuli on the basis of enhanced contact with one's own bodily reality with physical anchor points in the external world and (3) to help patients explore a range of expressive and communicative behaviours (movement and speech) in order to reduce emotional withdrawal and improve affective modulation. In the framework of body dialogues, it is often much easier to establish a positive, non-threatening social contact and ultimately trusting therapeutic relationship.

Embodied disorders (the body as source of suffering: e.g. severe Neurosis)

Severe depressive disorders

These (hyper-embodied) illnesses are symptomatically determined by pervasive feelings of grief, loss, hopelessness, loss of interest/drive, thought blocks and a multitude of bodily-vegetative symptoms (loss of vitality, functional organic disorders such as somatoform pain, low muscle tone, inhibited gait and motor retardation – occasionally also agitated psychomotor activity). There are specific forms of depression featuring mainly with bodily symptoms (masked depression). In addition, empirical studies show a pronounced negative assessment and preoccupation with the body as failing, negative (affective) cathexis/satisfaction

(Angsman & Schroer, 1983; Marsella, Shizuru, Brennan, & Kameoka, 1981; Röhricht et al., 2002). Patients suffering with depression often emphasise in their biography narratives suggestive of childhood neglect or abuse, and these histories have been found to be associated with the risk of clinical depression in adulthood and treatment resistance in depression (e.g. Chapman et al., 2004; Kaplan & Klinetob, 2000). Emotional neglect includes either a lack of parental care for the fulfilment of basic needs such as nurturing, attachment and acceptance and corresponding deficits with low self-esteem (accompanied by an increased preoccupation with the body as a burden, negative connotations) or a lack of autonomy in the context of parental over-protectiveness (which can result in distinct inhibition of the child's expansive motoric impulses). From a BPT perspective, these processes can be observed on a somatic level: e.g. muscular hypotonia in the neglected child versus hypertonia and successive shortening of those muscle groups of the extremities nearer the torso in the over-protected scenarios.

The literature on depressive disorders does not explicitly or systematically refer to a body-mind nature of depressive syndromes and with the exception of mindfulness-based cognitive behaviour therapy/mindfulness-based cognitive therapy the treatments focus either entirely on verbal interventions or on physical interventions such as exercising.

The projection of negative cognitions or unconscious conflict into the somatic sphere is also under discussion as a component of the manifold bodily symptoms of depressive patients; important in learning theory is the so-called 'cognitive triad' (Beck, 1967) with negative attributes or expectations towards the (body) self, the world and the future, and the model of 'learned helplessness' shows the successive exhaustion of mental and biological coping mechanisms. In the extreme case of a dynamic psychotic derailment, the body can be experienced as dying or dead. Co-morbid symptoms of anxiety are often related to the body in the form of hypochondriac complaints, when in extreme cases patients voice the conviction, that they are severely (or even terminally) physically ill. General principles in body psychotherapy for depressive disorder have been identified, encompassing the following main components (Röhricht, Butler, et al., 2014):

- Explorative movements, exercises and increased sensory awareness (to address lack of affect and reduced psychomotor activity – lack of drive/initiative).
- Techniques derived from neo-Reichian BPT, movement psychotherapy and psychodrama: exploring, enacting, revitalising and transforming, particularly suppressed negative/aggressive impulses, especially those featuring as self-destructive/suicidal tendencies; enhancing patients' affective modulation, psychomotor expressiveness and fostering healthy self-regulation.
- Interventions focusing on bodily strength, capabilities and other healthy resources, aimed at rebalancing patients' negative self-evaluation, strengthening self-demarkation.
- Working against gravity (physically and metaphorically) to counteract feelings of heaviness and the unbearable weight of emotional/mental pain.
- Body-oriented psychological work directed towards biographical backgrounds with a specific focus towards unmet physical/emotional needs,

nourishment and traumata (i.e. separation/loss), enabling patients to identify how self-destructive tendencies are diverted from external objects in order to identify a range of more constructive responses and solutions.

On that basis, more specific phenomenon-oriented body psychotherapy treatments for severe depression can be distinguished for three different clinical manifestations:

1. *Adynamic, inhibited conditions with profound sadness or feelings of insensitivity, psychomotor retardation and lethargy, with oral deficits and depressive (dependent) personality structure*: The guiding principle for therapy here is the resource-oriented strengthening of the person's self-potential, the developing of a forward-oriented and uplifting ('aggressive') position and a shift of emphasis away from 'taking' towards 'giving'.

BPT for this depression subtype focuses on working with facial expression and behavioural/interactive gestures in order to enhance the range of affective expression and muscular tone (e.g. working in front of a mirror or with feedback on guided alternative behaviour). Enactments ('bio-drama') help connecting with lived experiences; a variety of different scenarios is addressed within group therapy frameworks in particular, enacting primary feelings (such as joy, grief, anger, surprise, disgust with corresponding facial expressions and body gestures), using voice intonation and other expressive body language exercises for further exploration. The direct and careful use of tactile stimulation, such as massage techniques (only with the consent of the patient), as well as the directly aimed interventions on the skeletal muscles in the context of exercises conducive to emotional expression, are further important components in developing a position, that allows accessing a range of emotional states, particularly more negative feelings. At the same time, exercise sequences from play therapy and sport therapy (especially the use of balls in various ways), furthers the awareness of patients' physical potential/strength, which creates an important counterbalance to the cognitive knots of negative (bodily) self-images. Here, dance movement psychotherapy elements are also important, in which the patients at first just sense their body rhythms (pulse, breathing), and are then guided into contact with musical rhythm or movement impulses (e.g. Lewis, 1986). With regard to the (often indirectly expressed) demands for attention and the tendency towards symbiosis and dependent life structures, it does seem important to help patients experience these hidden impulses through expressive gestures (demands) in their (interactive) body schema (e.g. reaching-out or begging gestures or expressing desire through the eyes).

Patients with dominant hypertonic–hypertrophic physical defence structures, whose adynamic position is a result of chronically suppressed mobility (see above: a depressive pattern in response to overprotective parenting behaviour) could be treated in the sense of strengthening their own mobility and autonomic movement impulses as well as expansive motoric movements, so that patients can develop greater confidence in their own physicality: for example, slowly accentuating movements into the room, movements directed upwards against gravity and clinging to the ground, or symbolically against lingering in the 'morass' of the (maternal/paternal) body space, as for example through hopping and jumping, all of

those integrated with biographic narratives as they emerge in the therapeutic process.

When working with individual psychodynamic patterns or biographies in individual sessions, BPT often uses exercises that have an emotional, expressive character as a starting point for further exploration. Through the confrontation with the physical experience of the bodily expression of the feeling of hopelessness and the accompanying tendency to sink into resignation, the patients can build up somewhat paradoxically tension with the potential to be used for other patterns of movement. In this way, they can make contact both with the emotional-affective content of the underlying conflict (e.g. oral deficits), as well as with the suppressed psychomotor reactions to it (e.g. 'crying'/reaching out for help).

Agitated-aggrieved condition with severe crises of self-esteem and self-degradation

The basic BPT principle here is characterised by an effort to achieve a position of 'needs fulfillment' and BPT works particularly on the patient's tendencies to act out their narcissistic anger against the self, and thus to ward off the feelings of grief.

In the therapeutic process (particularly in group therapy), the focus is on the positive intensifiers of the bodily realities, such as gestures of (self-) respect, or relaxation exercises to reduce the arousal level or to make room for other, i.e. sad and needy feelings. In psychodrama activities, the patients can enact their self-(body) posture, which again, when paralleled in their individual therapy, is helping patients to recognise and reflect on their underlying conflicts more explicitly, embodied and experientially.

Condition of dynamic, psychotic derailment

This clinical syndrome is characterised by feelings of insensitivity/lack of vitality, nihilistic and inhibited thought schemata, delusional hypochondria and guilt feelings. Here, the body psychotherapist must be much more active and directive in the therapeutic process and should endeavour to 'relieve' the patient of his unbearable state of mind, as much as possible; this can be achieved for example with exercises where the patient is encouraged to let go of his weight, for example by leaning on/towards someone or an object, seeking containment and support physically and metaphorically. Also, the therapist will often offer emotional containment through guidance. BPT is aiming to re-establish secure anchor points within (body-) reality and can raise activity levels, hence potentially amplify suicidal tendencies to a level, where the patient may act on them. Therefore, it is essential that the patient with psychotic depression is continuously observed and also questioned about any self-harming or suicidal thoughts and tendencies.

Breathing exercises are used to treat severe disorders of ego vitality and external tactile stimulation – always administered with an attitude of respectful attention and following explicit consent – plays a major role here as well. Once a containing therapeutic relationship and basic grounding has been established and reality testing is improved, the experienced BPT therapist can use guided interventions leading to a regressive re-experiencing of the essential, unsatisfied primary needs; the group can function here as a 'good family' environment and thus allowing for a kind of

symbolic (wish-) fulfilment and induce important emotionally corrective experiences.

Severe anxiety disorders

This group of mental illnesses includes conditions with dominant free-floating anxiety, phobic anxieties and feelings of panic, often accompanied by considerable adverse effects on patients' social life (avoidant behaviour with emotional and social withdrawal). Similarly to the depressive disorders, anxiety disorders feature as hyper-embodied disorders with numerous physical sensations which can be described as 'somatic anxiety equivalents'; moreover, circumscribed disturbances in body experience are also reported by these patients (Röhricht et al., 2002), mainly negative body cathexis and body image disorders (weakening of body boundaries and somatic depersonalisation).

Psychological, psychodynamic models refer to repetitive traumatic memories, especially existential threats experienced in early childhood, as, for example, the lack of fulfilment of basic needs or separation/abandonment experiences or overstimulation due to the intensity of exposure to threatening or even dangerous situations, both resulting in conflict between dependency and suppressed anger (e.g. Busch, Milrod, & Singer, 1999). In later stages, the dynamics that underlie the primary fear and corresponding anger responses will be suppressed (e.g. embodied response schemes, basic motor impulses), then leading to the transformation of concrete fear into nameless anxiety. Thus, within the theory of depth psychology, anxiety is understood as the consequence of an unsuccessful, neurotic conflict resolution (possibly with weak and unstable primary ego functions). From the perspective of learning theory (e.g. Beck & Clark, 1997), other processes such as the conditioning of fears and phobias are more important; above all, the conditioning of negative learning experiences through intensifying mechanisms (e.g. physical symptoms of anxiety) with an assumed amplified sensitivity to stimuli or a biologically based oversensitivity to anxiety provoking stimuli (lower thresholds), associated with a range of (often avoidant) responses (e.g. overview of contemporary learning models in anxiety disorders; Mineka & Zinbarg, 2006).

Whilst body therapies aim to reduce stress levels associated with heightened anxiety through, e.g. aerobic exercises or relaxation techniques, BPT engages patients in relational embodied psychotherapy in order to address the complexity of underlying biographic narratives and corresponding psychological and somatic processes. General principles in body psychotherapy for anxiety disorder have been identified, encompassing the following main components (Röhricht et al. 2013):

- Initially in BPT, therapeutic engagement is facilitated through exploration of body experiences and movement/breathing pattern; particular attention is paid to bodily equivalents of anxiety such as muscular tension, increased heart rate and hyperventilation. BPT in anxiety relates to the common denominator of hyper-arousal whilst exploring a range of alternative expressive behaviours relevant to the neuropsychological axis 'fear-flight-fight-withdrawal/learned helplessness'.

- Based upon psychodynamic roots in BPT this includes careful clarification of traumatic memory backgrounds and personal deficits as trigger factors for what patients experience as unrealistic, unfounded fear. It is based on the observation that root causes have been dissociated, separating subjective feelings from physiological reactions.
- Clients are guided towards improved reality testing through grounding movements, establishing a firm 'stand' in the world. This enables individuals to relate to anxiety-provoking thoughts/experiences from a position of self-awareness, tolerating and enduring anxiety without being 'overtaken' by it, fostering experiences of reliability of their own musculoskeletal system and the weight-bearing capacity of the floor.
- BPT facilitates shifting of (holding, inward bound) breathing/movement pattern, suggesting a range of expressive body movements (supportive, releasing, directive, etc.) and rhythmic integration. Interventions include direct body-contact (self-soothing/protection/shielding) as well as exercises aiming to confront the perceived threat/aggression/danger in self-defence. This process enables re-evaluating reality on a complex conceptual and organismic level, whilst the anxiety syndrome was bound in negative self-evaluations and dis-empowerment. Hereby, emphasis is given to 'normalize' anxiety symptoms as a necessary, natural and functional part of organismic functioning, basic to encounter the threat of (inter)personal damage.

In the sense of a guideline to the embodied psychotherapeutic process for anxiety disorders, the principle of a modified exposure treatment is important (in the form of a psycho-/biodramatic re-enacting of the situation, which causes/triggers the anxiety and allows for subsequent exploration of corresponding bodily responses/expression). Often, this leads to dealing with aggressive emotional and behavioural content and the therapist's task here is to transform negativity into productive action tendencies (from latin 'aggredi' = to approach, 'gradus' = a step, therefore forward going in the most positive sense of the word's meaning). Working with breathing pattern helps accordingly to shift emphasis from 'holding back' to 'letting go' and expression: patients are encouraged and guided towards perception of their breathing pattern, acknowledging how often the emphasis is on breathing in and holding breath with a tendency towards hyperventilation in the context of panic disorder/attacks; forced exhalation can help releasing perceived pressure.

Another focal point of BPT in anxiety disorders is concerned with the maturation process of weakly developed ego functions and low self-esteem, which are often found in people of an anxious disposition. Here, we can employ for example Bioenergetic treatment techniques (such as grounding and falling exercises), tactile-sensory self-explorations and physical endurance training, to mention only a few. Less indicated – although sometimes recommended – are, in my opinion, methods that promote contemplative relaxation, as this can reinforce the experience of passivity in the face of a threatening situation. Instead, we endeavour to mobilise and successively re-establish active reaction patterns in order to rebalance the overdeveloped psycho-physiological arousal levels.

Patients can practice self-defence and protective as well as confidence gestures, which can be used in individual therapy in confrontation or exposure to the

anxiety-triggering stimuli (e.g. support exercises, imagination: 'Journey to my Strengths', ritual dances to 'banish' fear).

Over the course of psychodynamic background work, it can be useful to personify the anxiety in role-playing (e.g. placing the fear in one's opposite number or therapist). In view of the fact that anxiety usually manifests itself in complex, social situations, the therapy group can be used as an important framework for social experiments (see the 'support-confront', 'catwalk' or 'jostling' exercises – Görlitz, 1998; Röhricht, 2000 – for working with social phobias). In therapies that work almost exclusively on the verbal level, it is difficult to deal with unconscious 'frozen' anxiety, which usually manifests as phobic avoidant behaviour. If, however the patient is 'well-grounded', then it is possible to mobilise the affective material through BPT methods (e.g. hyperventilation techniques or the dyad exercise 'shock-shield-face', whereby the partners sit opposite each other, hands in front of their faces with the fingers spread out, making the impression of a combined shock/protection reaction). Other ways of achieving more conscious awareness of avoidance behaviour are those interventions whereby the muscular-postural schemata (observed by the therapist) are reinforced or over-accentuated and so become very clear (see also progressive muscle relaxation, which has been modified for our purposes here).

Personality disorders

This collective term comprises a group of exceedingly heterogenic mental disorders that are often difficult to distinguish from one another, and before the introduction of the diagnostic classification used today, were described in the literature as 'psychopathy', 'character neurosis' or even 'core neurosis'. I will only make a few general remarks on the use of BPT for these patients, given that there is so far only a very limited body of literature and no evidence from clinical trials. The vast majority of hitherto published information on BPT for personality disorders refers to borderline and narcissistic disorders. For these illnesses, a fragile ego structure is described, based upon dysfunctional developments during early preverbal stages or premorbid deficits. Those structures are characterised by an unclear or weakened sense of body-ego boundaries, lack of coherent self-identity and corresponding difficulties in affect- and self-regulation within social contexts. BPT strategies that seek to foster ego-maturation processes retrospectively, with non-verbal communication/interaction/empathy at its heart, can intervene here. A basic therapeutic attitude of empathy and support is specifically important whilst working with these patients; sometimes the therapist will provide functions of an auxiliary ego. Maaz (2006) describes this process whilst differentiating different structural levels of ego-development; with respect to low structured levels, he emphasises that the therapist must avoid fostering strong transference and calls the therapist's required attitude in this phase 'human embodied empathy' with respect to patients' profound needs for protection and nurturing. During the initial stages of therapy all interventions, that explore or mobilise feelings, or are aimed at a cathartic discharge, should be avoided as there is not enough ego control available to integrate the experiences. These patients (especially those with schizoid personality disorder) have not been able to extend their self-awareness adequately to the periphery of their

bodies and often present with a profoundly contracted basic posture, a manifested splitting-off in their experience of the body (right/left, horizontal/vertical, above/below) and an unstructured (fragmented) occupation of the body. Therefore, the use of integrative BPT techniques seems well indicated here: regulation of closeness and distance behaviour, encouragement of 'vessel-forming, containment oriented' (Schroeter, 1994) and movement patterns that help establish a secure contact with the ground/the environment. The splitting experiences of the patients are directly addressed (e.g. through specific verbalisation of the perceived distance between feeling and body, between the central parts and the periphery of the body, emphasising the difference between 'doing/acting' and 'perceiving/being'). Therapists will support patients in gradually recognising emotions through affective equivalents in expressive behaviours and in a second step re-possessing one's own emotions instead of projecting them into mental states of others. This is best provided within group therapy, so that other fellow patients can act as more neutral points of reference for the exploration of physical contact. Only on the basis of a previous improvement in the basic foundations of embodiment, can the therapist start to address the specific biographic context in individual therapy. Themes of primary rejection, threats to life and experiences of physical violence, basic abandonment and the corresponding flip side of merging fantasies are addressed. The process involves engaging with often severe, negative affects (self-harming, destructive or disintegrative tendencies including 'murderous' rage) in a regulated, channelled and systematic manner, so that patients can articulate them safely and then integrate them into a more coherent self-experience. Such a process presupposes that the therapist possesses a great deal of experience and structuring ability, so that he/she can contain the formidable tendencies of the patients towards disintegrative acting-out.

Summary, conclusion and outlook

A number of significant developments within the humanities and neurosciences, findings from psychotherapy research and the growing evidence base for the efficacy of body psychotherapy in the treatment of severe mental disorders have firmly established body psychotherapy as an important modality in the mainstream landscape of psychotherapy treatments. The recent literature (e.g. Gallagher, 2005; Hutto & Myin, 2013; Koch, Caldwell, & Fuchs, 2013; Röhrich, Gallagher, et al., 2014; Varela, Thompson, & Rosch, 1991) points towards a necessary shift away from a notion of representational and computational processes as building blocks of the 'mind' and emphasises instead increasingly the notion of embodied and environmentally-embedded cognition; neuroscience established the basic facts of neuroplasticity and how change processes in psychotherapy require simultaneous addressing of cognitive, perceptual affective and motor processes in order to impact upon the reorganisation of neural networks.

This goes in parallel with developments in the field of applied clinical BPT: the intervention strategies are now more specifically tailored to address disorder specific pathologies across perception/emotion/cognition and movement, whilst retaining their resource-oriented focus and a personal-growth strategy as a modality within the field of humanistic and relational psychotherapy.

Manualised intervention strategies have now been developed and are available for research and practice. Different to the range of talking therapies, BPT manuals are based upon an analysis of specific body-mind regulation pattern that developed in response to primary and secondary conflicts/problem constellations. BPT helps addressing those patterns of affect- and self-regulation in a holistic and comprehensive manner, offering new approaches to working with complexity and chronicity in mental health care of patients with SMI.

Clearly, BPT has its limitations and does not provide answers for all unresolved psychological or body-mind problems, and according to the principle of matching of therapists and patients characteristics, it works better for some than for others. As it is the case for all other therapies, BPT has potential side effects (e.g. overstimulation/flooding of emotional experiences, weakening of impulse control under certain circumstances) and contraindications: depending upon specific characteristics of the illness, the provisions of the treatment setting and the environment, and the individual background of the therapist some patients are not suitable for this experiential approach or require substantial adjustments of the intervention strategy. The following groups of patients are in my opinion not suitable for body psychotherapy treatment in an acute psychiatric state: patients with acute manic disorders in which self-control is impaired; patients with personality disorders, when the impulse control is underdeveloped and who have an observable tendency towards ‘acting out’ behaviours; acute suicidal patients; and patients with schizophreniform diseases, when a severe disorder of the ego structure or disorganised behaviour determine the condition.

It is conceivable how the growing evidence base for the effectiveness of BPT could place this psychotherapy modality alongside the other well-established main schools (psychodynamic, cognitive-behavioural and systemic, possibly humanistic). Another possibility is that the general trend towards an overarching, modular and disorder specific ‘general psychotherapy’ (Grawe, 1995, 2004) will lead to a new research focus on interventional specificity for certain therapeutic processes and responses. The techniques employed by body psychotherapists could feature centrally in such an integrative approach that goes beyond traditional psychotherapy schools. Future research in that respect should focus more upon the dynamics of specific therapeutic change processes, aspects of the therapeutic relationship and the matching between patients and therapists characteristics and expectations, on specific syndromatic outcomes in relation to intervention strategies and potentially also include patients choice of modality as an important mediating factor on outcome.

Finally, I would like to point towards suggestions to consider more radical changes to the way psychotherapy is practiced and evaluated: based upon a conceptualisation of BPT as applied embodied cognition, both researchers and practitioners started to explore new ways of therapeutic embodied engagements, ‘while casting fresh light on how therapists can successfully venture into the everyday life of their patients and their interactions with significant others’ (Röhricht, Gallagher, et al., 2014). In that respect, BPT with its emphasis on embodied and embedded intersubjectivity may pave the path for a new paradigm in psychotherapy research and practice.

Note

1. Concentrative Movement Therapy/CMT is a form of Body Oriented Psychotherapy, mainly practiced in German speaking countries, based upon a psychodynamic model and focusing upon body perception as composed of sensation and experience (concentrating on the conscious perception of the body in the ‘here and now’ and relating those experiences to biographic backgrounds of the individual’s narratives).

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