22

"Body Schema," "Body Image," and Bodily Experience

Concept Formation, Definitions, and Clinical Relevance in Diagnostics and Therapy

Frank Röhricht, United Kingdom

Translation by Warren Miller

Frank Röhricht is a consultant psychiatrist, head physician, and clinical director at the Newham Centre for Mental Health in London. He is a Body Psychotherapist and was trained in Neo-Reichian (Integrated Body Psychotherapy) and psychodynamic approaches. His extensive research and publications on the phenomenology of embodiment and Body Psychotherapy strategies of intervention for severe mental disorders are an extraordinary contribution to the field of Body Psychotherapy. His dissertation was on the topic of "Body Schema and Body Image and Their Relationship to Psychopathological Symptoms in Patients with Acute Paranoid Schizophrenia." He is also a member of the EABP Scientific and Research Committee, and he has led randomized controlled trials (RCTs) that demonstrate the efficacy of Body Psychotherapy intervention techniques on patients with chronic and severe mental illness, i.e., in schizophrenia, chronic depression, and somatoform disorders.

Currently, Professor Röhricht continues working in this area of research in association with the Universities of Essex, London, Dresden, and Munich, making him one of the preeminent researchers in the area of body image phenomenology in mental illnesses. His book on Body Psychotherapy (Röhricht, 2000) is the first textbook on the application of Body Psychotherapeutic methods in psychiatry. Additionally, he is a co-founder of the Dresden workgroup "Body Image / Body Psychotherapy," which works to foster dialogue between academic research and clinical practice.

He holds honorary professorships at the University of Essex (Centre for Psychoanalytic Studies) and St. George's Medical School, University of Nicosia/Cyprus; he is a Fellow of the Royal College of Psychiatrists, and a member of the German College of Psychosomatic Medicine, as well as the director of the science and research division of the German Association for Body Psychotherapy. His teaching experiences include teaching courses in psychiatry for postgraduates and numerous presentations at symposiums and conferences, a background that explains his matter-of-fact academic language.

Since the term "body schema" was first introduced to scientific literature more than a hundred years ago, a multitude of body-related phenomena have been gathered under this heading. Increased efforts toward demarcation of the term have begun only since the 1990s. For the German-language area, a consensus paper on terminological definitions and differentiation of distinct aspects of bodily experience was recently worked out (Röhricht et al., 2005). The difficulties in defining these terms can be viewed as stemming from the fact that this endeavor evokes the mind/body problem—the subject of an ongoing philosophical and epistemological debate—and touches on fundamental

questions of human existence (Röhricht, 2000). From the perspective of Body Psychotherapy, the engagement with this dimension of self-experience is practically relevant in two ways:

1. An operationalized, descriptive, and content-analytic description of the different aspects of bodily experience lends itself as an intervention-specific criterion of Body Psychotherapeutic evaluation for purposes of diagnostics and psychotherapeutic research.
2. Going with the general trend in psychotherapy practice and research to focus on specific disorders and associated phenomena, Body Psychotherapy can be utilized as an essential tool for orientation in the identification of patterns of disordered bodily experience.

Survey of the History of Concept Formation and Definitions of Associated Aspects

As early as the beginning of the 1930s, Conrad (1933) identified problems in the inflationary use of terms that aimed to describe the phenomenon of the perception of the body and concluded that clear terminological definitions were to be found only in rare cases. Meermann finds: "In regard to the terms body image, body schema, body perception, -ego, -self, -fantasy, -concept, etc., the scientific literature is characterized by nearly 'Babylonian' terminological confusion" (Meermann, 1985, p. 5).

A neurologist, Sir Henry Head, first described the term "body schema": at the beginning of the last century, Head (1920) used the term to conceptualize a function of the central nervous system—namely, the postural orientation of one's own body. According to Poeck and Orgass (1963, p. 539), the term referred to the neurophysiological phenomenon of a "spatial image of one's own body," developing "on the basis of tactile and kinesthetic sensations that accompany the initially automatic movements of the child in its first months of life." Poeck and Orgass (1963) furthermore cite writings by Bonnier (1905), who, even before the turn of the millennium, supposedly postulated a sense of space ". . . in which all parts of the peripheral and central sensibility jointly contribute to define the objective and subjective orientation." The conceptual images of one's own body that emerge in this way are structured schematically, based on neurologically patterned memories and information from stimuli that are organized by the physiology of perception. This definition of the "body schema" term was expanded upon by Head (1920), who postulated the "existence of organized models of our body" that prescreen, filter, and evaluate incoming sensory impulses, and thereby serve integration. Among these models, the postural scheme forms the basis for the perception of positions, movement directions, and postural tone; and the superficial scheme (body surface scheme) forms the basis for an exact localization and discrimination of stimuli. Poeck and Orgass (1963) summarize this theoretical perspective, emphasizing how the concept is to be understood in a physiological sense, as ". . . a standard that any stimulus can be compared with before entering consciousness"; they cite Head's comment, ". . . the schema contextualizes a sensation in its relationship to the body as a whole, before it reaches consciousness" (Ibid., p. 539).

Subsequently, all developments of the concept of sense perceptions that followed have been contextualized by this schema, while also simultaneously driving an ongoing reorganization of this schema. Paul Schilder (1935/1978) transformed and further developed the body schema concept by adding a psychological-psychoanalytic dimension, emphasizing the term "body image"; the introduction of the body image concept, however, seems to have paved the way for the previously mentioned "Babylonian terminological confusion."

Hartmann and Schilder (1927) drafted the body schema concept as the "image of one's own body, which is alive in us." The introduction of a subjective experiential reality that this alludes to is mirrored by the formation of "body image" as a term. Hartmann and Schilder (Ibid., p. 667) described a "spatial image" and a "representational image that everyone has of themselves." In this context, the authors speculated about the interplay of spinal and cortical centers with images of childhood memories. Drawing on psychoanalytic

libido theory, they assume that ". . . affective-libidinal factors influence the body schema. Federn is to be endorsed when he emphasizes that awake people too, depending on their drive-disposition, will experience particular parts of the body schema in particular ways."

Following Hartmann and Schilder, the expansion of the body schema concept, through the addition of the psychological dimension, is carried forward without terminological differentiation from the neurophysiological concepts of Poeck and Head (see above). Among others, Conrad points out the mix-up of the "body as subjectively experienced phenomenon on the one hand, and objective reality on the other." Then he claims to take the concept of body schema another step forward, prefacing his definition by stating that "this consciousness of one's own embodiment must be an expression of a holistic process in the truest sense of the word, and therefore be subject to the laws of Gestalt processes" (Conrad, 1933, p. 367).

Conrad viewed the consciousness of one's own embodiment as a unity as the *a priori* constituent and, via associating of concepts, he comes close to Head's notion of "preconscious schemas" while including the psychological dimension introduced by Schilder. Conrad's definition is as follows: "Consciousness of one's own body as a foreground before the background of the field of awareness and action as a whole, in the wider sense of gestalt psychology" (Ibid.).

With the introduction of the body image concept, Schilder created the possibility of a terminological differentiation between two different dimensions of bodily experiences. Federn picked up on this possibility in the 1950s and—in reference to Freud—introduced another term—namely, "body ego." Following Federn, the body schema represents a ". . . mental knowledge of one's own body; the body image is the changing mental representation of the body; and through all changes the body ego is the ongoing sense from the body" (Federn, 1952, cited by Meermann, 1985, pp. 14–15).

Joraschky (1983) defined "body ego" as the representation of experientially processed bodily experiences. In reference to Federn, Kiener (1974) defined the "body ego" as an agile spatial figure that essentially is characterized by a sense of "me," ". . . belonging directly to my self," and "suffused by me (my soul)."

Kiener published his examinations of body image (*Untersuchungen zum Körperbild* [Studies in Body Image]) in 1974 and differentiated between "body schema," "body image," and "body ego." The interactions among these matrices are sketched out as follows: "Although normally the body ego has the same figure as the body and shows the same expansion as the body schema, body ego and body schema are not identical; the body ego is that part of the body schema that is experienced bodily as 'myself'" (Kiener, 1974, pp. 335–336).

Meermann (1985) operationalized the term "body schema" for his disorder-specific, phenomenological examinations as the ". . . ability to accurately estimate the distance between bodies in reference to one's own body," and in his definition he referred essentially to Shontz (1974) and Kolb (1975). They differentiated four matrices: "body schema," "body self," "body fantasy," and "body concept," which they all subsumed under the general heading of "body image." The body schema matrix here is viewed as a stabile foundation for the other matrices of bodily perception, which in turn have a modulating effect on the body schema.

Baumann (1986) presented the term "body schema" from the perspective of kinesiology and cited the foundations of Ungerer's (1958) movement theory, which posit as prerequisite ". . . that prior to movement execution there must be a representation of the body, that is, of the body in its parts, and their position, organization, and expansion in relation with another."

An example for the psychoanalytic understanding of the term can be found in Torres de Beà's article "Body Schema and Identity" (1987). It becomes apparent that this perspective shuns a terminological differentiation of different aspects of bodily perception, as (for example) Shontz proposed under the heading of "body image," in favor of an understanding that encompasses all experiential domains (cognitive as well as affective). In his definition, he refers to De Ajuriaguerra and his contribution to *The Body Percept:* "He deemed it as the result of the cognitive and affective

organization of the person and pointed out the relationship between 'body schema' and the concept of identity, which follows the undifferentiated phase of ego-development" (De Ajuriaguerra, 1965, p. 175, my translation of the original). De Ajuriaguerra goes on to say that the body schema initially represents an undifferentiated body. As development proceeds, it is transformed into the representation of an articulated body, which not only is characterized by boundaries and surfaces, but also envelops "*particular contents,*" organs and differentiated segments with specific functions. The psychoanalytic perspective of the genesis of the body schema significantly differs from the concepts presented earlier; it is shaped by developmental psychology and comes to describe the body schema development in analytic fashion: ". . . the body schema of the child begins as preconception . . . in the mind of its parents. The sources of the body schema lie in these significant processes of development and differentiation" (Ibid., p. 176, my translation of the original).

The body schema is here viewed as a "representation of the body in the mind" and as such meets the psychoanalytic criteria of an "inner object." Plassmann describes the "function of the body as primary object" in a fundamental and guiding way: ". . . there is an accumulation of indications that support a primacy of bodily experience, that is, the function of the body as primary object. Possibly elementary, bodily based perceptions such as the phenomenon of being alive or embodied-being itself, are the very first contents (introjects) of the psychic apparatus, which constitute the very core of a subsequently much more differentiated self concept" (Plassmann, 1993, p. 263).

New impulses for the conceptualization of bodily experiences as constituents of self-(awareness) and interrelatedness are emerging within the field of (embodied) cognitive sciences. Fonagy and Target (2007) summarize from a psychoanalytic perspective: "A second aspect of the embodiment approach in cognitive science is the emphasis on the sense of having an extended self. This connects a perception of self with one's environment, culture, and history. Moving from the physical experience of being in and part of a world, the template extends to incorporate the construction of an autobiography and engagement with historical cultural narrative systems." Implicit memory systems (with their emphasis on procedural learning, nonverbal behavior, and emotional processing) serve as a central nervous substrate for the storage of embodied, biographical narratives. Between the subjective and objective poles of ambiguity, of the body as subject and object ("to be and to have a body"), corporeal memory systems span across all aspects of bodily experience (perceptual, cognitive, affective, psycho-motor, and self-reflective consciousness).

Bodily Experiencing and Diagnostics

The particular perspective of (psycho)therapists taking note of the bodily experience of their clients has diagnostic relevance. The specific history-taking in pre-therapy pays attention to significant events and facts: current physical complaints, illness, relevant previous physical health problems, operations, accidents and traumas (e.g., sexual/physical abuse or other physically traumatizing incidents), current and previous somatic treatments, important bodily experiences (e.g., processes in puberty, changes following pregnancy, relevant weight changes, etc.), and noticeable behavioral problems during childhood, such as stuttering, bed-wetting, prolonged thumb sucking, etc. Actual bodily realities and habits are also captured systematically: dietary habits, personal bodily hygiene, clothing, bodily activities (sports or gymnastics, exercising, etc.), sexuality, body contact, tics and ritualistic body-related habits, self-harming behavior, drugs and alcohol, and other toxic inputs.

Apart from collecting the biographical data of a client's individual bodily history, a body-oriented anamnesis (patient's history) can explicitly examine various aspects of bodily experience and gather further important information for a comprehensive problem analysis, an assessment of conflict-specific habitual reactions, and treatment planning. Body-related phenomena can be viewed not only as somaticized symptom formations of complex psychic processes but, further, as entry points for related therapeutic efforts. Analogous to the psychoanalytic process that captures information for interpretation from free-floating

verbal association, the therapeutic information gathering in Body Psychotherapy often starts with an exploration of feelings, thoughts, and attitudes as expressed through body awareness and movement. Observational categories include preferences, expression of needs, significant observations regarding any mismatch/incongruence between verbal and nonverbal contents, and behavioral coping strategies (such as adaptation or avoidance). Therapists pay attention to significant statements relating to the body such as: "My head is too heavy for my body"; "I found it difficult to relax in that particular situation"; "I felt uncomfortable to say no, and that made me feel tense around the shoulders"; "It was like hitting the wall"; "I feel like being wrapped up."

A brief, cursory overview outlines the disorder-specific peculiarities in the bodily experience of different groups of patients against the background of the currently available literature. These findings from descriptive, phenomenological psycho-pathology research allot Body Psychotherapy a particular methodological advantage, as it can draw upon body-based and/or related nonverbal intervention techniques, and therefore can offer creative therapeutic answers in response to these somatic phenomena. Specific assessments of bodily experience are called for to systematically assess this dimension of the disorder (i.e., questionnaires, self-assessments, projective and perceptive procedures, movement analysis, etc.). A further refinement of such instruments toward the development of practical, short versions for everyday practice is currently still outstanding. Relevant literature references and thoughts on specifically Body Psychotherapy treatment approaches can be found comprehensively in Röhricht (2000, 2009a) and in Chapter 70, "Body Psychotherapy for Severe Mental Disorders" by Frank Röhricht.

Mood Disorders

Depression

People suffering from depression experience the following range of symptoms, often leading to a significant reduction in their overall quality of life and psycho-social functioning: loss of ability to experience pleasure, inability to initiate and conduct activity, and negative and suicidal thoughts. Bodily vegetative symptoms feature centrally: disorders of vitality feelings, complaints of organ dysfunction, decreased muscle tone, and depressively inhibited—or also, but rarely, agitated—psycho-motor presentation. In addition, psychotically depressed patients suffer from body-related delusions with the following dominant themes: illness/death, contamination/soiling, functional disorders of body parts, and fragmentation; perceptual disorders comprise mainly experiences of "blockages" and "pressure."

Those symptoms are often associated with a corresponding set of bodily symptoms/somatic complaints, including severe fatigue, motor weakness, back and chest pain, headaches, gastrointestinal problems, etc. Phenomenological research identified specific patterns of body image aberration in depressive and anxiety disorders—i.e., patients displayed significantly higher body dissatisfaction scores, negative body images with boundary loss and somatic depersonalization, and a higher number of physical complaints as compared with other groups of patients (e.g., Marsella et al., 1981; Priebe and Röhricht, 2001; Röhricht et al., 2002). In relation to Laban's conceptual analysis of movement framework (North, 1972), anecdotal evidence in the literature suggests that there tends to be either a lack of engagement with the efforts in depression, resulting in passivity in relation to flow, time, weight, and space; or a predominance of the "yielding" efforts (free flow, sustained time, indirect space, and light weight) rather than the "fighting" efforts (bound flow, sudden time, direct space, and strong weight) (Stanton-Jones, 1992). Other research with a specific focus on the analysis of gait pattern and body posture in depressed patients similarly identified reduced gait velocity, increased standing phases, and slumped posture, with reduced vertical movement of the upper body (Wendorff et al., 2002; Michalak et al., 2009).

Physical complaints and body-related phenomena are now regarded as "common presenting features throughout the world" (Bhugra and Mastrogianni, 2003). The link between depressive symptoms and bodily experience suggests that Body Psychotherapy can be particularly effective in improving depressive symptoms (see the results

from a recent randomized controlled trial: Röhricht et al., 2013).

Mania

There is a relative paucity of research on bodily experiences in mania. Symptom descriptions include somatic phenomena as follows: psycho-motoric hyperactivity; body-size overestimation / expansive body schema, often pertaining to the hands; in psychotic states, patients describe somatic delusions and hallucinations (dominant theme: pregnancy); and abnormal bodily sensations / cenesthesia (flowing, burning, fluctuations in temperature).

Anxiety Disorders

Body-related phenomena in anxiety disorders differ little from those of depressive disorders, which leads to the question of a nosological commonality (cothymia concept); anxiety symptoms often manifest as a somatic "anxiety equivalent" (e.g., hyperventilation, thoracic tightness, globus, shaking, sweating, rapid pulse, etc.); also: body-boundary disorders, and de-somatization. Specific results from phenomenological research can be identified as follows: body perception is negatively correlated with anxiety levels (Röhricht and Priebe, 1996), a phobic anxiety-depersonalization syndrome has been identified (Noles et al., 1985), body image satisfaction is low in anxiety patients (Marsella et al., 1981; Löwe and Clement, 1998); from a clinical perspective, therapists often describe a so-called "Bermuda Triangle": anxiety–tension headache–anger.

Eating Disorders

Ever since the early work and publication by Bruch (1962), clinicians have been focusing on severe distortions of body-size perception as one of the main diagnostic criteria in anorexia nervosa (this is included as essential diagnostic criteria in ICD and DSM classification systems). Despite partially contradictory results from studies, the finding of disturbed body-size perception has also been identified as a significant prognostic predictor for the course of treatment; patients with significant overestimation of body width—in particular, in the area of the face, the trunk, and the thighs—tend to have more severe and chronic manifestations of the illness and/or relapse more frequently (e.g., Keel et al., 2005; Bachner-Melman et al., 2006).

Furthermore, bodily symptoms include identification with skeletal appearance; panic fear of the state of "being fat"; bizarre bodily perceptions in immediate relation to the taking in of food; and, in regard to the motor domain, hyperactivity with excessive sports/training, lack of the experience of tiredness, and denial of bodily weakness.

A summary of the literature on bodily experience in eating disorders (Röhricht, 2008) as a guiding source of information for the development of specific Body Psychotherapeutic strategies is as follows:

- General dissatisfaction with bodily realities and negative judgments regarding body weight, body proportions, and general appearance, associated with lack of self-esteem, uncertainties in respect of self-evaluation, low mood, and feelings of anger and disgust toward one's own body. A pervasive feeling of failure and bodily incapability (body image and cathexis aspects of bodily experience).
- Anorexia nervosa and bulimia nervosa patients overestimate all body dimensions, despite visual control and external corrections. The body-size estimations are characterized by bizarre and unstable judgments (perceptual aspects of bodily experience).
- The body is perceived often as alien, passive, and at times lacking in vitality, which often results in somato-psychic depersonalization. Patients suffer from obsessional focusing on negative body images, body control, and body weight (affective/cathexis aspects of bodily experience).
- The body is experienced as an unpredictable object and hence is constantly exposed to attempts of regaining control; this is often accompanied by an avoidant and controlling behavior pattern in respect to personal hygiene, clothing, social interaction, sexual behavior, and excessive exercising (psycho-motor aspects of bodily experience).

Personality Disorders

For these very heterogeneous disorders, no specific patterns of body schema have been described in the literature to date.

Schizophreniform Disorders

With regard to abnormal bodily sensations in schizophrenia, a variety of psycho-pathological symptoms have been identified in systematic phenomenological research (reviews: e.g., Fisher, 1970, 1986; Kolb, 1975; Röhricht and Priebe, 1997; Priebe and Röhricht, 2001; Jenkins and Röhricht, 2007).

Patients suffering from schizophrenia present with severely impaired reality testing, manifested in a loss of grounding with centralized body schema (perceptual "retreat" from the periphery of the body and underestimation of the size of the lower extremities and correlating body image distortions); aside from this static pattern, the body schema of these patients is frequently characterized by dynamic distortions: shrinking or ballooning, cenesthesias (qualitative abnormal body sensations), bizarre psychomotor presentation (extreme form: catatonic agitation or immobility), and—less specifically—body-boundary loss and de-somatization, subjectively experienced as fear of body loss/disintegration and resulting in reconstructive behavioral efforts (i.e., mirror exposure, compulsive rituals). Body-related delusions and hallucinations typically include: penetration; the imagination that there is an external control of one's bodily functions; sensations that individual body parts are missing; implantations of metals or other materials in one's body; changes in the brain and thought processes; as well as changes to gender identity. In terms of psycho-motoric abnormalities, patients display a range of stereotypical movements with repetitive self-contact, self-stimulation with clapping hands, and tapping body parts against objects (du Bois, 1990; Joraschky, 1983).

The overall picture can be best described as one of disintegration and disembodiment (Röhricht, 2000; Scharfetter, 1995). Sass and Parnas (2003) described two main facets of self-experience for schizophrenia patients: a ". . . decline in the fundamental sense of existing as a subject of awareness and action (diminished self-affection) and exaggerated, reflexive awareness of aspects of experience that are normally tacit or presupposed (hyper-reflexivity) . . ." This syndrome often results in a range of cognitive and behavioral consequences that seem to be directed toward "rescuing" core aspects of a coherent—even though compromised—self-consciousness.

Patients suffering from negative symptoms of schizophrenia often display features suggestive of an abnormal relationship with their own bodies, in terms of how their bodies move, their actual/phenomenological bodily experiences, and their verbal reflections on this. Movement tends to be slow and lethargic. Eye contact and emotional rapport with other group members, or with the therapist, is often completely lacking or very limited. Röhricht and Priebe (1996) found negative symptoms (BPRS-subscale anergia) to be associated with disturbed body-size perception. However, the evaluation of effects of Body Psychotherapy in chronic schizophrenia with predominant negative symptoms suggests that the "symptoms" of social and emotional withdrawal are better understood as coping mechanisms in response to perceived existential threats. The phenomenon of affective blunting is thereby more of an artifact: patients experience the full range of emotions, but cannot, and/or do not want to, communicate those to the outside as expressive gestures (Röhricht and Priebe, 2006).

Bodily Experience and Psychotherapy Research

The conception of an intervention strategy that is based upon a disorder-specific, or a phenomenon-oriented, approach allows for a clear definition of outcome criteria. These, in turn, should be plausible in relation to the chosen strategy of intervention, at least in a theoretical-hypothetical sense. Such an approach is particularly relevant for evaluative and comparative psychotherapy research, in which different schools of therapy jointly work toward the identification of strategies that can be generalized, in the spirit of

evidence-based medicine. Fiedler (2002) points out that this approach is not antithetical to an individual, client-centered psychotherapy, but that it recognizes the necessity of individual treatment planning. The course of therapy should be informed by a comprehensive analysis of relevant causal factors, disorders, and phenomena, and with reference to foundational knowledge, and should proceed ". . . between deficit orientation and resource activation . . . ; between biographical and present-time exploration; and between client-centeredness and psycho-education" (Ibid., p. 25). To date, a systematic appreciation of phenomenological research has not been done on body-somatic experiences as part of any Body Psychotherapeutic research, but this offers itself up for the design of future evaluation studies; in this regard, Body Psychotherapy has a specific perspective and a specific clinical approach in the sense of a specific therapeutic intervention strategy. While hypothesis-driven Body Psychotherapeutic research can refer to theories, such as those of Developmental Psychology in hypothesizing on the development of body-ego structure, it should simultaneously evaluate explicit concepts for the treatment of specific disorders in regard to the bodily experience, and define the body schema/body image disorders as primary or secondary outcome criteria in the design of the study.

Conclusions in Regard to the Clinical Practice of Body Psychotherapy

Staunton (2002) offered a description of the model of Body Psychotherapy: "The fundamental premise in body psychotherapy is that our core beliefs are embodied, and that until we begin to experience the pain held in them directly through our bodies, they will continue to run our lives" (p. 4).

Taking into account the centrality of bodily experiences for intervention strategies within Body Psychotherapy, I would like to offer an outline of a model of relational psychodynamically informed Body Psychotherapy:

- The process in Body Psychotherapy is initiated, centering around the immediateness of (bodily, emotional, and perceptive) experiences and through processes of focusing the person's self-experiences, attention, and awareness toward their bodily reality, whereby patients reach a position of basic embodiment.
- This results, via a mobilization of emotional and nonverbal or pre-verbal aspects of underlying conflicts, in some kind of critical (and partially cathartic) destabilization, which paves the path for a process of affect regulation.
- At this point, altering bodily processes is fostered, and an integrative, self-determined reorganization of reactive and solution-focused behaviors emerges; emotionally corrective experiences occur.
- Implicit interaction patterns/enactments will be exemplified and investigated, both verbally and nonverbally. This enables the conscious exploration of the past and present relational meaning-making, in terms of significant narratives.
- The field of Body Psychotherapy is aiming to identify the common ground between the various Body Psychotherapy schools, especially regarding their theoretical underpinnings and intervention techniques. The latter can be identified as follows:
- The body and its experience are viewed as important diagnostic mediums for the identification of (for example) self-potentials or conflict-laden material; the stages of body-ego development hereby serve as a frame of reference.
- Bodily expression, bodily spontaneity, and flow of movements are drawn upon as avenues of communication and are utilized therapeutically.
- The significance of the healthy personality-aspects and resources is emphasized, and an effort is made to identify the bodily experience of these aspects.
- Frequently, tension arcs are employed in which stimulation, charge, discharge, and settlement follow each other.

None of these potentially curative factors is the domain of a specific therapeutic technique or school. Instead, predominant values are ascribed to the quality of the specific embodied therapeutic relationship in Body Psychotherapy, and to the client-centered and resource-oriented perspective of the therapist in regard to problem resolution.

Treatment/technical considerations can be described as follows: For the practice of Body Psychotherapy, and in reference to Scharfetter and Benedetti (1978), we can propose a paradigm for its therapeutic approach: ". . . somatically oriented therapy is derived from insight-oriented psychopathology holding the experience of the client as its starting point and taking cues to the concrete further proceeding from his 'symptoms.'" The implied necessity of including the body in the psychotherapeutic process can be arrived at from different theoretical perspectives, including anthropology, Developmental Psychology, intervention-technique issues, ethology, (affective) neuroscience, phenomenology, and embodied cognitive sciences.

Referring to the last two of the above, in congruence with the main theme of this chapter, the evaluative perspective is shifted to a disorder-specific, syndrome-oriented view—that is:

- Toward the diagnostically classified dominant symptoms of the respective disease.
- To the specific patterns of disorder in bodily experience in the respective disease, as identified by phenomenological research.
- To the pattern of embodied and environmentally embedded conflict patterns.

This means that the key question is: "Which specific contribution can Body Psychotherapy make in the treatment of patients, with characteristics as described above—that is, in regard to disorder-specific and/or psycho-pathological symptoms that are body-based?" This systematization therefore necessitates a welcome departure from the narrower differentiations of Body Psychotherapy schools by their spectrum of interventions and, instead, emphasizes the overlaps and fundamental commonalities in theory and practice.

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