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Learning to Use the Power of Process to Heal the Body

I am a board-certified pscyhiatrist turned psychotherapist who works with patients in long-standing relationships both in individual and group settings. My growing freedom to be intimately involved with my patients is very satisfying and provides me moments of joy that balance those cooking and dancing with my children.

Years ago, and shortly after finishing my residency in psychiatry, I had the privilege of working with and under the supervision of unusually gifted clinicians. Fortunate to find an existing large group practice in which to begin my career, I was exposed to an intensity of post-doctoral training rarely available in the mental health community. In addition to seeing my patients individually, I worked as a co-therapist in eight on-going psychotherapy groups per week with five different senior clinicians, each of whom took an active supervisory role in my training. Countless were the hours of group and individual sessions, patient reviews, clinical meetings and theoretical conferences, as my skill as a psychotherapist was developed and gradually honed. Patient explanations of dynamics and theory and regular confrontations of my character were needed to slowly shape my understanding of the way in which psychotherapy cures emotional illness.

A bright, intellectually defended young woman, I found comfort in the apparent exactitude of my medical training. By contrast, I found the apparent boundlessness of psychotherapy practice especially challenging at first. I was by nature sensitive to the pain of others, having struggled long and hard with my own, but also overidentified with them, losing my way when the emotional involvement became intense. At other times I protected myself from this version of ego-boundary failure by intellectualizing and being more emotionally distant. In that state I listened to the presented facts, but too often missed the emotional messages patients sent, those which my experienced colleagues more routinely saw and heard. As I sought a crutch to help me hear beyond the words, I was offered a first fundamental pillar for practice. "Process," I was told, "always comes before content. How the patient *is*, is always more important than what he says." Thus started my education and gradual recognition that the therapeutic process is basically non-cognitive.

This was a discouraging discovery for me. Psychoanalytic theory and technique were emphasized when I served as a psychiatry resident. Smart and articulate, I was fairly good at understanding the symbolic meanings of patients' words, and

found myself able to construct sometimes elegant interpretations. Yet I was coming to learn that how I was as a therapist, as it is with my patients, was far more important than what I understood and knew. My effectiveness with patients was most strongly determined by how intimately I approached their lives, how comfortably I used my relationship with them to apply therapeutic pressure when needed, and how naturally I could be tender, firm, steady, thoughtful, reliable and emotionally present.

I was now being trained in a model of psychotherapy that placed the origin of emotional disorders at an age far earlier than Freud originally conceptualized. The lasting source of emotional confusion stems not from the oedipal period, let alone latter latency age and adolescent stages, but rather from the first days, weeks and months of life. Later experiences in the following years only reinforce or dilute the earliest life experiences.

But in my first years of training this was mostly theory to me. It was then still hard for me to appreciate life before the age of reason, before an understanding of cause and effect, the awareness of purpose, the context of events, the need to prioritize or other such adult constructs that had become so much a part of my daily living.

Yet from a purely rational standpoint much of human phenomena that I regularly witnessed made no sense. How could one feel hurt if the other's intention was to truly help? How could one feel angry if the other was seen as doing everything possible and it simply did not suffice? Why would a person behave so defensively or argue a point as if her very existence depended on convincing another of her "correctness" when no real danger exists? I could not put these questions aside. They were not simply questions I asked about others but rather ones I was forced to ask about myself. Particularly during supervisory sessions where I actively joined the process of focusing on areas of my confusion, I could not escape facing my unrealistic behavior and unrealistic hurt, anger and fear.

The answer to these and similar questions I posed all pointed to a similar response. Indeed, the many troubles that I and other human beings engender stem from pre-verbal, pre-rational and pre-cognitive experiences. Such developmentally early experiences, by definition, make no sense since they occur before understanding exists. They are most likely felt as global and immediately threatening at life's start since appreciation of gradations does not yet exist. And without an appreciation of surrounding events they are also likely felt as unpredictable. Such experiences include overfeeding and underfeeding of what the new infant's body exactly needs. They also include an embrace that is too loose, too tight, too often or too rare. Simply the inability to be the "right" temperature can be experienced as subjectively catastrophic. A sense of imbalance can signal danger, as can any discomfort the infant cannot avoid perhaps because he or she is unable to turn over, move away from noise, bright light, noxious smells and the like. In short, such developmentally early experiences encompass an immeasurable number of reactions to the objective state of almost complete powerlessness that is the newborn's daily fare (Bar-Levav, 1988).

Bombarded by internal and external stimuli, the newborn human, like any other animal, attempts to contain, control or avert the danger. It cries or grows still. It looks intently or grabs, roots, shakes. Certain parts of the body tense—the throat, shoulders, diaphragm, back, legs. And out of these random responses, patterns of behaviors and physical tensions emerge. The patterns are influenced and ultimately determined by whatever serves to best relieve the young organism from the experience of fear and pain. Each tiny person according to his or her unique set of circumstances gradually structures a character and characteristic physical patterns of blockage in the body, both of which serve to bind early fears (Bar-Levav, 1988; Reich, 1933).

Years later the person once held too tightly or too often and who needed more regularly to fend off intrusive stimuli tends to develop a style of living which keeps others at an emotional distance—whether married or single, socially gregarious or not. By contrast, the person who experienced only the intermittent presence of a comforting hold and soothing involvement tends to know the pangs of loneliness and more commonly clings to others, or is often endearing, unable to be confrontative or even firm since such behavior threatens to cause others to be more distant.

Dozens of other traits develop alongside these general patterns. Rigidity in the body and personality, a reflexive withdrawal from hurt, a buoyant and catching manner, an ever-busy jumpiness, a monotone, a tough persona and a tendency to intellectualize are all among the many creative solutions infants, and later children, find to absorb and diminish the experience of otherwise unmanageable feelings. Whatever best serves to keep fear and pain out of consciousness becomes most prominent. So was I taught to understand people's beginnings. With it, I was offered a second fundamental pillar for helping treat my patients. "The push away from fear and dread," I was told, "supersedes *everything*" (Bar-Levav, 1988).

Since humans, like other animals, tend to avoid what frightens and disturbs them, I came to appreciate that it was not a simple matter to help patients work through fears, hurt and anger, feelings that did not reside merely in their minds but in their bodies too. I was increasingly aware of how I protected myself from strong affect through the overuse of my brain and later recognized, too, that I often colluded with my patients in their doing the same by helping them talk *about* their feelings rather than actually experiencing them. Like my patients I, too, was uncomfortable feeling scared, hurt or angry. I sometimes experienced such feelings when I did not understand what was happening with a patient or when I felt criticized, inept, small and unimportant or simply "wrong." Unwittingly, I led patients away from open complaint about me or their therapy and forced my interpretation onto their words when they grappled to relate something that was ambiguous to me, all in an effort to dampen my discomfort.

Surely it was not a good situation when I as the therapist had infantile reactions to the process that unfolded in front of me in the clinical setting. Far worse, however, was that I unwittingly assisted patients to avoid their powerful feeling reactions to me and to other patients in their group. Why was this so important?

Because, as I came to witness, it was the very ability to powerfully experience developmentally early feelings under the impartial watch of a previously unavailable adult ego that causes corrective, therapeutic changes in a patient's *body*. When the experience of the young infant could be juxtaposed to that of the adult's real circumstances, the physical record that makes up memory in the tissues of the body becomes modified. The greater the discrepancy and the more powerful the experience, the deeper is the correction. In this way a person's body recalibrates its "old" reactions to current reality, which is generally far safer and more benign than is experienced by the vulnerable infant (Bar-Levav, 1988). It is in this way that a monotonous voice slowly takes on inflection, tight musculature softens, and the tendency to withdraw or be boisterous or compulsively nice or prickly slowly diminishes.

My efforts to help patients make basic changes in the way they live, therefore, required ongoing work with myself in a way that also affected me on a physiologic level. When I was anxious I reflexively became quite busy, thinking too much, talking too much, calculating, interpreting and attempting to figure out too much. I could not be faulted for my understanding of my patients' dynamics nor my conscientiousness to "do right" by them. Nonetheless, following very many sessions during the early weeks, months, and even years of my training, I was repeatedly critiqued for not having done what was necessary with patients. Again and again I would hear that I was "too busy," "not present" or did not "see" the patient. Worse still, despite my best efforts I could not truly appreciate exactly what was wrong.

This portion of my training was grueling and very painful, particularly because it stood in such contrast with the rest of my education in medical school and residency where I excelled and commonly received praise for my work. As the months wore on I found myself deeply discouraged, even despairing that I could ever be an effective therapist. So much of my self-esteem was attached to being able to do my work well that for what felt like an interminable period I had trouble getting through my days, feeling more of a failure as a human being than simply as a psychotherapist. Yet in the very same period that I struggled so painfully with my shame and character difficulties, subtle but significant shifts in my body began to take hold. When faced with some shortcoming in my peer supervision group and overcome by a flood of shame I would cry, look away and emotionally pull inward. My colleagues often helped me lift my eyes and keep contact with them, which allowed me to visually remind myself of the fact that I sat with peers. My reflexive tendency to fold in was blocked many times in this way and in time these episodes became less severe.

On one memorable occasion I found myself very confused by what my colleagues were trying to tell me about myself. Though I could not make sense of what they were addressing, my body reacted as if it had been directly threatened. I wanted desperately to understand what they were saying in an effort to "correct" myself and lessen my fear. I was urged by my peers instead to simply sit and breathe since they could see I was clearly overwhelmed by feelings and literally

unable to process their comments. The suggestion that I simply sit and do nothing made me feel more anxious still. I felt I *had* to understand what was said. My whole body sweat, and before long I found myself physically shaking and crying with pain and fear as if I were a trapped animal. In truth I was being restricted, but only from my body's typical way of reacting to what I experienced as danger, though in reality all was well. When the storm passed I was surprised by the friendly involvement of others, since I was embarrassed by what I had just gone through and had barely "remembered" that my colleagues were friends at the height of feelings. I was left physically spent, raw and without any clear cognitive understanding of what had transpired. I knew only that my body had surely been sending me false cues. This event and many others I went through helped me appreciate the value of therapeutically guiding patients away from characteristically exercised defenses.

With time I developed a better ability to suspend my intellect, which allowed me more room for emotional involvement. I was increasingly able to examine myself and my various co-therapists' work with a freer and more investigative eye. I noticed on many occasions that as I readied to help patients elaborate on some story they presented, a co-therapist would step in and take the process in a direction I had not considered. Very often the first intervention was one that helped patients make a physical shift, sitting forward, slowing their speech, focusing their eyes on another human being. The co-therapist would then continue to steadily guide the patients. Seemingly abruptly, strong affect would soon surface in the form of tears, anger or visible fear.

Gradually I, too, focused my attention more typically beyond patients' words. I noticed more and more how they breathed, whether their ears seemed to take in my voice and their eyes that which was in front of them. I had always been sensitive and observant. But I generally missed these cues when I was anxious and busied myself trying to "figure out" explanations for what I saw. Over time much less of my work made me feel so very vulnerable and afraid.

These changes did not and would not have come about spontaneously. Since the "push away from fear and dread supersedes everything," such changes required the use of external force. Both the peer supervision groups to which I belonged and my personal therapy group (conducted along the same model) had at their core a non-acting-out contract that was critical to the effectiveness of the work. It held that no action on the basis of feeling, regardless of the intensity, was ever condoned. Ultimately all action was instead to be based on what made most sense in reality. I had bound and committed myself to this principle, as did the other patients in my therapy group and my colleagues in our peer supervision group. It was this agreement which I shared with others with whom I was involved that made it possible for me to make use of the urging by my colleagues to lift my eyes when I felt extreme shame and remain in contact with others even as my feelings urged me to pull in and away. It similarly helped me hold my tongue when I most felt a desperate need to defend myself and justify my work.

In these and hundreds of similar instances I felt a surge of anxiety, sometimes extreme, as I was helped to behave in ways that were literally "out of character" for me. This is understandable since character, and the behaviors and patterns of bodily tension that make up the character, serve to bind anxiety (Bar-Levav, 1988; Fenichel, 1945; Reich, 1933). Yet each instance was also remarkable in that my body simultaneously experienced a piece of reality beyond the flash of anxiety. My shame did not in reality cause me to disintegrate or to be ostracized as I half-knowingly feared. No danger befell me as a consequence of my remaining silent and not explaining, defending, correcting or justifying myself. On the contrary, I slowly began to feel more assured and less driven by the need to look "right" or be certain. In clinical terms, my ego-boundaries had become incrementally more competent, helping me demarcate between felt and real dangers and between myself and others.

These and many other therapeutic experiences that affected me on a physiologic level also made it increasingly possible for me to work with process rather than explaining content to my patients. I was more able to see patients' character defenses as they displayed themselves in sessions. With improved "vision" I could more effectively help my patients beyond the limitations their fear characteristically imposed on their living. I could more effectively help the person who shied away from anger to openly rage, provided no spontaneous action accompanied it. Through my repeated sensitivity to the fragile infant within, I helped the person who felt too vulnerable to cry to take more risks. With encouragement, he could purposely soften his manner, voice and face, bypassing physical blocks that served to keep him "together" and allowing him greater access to his long-held pain.

No damage was sustained by the open expression of my patient's rage either physically or to the relationship with me since it was respectful, made with good contact and within the parameters of the non-acting out contract. The person who softened his demeanor spoke with a new gentleness and found room to sob, something his body had not previously known to be safe. Just as I had "learned," so too did my patients slowly but surely acquire new physical "knowledge" of how life is and can be, not primarily by using their reasoning but much more importantly through new physical reactions in their bodies.

Just as surely, many of the lessons I had learned about conducting psychotherapy took on deeper meaning. I had known for years, for example, that the here-and-now must always be connected with genetic roots from patients' distant personal past. Conversely, patients' talk of the there-and-then is made meaningful only when its impact on current living is seen. This had long made sense to me since I understood that the juxtaposition of the adult's and child's experiences was necessary for a person to appreciate the confusions and damage feelings can cause in one's life. But I placed far too much weight on the value of recognizing and cognitively understanding such distortions. I had not appreciated well enough how the power of feelings nonetheless dictates behavior and compels human beings to repeat self-damaging tendencies time and again. Even the ability to

reality-test and recognize distortions is sometimes severely impaired when thinking itself is caught in the grip of feelings. As the non-cognitive nature of the therapeutic process became more evident to me, my use of therapeutic "technique" also changed. Much more than simple cognitive integration or "insight" needed to take place when I helped patients reflect back to the "there-and-then." I increasingly assisted them in being more emotionally involved with what they recalled. Strong reactions to current conflicts in their lives were soon experienced with the progenitors of those feelings in their past.

Often the eyes, facial expressions and manner of the child came alive and active in the body of the adult. Not infrequently the cries of a frightened baby could be heard through the throat of a grown patient. So, too, could the complaints of the impetuous 2-year-old. Yet to be therapeutic the watchful adult ego needed always to be concomitantly present, as patients experienced these strong reactions (Sterba, 1934).

Often, patients' very presence in the room with other adults who were all gathered for treatment in the doctor's office provided a sufficient reminder of reality. On occasion a stronger call to patients' observing ego needed to be made when the strength of feelings blurred their appreciation of current circumstances. At times this requires my patients to recommit themselves verbally and behaviorally to the non-acting-out contract in an effort to separate their feeling reactions from their thinking and behavior. Since sacrifice of the therapeutic relationship itself is sometimes at stake, the therapeutic contract served powerfully to enlist the adult ego to take charge when a patient's infantile posture threatened to damage the necessary realistic nature of our involvement (Bar-Levav, 1995).

Helping patients keep their "observing ego" active in the presence of the intense emotion of their "experiencing ego" (Sterba, 1934) has been the most difficult balance for me to achieve and the most challenging skill for me to refine. The clinical situation has required the combination of my patience and forcefulness, sensitivity and directness. Developing the flexibility of character to do this has been a long, sometimes painful and frightening struggle.

Looking back a decade, I can see that the content-oriented treatment I had been taught during my residency fit my intellectual defenses reasonably well and protected me from experiencing episodes of embarrassing and painful ego-boundary failures. I learned in a very immediate way how much more stressful process-oriented therapy is to a therapist's ego-boundaries since the emotional involvement is far more intense and more real. But I also learned in a personally direct way that there is no real way around it if I, or anyone, is to help others truly change in character, mind and body.

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COMMENTARY

Someone who ought to know (William James? Alfred North Whitehead?) once wrote that "A great Truth is one whose opposite is also a great Truth." This simply and beautifully written article recounts a "true believer's" personal rediscovery of one such Truth. It expresses the Romantic optimism which is a perennially dominant theme in the culture and literature of psychotherapy. "I once was lost but now I'm found," as we regularly sing at our meetings.

The opposite Truth informs the Tragic or pessimistic view of our work: "I once was found but now I'm lost." Such a view tends to emphasize much more the enormous fact of innate temperament and the need to adapt as best as we can to what cannot be changed or re-parented out of existence. In the Tragic perspective, affect cannot always be trusted—it can potentially kill us as well as heal us no matter what contracts we make with ourselves or our therapists—and those whipping boys "cognition" and "words" sometimes offer the only Salvation (though that is a Romantic term; salvation in this view is only relative). Here, verbal thought can be a freeing thing, not just a defense or a block.

Our own David Mermelstein once wrote in this journal of how he had come more and more to honor and respect his patients' defenses as his career went on. The Romantic view, lovely as it is, conceals a basic non-acceptance of the Other. It is always wanting to heal away defenses and remake the Other in its own Romantic image. The Tragic view offers the possibility of enjoying and appreciating the Other *as Other*. Yet the ability of the Romantic approach to sometimes cure is undeniable. Left unconscious, these two opposite therapeutic Truths find natural homes in different stages of one therapist's career, or in therapists of different temperaments. The few master practitioners I have known are sometimes able to hold the Whole Truth within their healing and helping work, keeping both opposite principles simultaneously in conscious view.

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