

II Integrative body and movement therapy: A multimodal approach to the 'body subject'

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The field of body and movement therapy

The area of body and movement therapy with a psychotherapeutic orientation is characterized by a growing number of methods, schools, and approaches.

Consequently, the outsider is overwhelmed by the emergence of novel methods. A thorough examination, however, will reveal variations in several basic approaches, of which the following will be discussed:

- 1 Reichian and Neo-Reichian approaches, such as Rakne's version of Vegeto-Therapy, Lowen's Bioenergetics and Boysen's Biodynamics, which in terms of metatheory are traceable to the Freudian paradigm of psychotherapy (incorporating such concepts as energy, resistance, repression, and the unconscious), although the treatment techniques are modified in quite a distinct manner (cf. Petzold, 1977).
- 2 Humanistic-existential approaches drawing on concepts of Moreno (1946), who coined the term 'Body Therapy' in 1937, and on Perls and Rogers. Eugen Gendlin's body-oriented 'focussing' (Gendlin, 1987) and the method of Gestalt-Body Therapy, as it has been developed by Barry Stevens or James Kepner (1988), can be mentioned as well as Albert Pesso's Psychomotorthérapie (Pesso, 1969).
- 3 Oriental approaches emanating from the wisdom of Chinese, Indian, Japanese, Tibetan, or Thai medicine and their Western modifications (Do In, Hakomi, Reiki, Kum Ny, Yoga, Shiatsu, etc.).
- 4 Movement and breathing therapies originating from the field of functional exercises, gymnastics, and physiotherapy. These are associated with several pioneers, such as Elsa Gindler, who treated Wilhelm Reich (according to Reich's daughter Eva) and stimulated him to implement direct body contact in psychotherapy. As a teacher of Charlotte Silber, i.e. Charlotte Selver, Gertrud Heller, Lily Ehrenfried and others, she is the little known but influential figure behind the 'Sensory Awareness' approach of Ch. Selver, Ch. Brooks and B. Gunther, and the 'Concentrative Movement' Therapy of H. Stolze and others. Furthermore, Laura Perls, Fritz Perls, Ruth Cohn and Hilarion Petzold have been exposed to the work of the Gindler school, which has had an impact on their therapeutic approach (Kirchmann, 1979; Stolze, 1988). Gerda Alexander's 'Eutonie'

- (‘eutonics’) should be mentioned in this context, as well as the breathing techniques of Ilse Middendorf (1984) and Volkmar Glaser (1957, 1981), the leading figures in the field of breathing therapy (Derbolowsky, 1978). A more physiotherapeutic background can be seen in Ida Rolf’s method of ‘structural integration’ and its subsequent variations (Rolf, 1972, 1977).
- 5 Dance and theatre have been influential in providing a background for the approaches of modern ‘dance therapy’, ‘expressive movement therapy’, ‘movement-dance therapy’ etc., associated with the names of Elisabeth Duncan, Mary Wigmann, Rudolf Laban and the South African actor, F. M. Alexander. Moshe Feldenkrais had extensive contact at the outset of his work with the last-mentioned practitioner. The ‘Alexander method’ or the modern forms of ‘clinical dance therapy’, as inaugurated by Marian Chace (Chaiklin, 1975), Trudi Schoop (1974), Lilian Espenak (1981) and others, form a substantial part of our professional field (Willke, Hölter & Petzold, 1990).
 - 6 Finally, the eclectic and the few integrative approaches will be considered – ‘eclectic’ implies a pragmatic combination of a more or less arbitrary or at best ‘heuristic’ selection of methods and techniques originating from several of the above-mentioned approaches, and integrated with various forms of psychotherapy and a variety of theoretical concepts. For example, Lomi therapy draws on Gestalt, Reichian, and oriental techniques, blending them into an effective praxeology (Leeds, 1977).

Eclecticism is surpassed by integrative approaches which attempt to bring diverse practical strategies under the aegis of a unifying methodology and establish an encompassing theoretical framework that provides a rationale for the selection and application of practical interventions. Dublin’s existential body therapy (Dublin, 1977), Mindell’s holistic approach (Mindell, 1984, 1987), and Petzold’s ‘Integrative Movement and Body Therapy’ (IBT) represent attempts to accomplish this task.

At present we are in the situation where it is necessary for these existing schools to develop their constructs and practice in the direction of a more profound clinical elaboration, characterized by a more sophisticated and consistent theoretical conceptualisation, as well as striving for evaluation by empirical research (rigorous comprehensive investigations and follow-up studies). On the other hand, empirical and theoretical studies should focus on integrative concepts in the area of growing diversification in the field of body therapy, reducing the proliferation of methods that are nothing but technical variations, another merchandise to be sold on the flourishing market catering to human needs and suffering. An ‘explosion’ of body-oriented therapies would be just as disturbing for our profession as the ‘psycho-boom’ (Bach & Molter,

1976) was for psychotherapy: Practitioners ought to be sensitive to such problems created by market needs.

‘Integrative body and movement therapy’: Fundamental concepts and ideas

In this chapter we will try to elaborate some essential concepts and ideas of ‘Integrative Body and Movement Therapy’ (note 1) as developed by Hilarion Petzold in France since the mid-sixties (cf. Zundel & Zundel, 1987), and by his collaborators (Hildegund Heintz, Ilse Orth and others) at the ‘Fritz Perls Institute’, Düsseldorf, and the ‘European Academy of Psychosocial Health’, Hückeswagen, Germany, from the beginning of the seventies onwards (cf. Petzold & Sieper, 1993), predominantly in clinical settings, working with psychiatric, psychosomatic and geriatric patients (Heintz, 1985; Petzold, 1974, 1977, 1985b, 1988b).

A broad and encompassing definition of body psychotherapy and its practice as it is understood in the Integrative approach should come at the beginning: Body psychotherapy is based on the anthropological assumption that the body as a whole is the person. Its practice is therefore the purposeful and theory-based influencing of attitudes, behavior and social contexts, i.e., of physical, emotional, cognitive and social styles of the body subject through verbal and nonverbal interventions within the framework of a therapeutic relationship aiming at curing disease, easing suffering, solving problems, promoting health and fostering personal and interpersonal growth and creativity. The enhancement of ‘complex awareness’, of the perceptive, memorative and expressive capacities of the body, where they are inhibited or lost, particularly the mobilization of muscular tension, dysfunctional breathing, movement and communication patterns, which result from pathogenic biographical experiences, are some of the main objectives of treatment. These can be achieved by working through transference-countertransference constellations, resistances and defence mechanisms, on the grounds of a consistent theory of health and illness, and by an elaborated praxeology, i.e., body-oriented, psychological and socio-communicative methods, techniques and media, which enable the body therapist to deal with the physical, the phenomenal and the social body – the body subject in its totality.

Sources of Integrative Body and Movement Therapy

The sources of a therapeutic approach are important in order to gain an understanding of its orientation. We were originally trained as psychoanalysts: Orth in Jungian analysis with Maria Hippus Gräfin Dürckheim, and Petzold by the

Ferenczi pupil Vladimir N. Iljine in the tradition of the Hungarian School. Sandor Ferenczi (1964) developed (in his 'later' period) the 'active and elastic technique' (Ferenczi, 1927/1972), the principles of neocatharsis and relaxation and his genial approach of 'children analysis with adults' (Ferenczi, 1964), in which he used direct body contact as a means of intervention to create a 'new socialisation climate' of 'motherly love and tenderness'. With his friend Georg Groddeck, Ferenczi pioneered body work prior to the entry of his close associate, Wilhelm Reich into this field. Ferenczi's conceptualisation was, however, quite different from Reich's intentions, which focussed on 'breaking through the character armour' to remove 'blocks' in the human body, permitting a free flow of 'energy'. Ferenczi used bodily interaction as a reproduction of an early socialisation climate through regression (Balint, 1932/1988) in order to achieve a 'corrective emotional experience', as his pupil Franz Alexander called it (Alexander & French, 1959; Schuch, 1990). Ferenczi touched his patients because he was touched (Eisler, 1991; Petzold, 1970) by their pain, their misery, their life history full of mistreatment or lack of love and comfort. He wanted to offer them some of the nurture they had missed, some of the trust that they had not experienced, and the care, warmth and shelter that parents give quite naturally and intuitively to their children in processes of 'sensitive caregiving' (Vyt, 1989). With his approach he inaugurated the concept of 'emotional adoption' or 'parenting' (Ferenczi, 1927/1972), which is nowadays convincingly supported by the findings of empirical baby and infant research (cf. the concept of 'intuitive parenting', Papousek & Papousek, 1981). Ferenczi's analytic grandson, Donald W. Winnicott (analysed by Melanie Klein) phrased the famous postulate: A therapist has to be a 'good enough mother' for his patient (Winnicott, 1973).

These concepts were not oriented towards the 'manipulation of energy flow' in the Reichian manner (Russelman, 1988) but rather focussed on 'atmospheres' and 'emotional microclimates', typical of parent-infant interactions, drawing heavily on experiences in child therapies and findings from investigations conducted by child therapists and infant researchers from the tradition of the Hungarian School such as Melanie Klein, Alice Balint, René Spitz, Margarethe Schönberger (i.e. Margret Mahler) and Donald Winnicott. These experiences, complemented by psychobiological (Osofsky, 1987) and longitudinal (Oerter & Montada, 1987; Rutter, 1989) research, have influenced 'Integrative Body and Movement Therapy' profoundly. A complex vision of socialisation and developmental psychology, set in a 'life span perspective' (Baltes & Eckensberger, 1979; Petzold, 1988a, 1991), and oriented at the interactional field between mother, child, father, and other relevant caregivers as 'body subjects', is the core orientation of 'Integrative Body and Movement Therapy'.

An additional central influence on the theoretical concepts of our approach emanated from the French school of phenomenology and hermeneutics (e.g., Maurice Merleau-Ponty, Paul Ricoeur and Gabriel Marcel). Petzold studied with Ricoeur and did a doctoral dissertation as a pupil of Marcel, who in 1935 introduced the distinction between the 'object body' that you have and the 'phenomenal body' that you are (Marcel, 1935), which has become a central tenet for many body and movement therapists. Merleau-Ponty (1945, 1964) introduced the concept of the 'sujet incarné', the 'body subject', and of 'intercorporalité' – 'Zwischenleiblichkeit', intercorporality. Paul Ricoeur (1986) dealt with the meaning of the body subject's actions and temporal being-in-the-world, which opens doors to the understanding and interpretation of physical interactions between human beings in a common 'field of experience', the *Lebenswelt*. Also the 'phenomenological' body philosophy of Hermann Schmitz (1989) became important for IBT, in particular the concepts emphasizing that the body is not just a physical, material and energetic reality ('Körper'), but a perceived corporality in a given context or continuum: 'der Leib', consisting of self-perceived 'body islands' (Schmitz, 1989), 'zones of arousal', co-responding with the 'field' and constituting the experiencing-experienced 'Leibsubjekt-in-Lebenswelt' (Petzold, 1970), the 'field of the lived body-life-world' (Tiemersma, 1989). Such a position, based on phenomenology and hermeneutics and supported by the findings of perceptual and developmental psychology (Arnheim, 1954; Gibson, 1979) as well as by concepts of field theory (Lewin, 1935; Sheldrake, 1981, 1990; Tiemersma, 1989), helps us to avoid the highly problematic recourse to the energy concept, so common among body therapists, which, when carefully examined, turns out to be a prescientific energy mysticism or pseudophysicalism (cf. the critical discussion of the concept of 'bioenergy' by Russelman, 1988).

To illustrate some of these concepts mentioned so far let us look at a short exercise from a lecture:

'Close your eyes, please, and try to perceive your body from the tips of your toes up to your head. Please do not visualise parts of your body but just try to perceive them, to feel them.' (After a while) '... Please tell me what you have observed.' (Most of the participants have sensed zones of contact, the chair, the table on which they were leaning, others have noted a zone of tension, others have perceived a 'body atmosphere' or 'totality feeling' of warmth, heaviness, freshness, or tiredness.)

The phenomenal body can only be perceived at areas of contact, zones of tension, in body islands or in body atmospheres ... 'Can you feel your shinbone?' The majority could not feel it. 'But now imagine that you have knocked your leg against something! What happens now?' The participants are startled and astonished. Some touched or rubbed their shinbone, for most of them had

a sensation of pain or the fading away of the pain. The pain has been called up out of the 'body memory' as an apparently common 'field of experience'. It is there, although there was no real damage or hurt and it caused physical reactions (e.g., movements, feelings, expressions).

With this short exercise we have a practical demonstration of 'emergent monism' (Bunge, 1987; Stoerig, 1985), where the emerging phenomena of differential quality have been evoked through the body's relation with the field. Therefore this concept of emergentism has to be supplemented by a relational (Tamboer, 1991) or an interactionist view and by the idea that there seems to be a 'common field of experience' giving rise to forms of expression (Petzold, 1990). The conclusion is that the emerging reality becomes, and participates in a reality in its own right, i.e., the transmaterial reality that interacts with other transmaterial realities (e.g., thoughts, systems of information) and with the material world (cf. Delgado, 1979; Popper & Eccles, 1977). From our position, which can be considered as interactionistic, and as the position of a 'differential emergent monism' (Petzold, 1988b, p. 287), we gain an appreciation of the 'phenomenal body-in-relation' and the 'body islands' – differential phenomena that (although 'emerging' from 'bodily matter in interaction') are not a material, but rather a transmaterial reality. We can refer here to the phenomenon of the 'phantom limb'. If an adult loses an arm in an accident, he still can feel it. It is there! (Frederiks, 1969). The object body is mutilated but the phenomenal body is complete. On the other hand there are, for instance, depressive patients who cannot use their hands aggressively to approach the world. Their hands are cold, wet, lifeless. The material body is complete but the phenomenal body is deficient as a result of decarnation processes (punishment, humiliation, etc.). Neurologists agree that babies who have undergone amputation following an accident or a sarcoma do not appear to exhibit phantom signs, or at least phenomena clearly identifiable as such. The 'phantom body' is not yet developed, and also in later childhood, phantom phenomena are not very persistent, fading out quickly. The duration of the phantom phenomena increases as the child grows older (Frederiks, 1969; cf. however Poeck, 1964).

This material indicates that the phenomenal body is mainly the result of proprioceptive and exteroceptive experiences that result from interactions with the field (which includes the object body) and that are incarnated, 'inscribed' in the body memory which eventually participates in and contributes to the 'memory of the field' (cf. Sheldrake, 1990). These concepts have considerable clinical relevance for body-oriented therapies. Let us take as an example the clinical observation and treatment of anorexia nervosa in adolescent girls. We found that they often say, in spite of being dramatically underweight, that they feel 'fat'. If we examined photographs or interviewed parents or relatives about their physical appearance prior to becoming anorectic, we frequently

Scheme 1. Tree of science (Petzold (1991)

I. Metatheory

Epistemology
phenomenological-structural, hermeneutic
Theory of science
evolutive-pluralistic, metahermeneutic
Cosmology
evolutionary, Heraclitic, ecosophic
Anthropology
existentialistic, intersubjective, creative
Theory of society
synarchistic, critic-pragmatic
Ethics
discursive, situative/historic
Ontology
co-existive, chronosphic

II. Reality – explaining theories

General Theory of Therapy
intersubjective, depth-hermeneutical
Theory of personality
developmental-relational
Developmental theory
synoptic, interactional, ecological, lifespan-oriented
Theory of health and illness
context-oriented, multifactorial
Special Theory of therapy
multiperspective, systematic-heuristic

III. Praxeology

Process theory
differential, variable
Theory of intervention
multimodal, multilateral
Theory of methods
elastic, pluriform, integrative
Theory of institutions, fields of practice, target groups
systematic, differential

found that they really were well nourished and may even have been plump. Although they are exceedingly thin, they persist in perceiving the shape of their body as round and pot bellied: Phantom shape.

From all this we learn that the perceived body is not limited to the perception of an actual material reality, but includes phenomena stemming from the transmaterial 'field' that are stored in the 'body memory'. They constitute, when activated, missensations, coenaesthetic phenomena (Huber, 1971), body hallucinations, so to speak, that are of a relatively persistent nature. We can diagnose these phenomena and their background to some extent by projective methods and techniques that have been specifically developed by us: The 'body sculpture' (Petzold, 1988b; Petzold & Kirchmann, 1990) and the 'body charts' – clay models of the body, paintings of the body scheme – which can disclose incarnation deficits, misincarnation and decarnation phenomena (Orth & Petzold, 1991).

The philosophical concepts of body phenomenology and body hermeneutics that we have summarized here have been of central importance for the conceptual framework of IBT, its anthropological position and clinical orientation, making it possible to integrate the various sources mentioned so far – particularly the active psychoanalysis of Ferenczi – as well as other impulses such as Iljine's 'Therapeutic Theatre', Moreno's 'Psychodrama' and their principle of dramatisation, Fritz Perls' 'Gestalt Therapy' and its method of focal intervention, the 'hot seat technique', and the sensing exercises of Gindler's pupil Lily Ehrenfried (1956) – therapists with whom Petzold has worked, and who have influenced his IBT approach. The final source to be mentioned is Ola Raknes and his gentle technique of vegeto-therapy (Raknes, 1973).

Concepts of IBT

The IBT concepts are complex and thus can only be presented here in an abbreviated and selective form (cf. Petzold, 1988b).

Scheme 1 gives the structural framework that every elaborated form of therapy should be able to fill with contents. The scheme of the 'Tree of Science' (Petzold, 1991) is divided into three main areas.

- 1 Metatheory, i.e., general, large-scale 'background theory', such as epistemology, the theory of science, anthropology, cosmology, and the theory of society and ethics.
- 2 Reality-explaining theories offering a mid-scale or range frame of explanation for the 'facts of life': E.g., the general theory of therapy, personality theory, developmental theory, the theory of health and illness (psychopathology), and the specific theory of therapy.

- 3 Praxeology: Theory about practical applications, including the theory of interventions, methods, techniques, media, process theory, etc.

We will attempt to present a concise description of two major segments of this sophisticated theoretical framework: Epistemology and anthropology. As we will be able to fill only a little of this exhaustive frame in this paper, we will have to refer to the extensive IBT literature for further information (Kirchmann, 1979; Petzold, 1974, 1988b, 1990, 1991; Schmitz, 1989).

Epistemology – the theory of how ‘episteme’ (knowledge, understanding) comes about. Here we affirm the ‘body a priori of knowledge’ (Apel, 1963). The body is the ultimate source of knowledge. Without it, no cognition, insight, recognition, introspection, awareness, consciousness is possible, as several philosophers (e.g., Merleau-Ponty, Schmitz and Apel) have convincingly demonstrated. Thus we shall commence and end with the body as far as knowledge is concerned, and every therapy is concerned with knowledge, for it is the goal of the human being to understand himself and the world: ‘Man, know thyself!’ as one could read on the temple porch of the Delphic Apollo, the god of healing, the arts, and science, or as we read in Heraclitus: ‘It is natural for a man to know himself’ (cf. Petzold & Sieper, 1988).

A second a priori has to be introduced here, that of consciousness, for it is the (self-) conscious body which generates ‘episteme’ and gives it symbolic forms (e.g., verbal and nonverbal language). Symbolic forms, as a prerequisite for human knowledge, are created by the societal organization of man and thus we come to the third, the societal a priori of knowledge (Petzold, 1988b). People, objects, situations that were perceived by the body through its sensory apparatus and were made conscious are brought into the societal discourse, into intersubjective co-responsiveness which generates consensuality that is shaped into concepts essential for any form of cooperation (Petzold, 1991). The hermeneutics exposed here is not language-centered. It starts with bodily activities: From perceiving to grasping to understanding to explaining and again to perceiving, etc., progressing like a spiral in a combined effort of subjects to approach and to understand the world.

Anthropology – the theory about the nature of human beings. Some fundamental assumptions (cf. Petzold 1980, 1988b, 1991) are the following:

- 1 The human being is his body. Subject and body cannot be separated. In reality I can only say: I have my body, because the subject, voicing these words, is the body. Therefore in the human body, subject and object are coincident. The Ego can have some excentricity (Plessner, 1928/1975) with respect to the body, but it is centered in its organismic functioning, and if

- this stops there is no Ego and no excentricity. So the body cannot be a 'possession' that is totally controlled by the Ego, as is witnessed in pain, nausea, or aging – body processes that are ultimately beyond our influence.
- 2 The body is the source of consciousness, which requires a certain level of arousal or vigilance in the human brain and the nervous system.
 - 3 The human body is fundamentally 'intercorporalité', a part of the 'Lebenswelt' of the 'chair du monde', the 'flesh of the world', as Merleau-Ponty (1964) calls it, because of its genetic inheritance and its intentionality that has developed in the course of evolution. Intentionality means that the body is oriented towards the world – body in relation (Tamboer, 1991): The eyes are made to see, the ears to hear, the hands to reach out, facts that lead most of the phenomenological and existential body philosophers to assume a 'basic intentionality' of the body (Merleau-Ponty, 1945), or the 'coexistent nature' of the body (Marcel, 1985), or the primordial interconnectedness of the body (Petzold, 1970), moving towards the world (Buytendijk, 1956).
 - 4 Consequently the body is always a 'social body', 'grand être', as Auguste Comte called the 'body of mankind', of which the individual bodies are an integral part. The social dimension of the body is shown by its interactive qualities, its commotility in play situations, its participation in language, verbal and nonverbal, its ability to incorporate social attitudes and behavior by mimicry (and joined actions), and by its capacity to embody roles that become 'flesh and blood': Incarnation. 'Die Rolle ist mir auf den Leib geschrieben, mir in Fleisch und Blut Übergegangen', 'this role has become a part of me' (remember the Latin expression for rôle in the theatre was *pars* - 'I am playing the part').
 - 5 The body is history, body-history, a chronicle, because in its archives everything experienced is stored: In the neopallium, the limbic system, the formatio reticularis, and probably in the spinal and peripheral nervous centers, as recent findings about 'low level autonomy' for certain information processes suggest (Meijer, 1988). The body is a history. My body is my history, in which joy and pain are inscribed, engraved, incorporated, as is displayed in every wrinkle, as well as in postural and movement patterns. Therefore the body as history, the body memory, the time-body, which determines my physical and life rhythms and my lifespan (the body is the beginning and the end of my life), represents a central concept in our approach and a starting point for intervention.

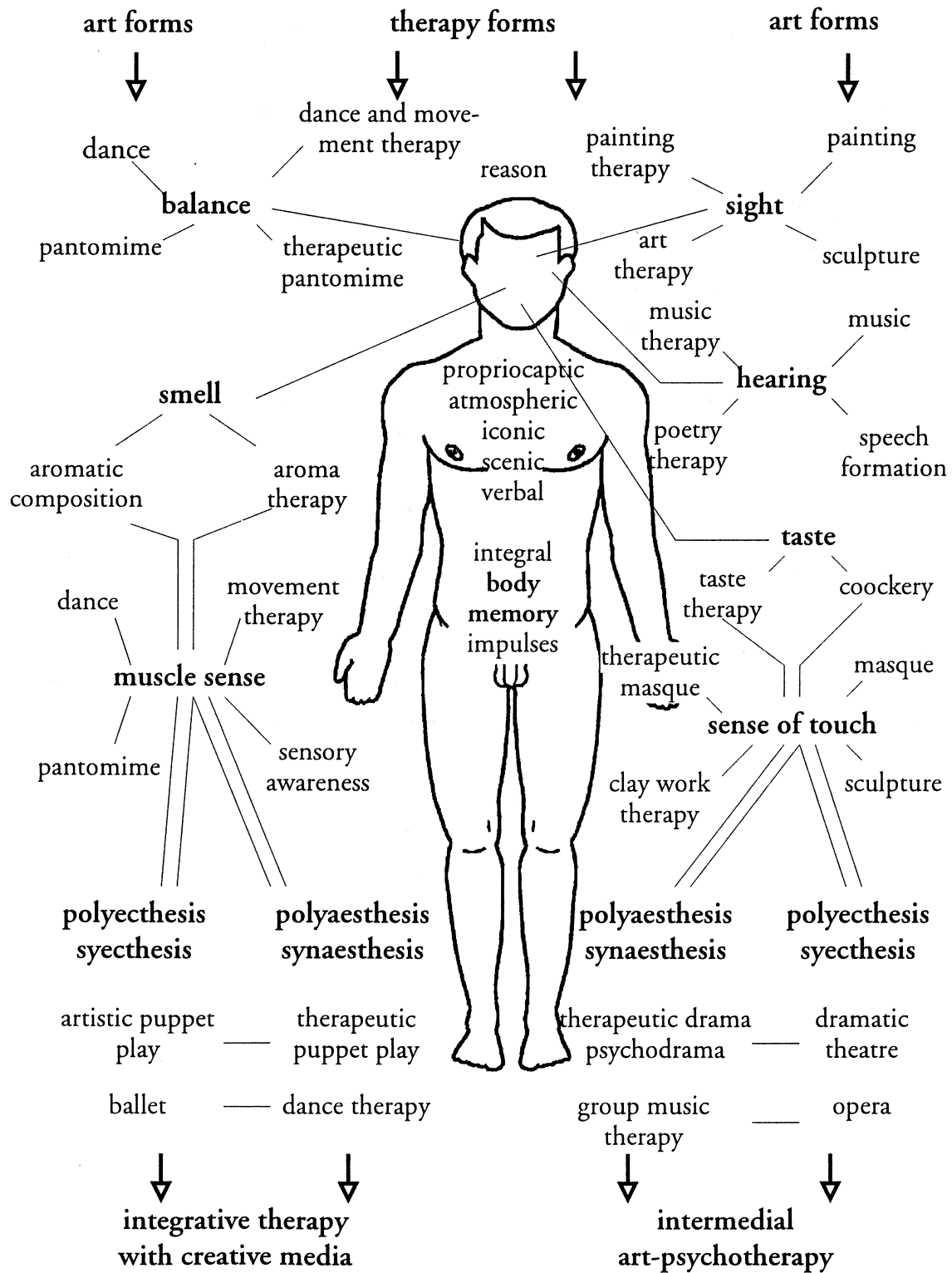
We have attempted briefly to develop here a multi-dimensional, integrative concept of the body (Petzold, 1988b):

- 1 the body object, 'Objektkörper' – physical and organic matter, a material reality, body in space and time with extension and weight;
- 2 the body subject, 'Leib-Subjekt', as the sum of perceptions, feelings, cognitions, memories – a transmaterial reality, opening up perspectives to
- 3 the time-body, 'Zeitleib', which (within my lifespan) is my embodied history, a chronicle of experienced life events, adversative and protective ones (Petzold & Hentschel, 1991)
- 4 the social body, 'Sozialleib', a further dimension: My body is a social reality, a part of social reality, as can be seen in the process of role-taking and role-enactment, through embodiment (be it spontaneous or forced on us), and by general transcultural body language, as the findings of Ekman's (1972) research have demonstrated, or specific cultural body language, for which Lorenz and Leyhausen (1968), Argyle (1975) and others offer a multitude of examples. From here we move easily to the concept of
- 5 the metaphorical body, 'Sprachleib', which is impregnated by language and metaphors, dating from the time a child can name the parts of the body – nose, eyes, ears, thumb, feet, arms – the quality of the body is changing. It becomes very specifically a 'human body'. No cat can name its claws, nor can a horse thing: 'My heart is rejoicing or sad.' The gut-anger, the pain in your neck, the responsibility on your shoulders, the deception that you cannot stomach ... that is the realism of the 'corps métaphorique', the metaphorical body. It is very close to
- 6 the dream-body, 'Traumleib', 'corps phantasmatique', representing the body as 'container' of dreams and phantasies emerging from its store, from its phylogenetic and ontogenetic memories, from its basic spontaneous creativity that allows us to dream, from both the beautiful and from the ugly, disfigured body (Mindell, 1987) – articulations of the unconscious.
- 7 the working body, 'Arbeitsleib' (Petzold & Heintz, 1983) is the dimension with which we will conclude our presentation of a complex, 'integrated' body concept. Every form of work is performed by bodily activity, be it by our hands or brains. When we have to sell our 'working power' on the 'market', we are selling – as Marx has lucidly shown – our body (its health and well-being, its lifetime: Think of the grey time bankers in Michael Ende's 'Momo' (Ende, 1988). Sometimes this occurs to such an extent that it ends in 'Verdinglichung', reification, objectivation (as Lukacs named it), 'Entfremdung', alienation (as Hegel and Marx have analysed it): The human being becoming an object, the body subject merchandised. 'Die Verdinglichungstendenzen des Kapitals' [the reifying, the objectifying tendencies of capital] force people to self-objectivation: You make your body, your body-self, a working-machine, a fighting-machine, a pleasure-machine, or a consumption-machine.

The machine concept of the body as elaborated by Deleuze and Guattari (1974; both famous protagonists of the antipsychiatric movement), should sensitise the body therapist to the dimension of alienation as a main source of psychopathology (Petzold & Schuch, 1991). Alienation is a pathogenic factor of which the Austrocommunist Wilhelm Reich was highly aware and dealt with in his theory and practice: The Sexpol Movement, the street clinics, and sexual counselling centers for workers. There is little remaining of this political vision of the body in Reich's successors, as expressed in bioenergetic and Neo-Reichian literature. The political Reich has been repressed by body therapists in the same way that the political Paul Goodman has been repressed in the Gestalt Therapy movement (Blankertz, 1990). The body is individualized and people are not sufficiently aware that in its 'armour' (Reich) the symptoms of the collective 'war between the rich and poor, the war between the man and the woman' can be observed as Leonard Cohen puts it in his famous song. We have to hear that an individual crying, yelling and screaming in a body therapy session is an expression of thousands of children crying, and an expression of the oppressed and the wounded screaming throughout the world (Petzold, 1985c). These crucial topics have been completely neglected by body therapists and we must invest our strength and energy in order to develop methods of treatment aimed at fighting the alienating influence of a reifying society on the body level. Here we should continue with the inheritance of the political Reich and his pupil Paul Goodman, work that is just as important as the elaboration of clinical concepts. Petzold (1986a, 1986b) has repeatedly pointed out that the lack of a 'politics of the body' among body therapists is in itself a sign of alienation, because they insufficiently recognize the body as the ultimate locus of violence and repression (Foucault, 1969/1972). If you look at people whose bodies are convicted, punished, tortured, and finally annihilated, be it in individual extermination or genocide (Kuper, 1981), by war or purposeful intent, e.g., lack of food and medical care as is experienced in so many Third World countries, receiving only very limited aid from other countries in which people can afford body therapies at prices for a single therapy session which would enable a family in the Upper Volta or Sudan to live and survive for several months. Where are the movement therapists who are moved by these facts? Where do body therapists show care for the 'collective body', the body of humanity, and what can our art and science contribute?

From this – the IBT approach as a central political perspective – we want to shift to a final but clinically very relevant dimension in our anthropological model and our 'integrative body concept': The perspective of the 'schöpferische Leib', the 'corps créateur', the body as the source of creativity, participating in the generativity and cocreativity of the evolutionary process (Iljine,

1990; Petzold, 1990), of which every individual corporality and the collective social body of mankind as a whole is a manifestation.



Scheme 2 is a presentation of the perceptive, the memorative, and the expressive body – the dimensions of the ‘body subject’ as a totality. The senses, the perceptive capacity of the body are ‘windows’ opening on to the world: An optic, acoustic, olfactory window. They allow us ‘to have’ a world that we see, hear, taste, smell, and touch. The physical body, the material, organic substrate of the personality, is a part of this world, ‘Teil der Lebenswelt’. Proprioceptions from the internal world of our body and exteroceptions from the ecological and social environment are stored in the ‘memorative body’. We can only briefly delineate there our ‘heuristic model of body memory’ (Petzold, 1989).

In prenatal life the body memory is mainly a proprioceptive ‘visceral memory’. In early postnatal, life a manifold ‘concert of impressions’ flows towards the neonate, being perceived by the human infant more as an atmosphere than as an isolated, clearly outlined perception. The atmospheres are stored in the ‘atmospheric memory’. Then the ‘iconic memory’ emerges. Fragments of images, growing concrete figural perceptions are engraved in the ‘iconic memory’. Later, at around 18 months, complete scenes are registered in the ‘scenic memory’ along with the rapidly developing ‘verbal memory’ that records sentences and more and more complex syntactic narratives. Finally these dimensions of mnesic functioning merge to form an ‘integrated memory’ (Petzold, 1989, 1991). The layers of the memorative body and the capacities of the perceptive body are interlinked, and both are interwoven with the expressive body. These three dimensions form one tissue with manifold colours and patterns.

Scheme 2 shows that every sense of the body with its perceptive capacities gives birth to specific expressive abilities: The ear (hearing) leads to musical and vocal expression, the eye (vision) to painting and sculpture, the kinaesthetic and vestibular senses offer a basis for dance and pantomime, the nose (smelling) offers the art of creating scents and perfumes, the art of cooking is connected with the gustatory senses; furthermore, the monaesthetic and monecthetic line, i.e., unidimensional perception and expression reaches its peak in the arts of drama, puppetry, dance theatre, in which several senses and expressive modalities interact: Polyaesthesia, polyecthesis, multiperception and multi-expression.

It is, however, not only in the fine arts that the expressive abilities of the creative body may be manifested. We also see them in the activities of children or primitive cultures, in singing, dancing, making masks and sculpture etc. They are an integral part of daily life. Therefore it is not surprising that the use of creative and expressive activity (e.g., dance, chanting, dramatic miming, body-painting and mask performance) is a constituent element in the ancient practice of healing, be it in the atavistic neolithic rites as depicted in cave paintings, in archaic shamanistic rituals or in the Greek temple hospitals of Aescu-

lapius himself, the son of Apollo, the god of medicine), and the doctors (Petzold & Sieper, 1990). Apollo was not only a god of healing, but he was also simultaneously god of music, poetry, dance, and science. This, the art of healing, and the arts of poetry, music, movement, drama and imagination were used in Pythagoraic and Aesculapian medicine. There was awareness about the 'creative body' as a source of health, happiness and well-being.

This knowledge was lost in the course of time and in the turmoils of history. Not until the rise of modern psychiatry at the end of the 18th and the beginning of the 19th century were various forms of creative therapy reinstated, e.g., drama, aroma, and music therapy, as is apparent in the writings of Reil (1803), whereas art, poetry, and movement therapy are referred to in the works of Jacobi (1834) and others (Petzold & Sieper, 1990). In the first decade of this century psychodrama was practised by Moreno, and 'therapeutic theatre' was used by Iljine. The latter drew extensively on techniques of body training as developed in the Stanislavsky method, implemented in actor-training programs. This is another source of the elaborated forms of the new creative therapies, which are nowadays well-established in the clinical field. However, with this development in modern psychiatry, the creative body as a whole became splintered and fragmented. The multifaceted art of healing that incorporated the totality of the body's perceptive and expressive potential became one-dimensional. And it is only as a consequence of contemporary developments in integrated approaches of body-centered therapy and of intermedia approaches in expressive art therapy that the ancient art of integral healing has been rediscovered and recreated, since the old approaches required a new format – we are living in a new era with unprecedented problems to which old ways must adapt.

Clinical praxeology

Our anthropological position in IBT – the 'anthropology of the creative man' (Petzold, 1987; Petzold & Orth, 1990) – is relevant to the therapeutic vision as it is supported by clinical and empirical findings, offering specific approaches to psychopathology: The concept of incarnation deficits or of decarnation (Orth & Petzold, 1991). Let us consider the following decarnative phenomena: In repressive socialisation climates, the perceptive body is anaesthetized. It is not permitted to hear, smell, touch or feel, and subsequently loses its full perceptive potential and capacity. Or it becomes analgesized, because the situations that the body has had to endure have been too painful and threatening, and such 'perceived events' weigh heavily on the memorative body. It is not allowed or able to memorize the frightening and humiliating scenes, the early traumas, the emotional poverty and the lack of caring. And in these acts of repression (of blocking the body memory), positive events and useful experi-

ences may become inaccessible to the person, narrowing down his potential. The memorative body becomes amnesic. In these negative socio-emotional micro climates, which lead to oppressive atmospheres, the expressive body may also be affected. It is inhibited, mutilated or even dismembered, as in the case of people who have those cold, wet, lifeless hands that do not seem to belong to them, or people who paint in bodycharts or make a clay sculpture of their body image without any arms or legs (Petzold & Kirchmann, 1990). They had no chance to enjoy the body games babies play with their parents, were deprived of the 'dialogue tonique' (Ajuriaguerra, 1962), did not experience the joys of commotility of joined activity. They have been hit on their hands, forbidden to grasp, to capture, to 'talk with their hands', to move away, to run around, to explore, to be expressive, and to be e-motional (which in its Latin root, means 'to move from the inside out to the open', 'e-movere'). So our therapy is geared towards opening channels of the perceptive body, putting an end to anaesthesia, and enabling the patient to see, hear, smell, taste, etc., which is the basis for incarnation, i.e., incorporating the world. We are striving to unlock the body memory archives so that our history with its pain and joy, with its depressing and enriching events may become accessible to us, because we need our history in order to be able to have an identity, a personality that is resourceful, with a broad range of emotional, social and spiritual riches at its disposal.

We hope that the metatheoretical and theoretical concepts exposed so far provide good reasons for a multimodal, integrative and creative approach to therapy which attempts to reach the body subject as a person, as a whole. Our praxeology, i.e., our methods, techniques and media in their therapeutic process, have therefore been designed to actualise the creative resources of the patient. We are trying to explore the archives of the body, to trace beneficial and detrimental proprioceptors, atmospheres, images and scenes in a way which allows the re-pressed to be ex-pressed, the frozen to be melted, the paralysed to be mobilized, the inhibited to be exhibited, and the concealed to be openly disclosed. For this purpose we have devised a multitude of techniques and exercises to foster the therapeutic forces and unveil what is buried in the shadows of the unconscious (Petzold, 1991), in the hidden dimensions of the memorative body. Through creative movement improvisation we discover and uncover interrupting and interfering events from the past, and because of the encouragement and support offered by the therapist and the group, the patient can fight back, confront the intruders in his personal sphere, and save his own socio-emotional territory. In a process of body-painting in our therapy groups (Petzold & Orth, 1990), symbols emerge from the body, making visible what was 'imprinted' in the body memory and can be seen in muscles and tissue, revealing what was hidden under the surface of frozen body postures and facial masks. These symbols and images, scenes and atmospheres from the past are

'felt through', 'acted through' at a deep emotional level, involving the whole person: His voice and breathing, hands and feet, muscles and skin, eyes and ears. By body sculptures, a technique that we first described in 1965 (Petzold, 1985d) and have used intensively, we encourage the individual to use his own body as if he were modelling clay (Petzold & Kirchmann, 1990). On three levels, lying, sitting and standing – he expresses his anger or joy or pleasure, his fear or bitterness or whatever. The sculpture of grief can thus subsequently be transformed into movement, grief into motion, and eventually the movement is expanded into dance, the dance of mourning, of grieving, of anger or of relief (Petzold 1988b)

Case example. In order to illustrate our theoretical ideas, a brief case example from the field of gerontotherapy, a domain long neglected by psychotherapists and movement therapists.

A group of elderly patients in an old people's home have two sessions a week of Integrative Movement Therapy. The participants, seven women and four men, are between the ages of 68 and 77. Their main complaints are 'somatic' ones, and by means of various techniques of analysis – anamnesis, resource analysis, need analysis and life-context analysis (cf. Petzold, 1988b) – a fair share of the multimorbidity 'typical of old age' can be classified as psychosomatic. Thus disturbance of sleep, vague pains in the abdomen and limbs, gastrointestinal complaints and cardiovascular problems could be linked with problems from the daily routine in the home or problems with the family. The main psychological problems were depression, restlessness, confused fears, and the fear of death. One patient suffered from compulsive thoughts, and another had paranoid fantasies of varying intensity about being poisoned.

The group session was usually led jointly by the therapist and his female colleague and always began with the 'exercise-centered/functional mode' (Petzold, 1988b) because functional objectives such as mobility, the ability to relax, and cardiovascular stimulation (vitality training) played an important role in the method of treatment. Moreover, this 'warms up' the group for social action and conflict-centered work (as in the initial phase of the 'tetradic process model' of IBT (Petzold, 1988b)

Therapist: 'Let's begin today with stretching. Walk round the room at a comfortable pace.' (Level of the 'body in space' (cf. the body object),

Therapist: 'Stretch out your arms...stretch your back...and keep moving!'

Therapist: 'Yes, Miss Bayer, you can yawn out loud if you like. Everyone could try that. It helps you to breathe deeply.'

Therapist: You can now go over to the couches...Make yourselves comfortable. We'll begin by stretching the whole body. First the feet...stretch out.

Imagine you're getting taller, as if you were growing...' The whole body is stretched, from the feet to the neck, and as in isodynamics (Petzold, 1985a), the imagination is involved and assistance is given through direct physical intervention ('relaxant organ gymnastics', cf. Petzold & Berger, 1974).

Miss B: 'My body is ever so painful again. Especially my leg.'

Therapist: 'Imagine that it's floating on warm water, like a cork, and you are gently massaging it.' (Level of the corps métaphorique, cf. 2.2.2e)

Miss B: 'It's like a log. (Whines) I'm so tired of this leg.'

The therapist goes over to the patient, massages the leg a little and addresses it directly: 'You have carried Miss B. for many years (working body). It's not surprising that you're tired!' The aim is to reduce the reification.

Therapist: 'Now, Miss B., carry on massaging, and talk to your leg nicely!'

After the relaxation exercise the participants walk round the room again, gently, as if on cotton wool. After this experience-centered work (cf. Petzold, 1988b), there is a short discussion in the group about the participants' experiences.

Mr. K: 'The relaxation did me good. Afterwards I was able to move round the room ever so lightly.'

Miss F: 'I could move about quite well too, but you notice your age so much. When I think how well I used to be 'able to move...'

Therapist: 'What are you thinking about now?'

Miss F: 'About going for walks, and dancing. I was a good dancer.'

Therapist: 'Imagine you're on the dance-floor. Try to hear your favourite tune, then begin to swing your body to the rhythm. Start with just your head. If the others want to do this too, they can. We address the 'time body' and start the action phase of the 'tetradic process' (Eisler & Stehrenberger, 1990). Almost all the participants join in: some sit and some move round 'the dance-floor' in the exercise room and dance alone. A couple is formed. The atmosphere is pregnant and totally different from that of the over 60s' dancing afternoon in the home. Miss F is crying. The therapy acquires a conflict-centered direction (Petzold, 1988b).

Therapist: 'Miss F., try to express your feelings in movement.' -Miss F makes gestures her refusal. 'I do not want...'

Therapist: 'What?'

Miss F: 'Slowly getting smaller and weaker. (She is crying more intensely.) I was a very beautiful woman.' The dismissive gestures are now strong, even violent. We get the impression that Miss F wants to ward off death and physical decay, but we consider it inappropriate to give an interpretation. Suddenly her movements become calmer.

Therapist: 'What's happening to you?'

Miss F: 'I feel lighter. It was like a struggle between old age and the young, beautiful woman of former times. But now I'm old, and my life has been long and rewarding.'

Therapist: 'See what you've still got from those times.'

Miss F is quiet. After a while she begins to sway.

Miss F: 'The tunes and the rhythm that's what I've got.'

Therapist: 'And the pleasure in them too, I hope.'

The grim struggle between the young, beautiful body and the elderly body is over (level of the 'corps phantasmatique') This makes a strong impression on the group.

Therapist: 'Gradually slow down and stop. Find a place again. Then we can talk about this.'

The integration phase of the 'tetradic model' begins. Most of the participants feel moved.

Miss F: 'I've got a bit younger, and the old feeling...it was something like those happy times.'

Miss B: 'But we're old now.'

Miss F: 'Yes, but you don't have to be so miserable. On the dance afternoons it's often forced, such hard work. For me it was good just to sit and sway my head to the rhythm.'

Mr. K: 'In these dancing hours we must behave as though we were still young and fresh.'

The groups leaves the grim subject and talks about the dance afternoons, which are 'done' by a stern nurse and where the 'compulsion to be vigorous' has up till now left the residents in an unrecognized and unverbilized dilemma. Thus the issue of evaluating the behavior of the 'old body' is touched upon, which is occasionally discussed by the group in other sessions. The expectations of the nurse and the children ('Dad, you must do something: You must get some exercise!') are experienced as pressure rather like social norms ('the enemy outside') which the elderly person cannot really accept. On the other hand, there is the feeling that people deserve their peace and quiet in old age, and this can easily turn into passivity ('the enemy inside', cf. Petzold & Berger, 1977).

Therapist: 'Even in old age people are strongly influenced by external pressures: This is right, that is wrong, you should do this and not do that. But it's a case of finding out what you really want, what's good for you, and everyone clearly enjoyed the exercises... I suggest we get moving again, sitting or in the exercise area, and everyone should do whatever he feels like doing!'

This leads into the reorientation phase (Petzold, 1988b). The participants follow their own impulses to movement. Pairs or small groups form spontaneously, moving about for a while, then sitting or resting or just swaying. The group session is over.

Conclusion

Methods such as improvising movement and creative body expression, using the diverse media at our disposal, aim at multiple stimulations (Petzold, 1988c) to evoke scenes from the memorative body, to revive what has become dead, to 'remember, to repeat and work through' (Freud) elements that have been repressed. The verbal 'working-through process' during or after the 'acting through' sequences is crucial in the IBT approach. We do not believe in purely nonverbal therapies since, for the body subject, verbal and nonverbal, preverbal and transverbal dimensions are interwoven. Man speaks, if not in words then in signals, gestures, mime – symbols which can be transformed into words. The adult has to find a name for the unspoken fears of preverbal infancy that are still lingering beneath his skin, dwelling in his bones, overwhelming him with unvoiced horrors. We have to give words to events that the patient was not allowed to mention on pain of death: 'I'll kill you if you tell mother ...!' Even the transverbal experience of joy or elation, of awe or veneration, that surpasses words, can at least be encompassed by the language of poetry, dance, or music, by the wordless language of the painter's brush. What is beyond this warrants silence: 'Worüber man nicht reden kann, darüber soll man schweigen', as Wittgenstein has taught us in his later writings. As with the silent language of words and gestures (Goodman, 1971), and with the 'action language' (Austin, 1963) of the 'speaking body', the therapeutic process is rooted in the basic milieu of co-existence (Marcel, 1985), of 'intercorporalité' (Merleau-Ponty, 1945) of 'commotilité' (Petzold, 1970). The words are an articulation of a mouth directed towards an ear, whilst the ear is directed to a mouth and its whispers, murmurs, utterances, shouts and screams. The eye sees another eye, hands reach out for other hands, the body longs for the embrace of another body: 'Zwischenleiblichkeit', intercorporality.

The bodily interconnectedness is the healing quality that should emerge from the bonding and holding, from the love and the caring that constitute the process in a therapeutic relation. And only when we succeed in establishing a milieu of 'Zwischenleiblichkeit' (Petzold, 1980), or the intercorporal bond of 'primary love', as Balint (1988) has called it, the love of a 'good enough mother', a 'good enough father' (Winnicott); only when we manage to 'emotionally adopt' our patients (Ferenczi, 1931/1964) is it possible to instil a new socialisa-

tion process. It is not a process of channelling and disciplining the perceptive body or controlling and censoring the memorative body or dominating and domesticating the expressive body, but a process of growth and enrichment, in which the body subject can realize its potential as an individual and as a member of the body of humanity.

Note

It is taught as a four-year postgraduate program in psychotherapy at the 'European Academy for Psychosocial Health', Beversee, a state – recognized training institute for the helping professions, founded by H. Petzold. When Hilarion Petzold was appointed Professor for Clinical Movement Therapy at the Vrije Universiteit of Amsterdam's Faculty of Human Movement Sciences, he began to teach and examine his approach in the framework of the university.

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