Body-Centred Psychotherapy (BCP) takes as its starting point the principle that all psychological experiences, pleasant and unpleasant, are embodied experiences (Keleman, 1981). As philosophers are keen to remind us, we do not just have bodies, we are bodies (Marcel, 1964). The world around us from conception onwards affects and leaves its mark upon the body; a point increasingly emphasised in developmental interpersonal neurobiology (Siegel, 2010) and developmental psychology (Gerhardt, 2006). For this reason, BCP asserts that the body deserves great attention in clinical practice.

Recognising the importance of the body is not unique to BCP however. Therapies from the cognitive-behavioural tradition, for example, stress awareness of physiological phenomena and include bodily awareness in their formulations (e.g., Padesky & Greenberger, 1995). Eye Movement Desensitisation and Reprocessing (EMDR) considers physical sensations a central part of the trauma treatment protocol (Shapiro, 2001). The humanistic school of psychotherapy equally pays great attention to the body. Gendlin, a philosopher working alongside Carl Rogers, developed ‘focussing’, a technique by which an embodied felt-sense expresses itself in language (Gendlin, 2003). Likewise, several of the therapeutic experiments designed by Frederick Perls aim to foster awareness of habitual gestures and bodily responses (Kepner, 1987).

Similarly, psychodynamic approaches demonstrate interest in bodily experience, and the muscular tensions and somatic symptoms habitually reported by analytic patients (Reich, 1980; Young, 2006). Some psychodynamic practitioners have even been so bold as to state that the body is the unconscious (Lowen, 1975). Contemporary BCP draws upon, or incorporates, many approaches, but in recent decades it has undergone considerable theoretical development. Carroll (2003) suggests that there is a ‘cultural and paradigm shift’ towards recognising the embodiment of psychological processes and therefore the importance of the role of the body in therapy. Research on psychological trauma (e.g., van der Kolk, 1996, 2014) and the neuropsychological literature with links to attachment theory (Schore, 2003; Solomon & Siegel, 2003), has further driven BCP to gather a repertoire of therapeutic techniques, many of which are outlined below.

BCP is therefore most accurately viewed as a cluster of psychotherapies rather than a single approach (Totton, 2003) and can be usefully grouped into three discernible models: the adjustment model, which views the correct aligning of the body as a way to psychological health; the trauma model, which holds therapy to be a process of abreaction or emotional expression in which past trauma is released from being trapped in the body; and the process model, which aims to sensitively facilitate the healing or psychological growth process latent in the body. Each of these models has
Empirical Evidence

In terms of evidence-base, BCP as a movement has tended to eschew randomised controlled trials (RCTs) and other clinical research methods. Dinas (2012) highlighted the difficulty of constructing useful outcome measures or psychometric instruments when therapeutic changes are difficult to put into words. In addition, it is challenging to devise an RCT with a therapy that tracks the client so closely and alters technique.
based on the in-session experience of the client and in-vivo experimentation. Similar problems of evaluation are reported in other therapeutic approaches that construct a bespoke treatment strategy for each client (Yalom, 2009).

Nevertheless, some single-case and anecdotal evidence for BCP effectiveness has been accrued. Individual clients report the benefits of the approach (Dinas, 2012; Fisher & Ogden, 2009), as do participants in a stabilization group intervention (Langmuir, Kirsh, & Classen, 2012). In addition to this, clinicians in the trauma field endorse the theoretical necessity of focusing on the body (Lanius, Lanius, Fisher, & Ogden, 2006; Levine, 1997; van der Kolk, 1996, 2014) and have published case examples (Rothschild, 2003). However, further studies on BCP are needed to establish the evidence-base for this approach.

9.2 Formulation in Action

The formulation presented in this chapter therefore uses the term ‘body centred psychotherapy’ (BCP) to refer to Hakomi and Sensorimotor Psychotherapies. Within this approach, key factors to inform an initial formulation include: indications of past trauma (either event-based trauma or attachment-related developmental trauma), character strategy, and how present moment experience is organised, and could provide a frame to access ‘core material’ for intervention.

Our initial hypotheses were that Molly’s main issues were driven by character strategy developed in her early and subsequent attachments and relationships. However, there may also be traumatic roots to her difficulties.

9.2.1 Character Strategies

When looking for possible character strategies, we pay attention to how they currently appear and play out in relationships, work, decision making and other key areas of a person’s life. In the assessment phase, we would assess particularly how the character strategies are manifested in the body and what the current ‘felt sense’ is within the session when attention is paid to elements of the story or difficulty being described. From the case description, we will highlight certain information which may indicate certain character strategies. However, accurate identification of character strategies requires a therapist to be in contact with a patient (Glazer & Friedman, 2009), and any conclusions drawn from a written account are therefore reflective of working hypotheses.

On first reading it appears that Molly exhibits what BCP would call Sensitive-Withdrawn (S/W) character strategy. She takes refuge in withdrawing from people as it feels threatening to be in contact with others. The other main character strategy evidenced in the case is named Expressive-Clinging (E/C) in the BCP nomenclature.
This is a strategy that attempts to maintain contact with others by dramatising to sustain attention. The indications of clinginess in relationships and words such as ‘dramatic’ used by her parents to describe Molly give a clue to this strategy. While other strategies may also be present or uncovered during therapy, the initial formulation stresses the tension exhibited in Molly between her dominant S/W presentation and the signals of an E/C strategy. While the S/W strategy seeks to withdraw from others, the E/C strategy clings to them. They therefore represent conflicting needs in Molly and it is possible that she is pulled between the opposite desires of seeking separation yet needing togetherness. This inner conflict is seen in contrasting behaviour, cognitions, emotions, body posture, inner sensation, movement, and five sense perception – what Kurtz (1990) terms the ‘core organisers’ of present moment experience.

9.2.2 Trauma

During the assessment and therapy process, signs of the remnants of unresolved past trauma would be tracked in the body. The sexual abuse disclosed is said to have occurred when Molly was aged nine, so traumatic elements would be considered in the context of developing character, also acknowledging the additional affects the trauma may have had on Molly, and how this is held in her body. It is difficult to suggest, without further information or observation, how much impact the sexual abuse has had on Molly. Therefore some assumptions will have to be made during formulation. It would be important to think about the context of the sexual abuse and also the developmental stage which normally occurs around age nine, as the abuse may have interfered with that development (Putnam, 2006). There are some indicators within her account that she has difficulty with sexual intimacy (reporting anxious thoughts about it “going too far” and feeling “dirty”), which are responses commonly reported by sexual abuse survivors (Sanderson, 2006). Pelvic pain and IBS are also commonly reported by sexual abuse and trauma survivors (Paras et al., 2009); IBS has been linked by some authors with chronic hyperarousal (Kendall-Tackett, 2000), and pain has been described as “procedural memory for the sensorimotor experiences of the trauma” (Scaer, 2014, p. 104), so we would see the physical symptoms as potentially linked to a trauma response within Molly.

Trauma is tracked in the present moment via autonomic nervous system (ANS) arousal. Some of Molly’s currently reported difficulties, such as ‘butterflies in the stomach’, needing to go to the loo, difficulty sleeping, and shallow breathing, are indicative of ANS arousal in response to perceived threat (a trauma response). However, it should also be noted that the S/W character is also a trauma-based strategy and tends to have high ANS arousal in response to attachment based threat, so an observed high ANS arousal could be linked to character and/or the past abuse history.

Central to BCP theory and practice is the ‘Window of Tolerance’ model of ANS dysregulation (Siegel, 1999), which proposes that between the extremes of hyperarousal
and hypoarousal, there is a ‘window’ within which emotions and body sensations can be tolerated, and information can be processed and integrated with this experience. Animal defensive responses, such as ‘fight’, ‘flight’, ‘freeze’, ‘submit’, and ‘attach’ are mapped onto this model of autonomic arousal at the two extremes (Corrigan, Fisher, & Nutt, 2011). The model is utilised widely within BCP to track the client’s autonomic arousal, with the aim of increasing their ability to be aware of their arousal patterns and triggers, and to ultimately be better able to regulate their arousal levels (Corrigan et al., 2011; Ogden, Minton, & Pain, 2006). Molly’s ANS arousal would therefore be tracked during sessions, and this model discussed with her so she can start to mindfully track her own arousal levels and any triggers which may lead to hyper- or hypo-arousal. We would also look for signs of dissociation occurring within the session or client report. There is little in the case description to suggest the presence of problematic dissociative experiences. However, we would continue to be vigilant for this and work with it using Sensorimotor Psychotherapy (Ogden & Fisher, 2014; Ogden et al., 2006) if it was present.

9.2.3 Present Moment Experience

When meeting with Molly, present moment to moment experience would be tracked and contact made with what is being experienced. From the case description there is little information about the ‘core organisers’ which Molly experiences during the therapeutic sessions. However, there are some interesting details which allow for supposition and inform the formulation below. Molly’s anger with the therapist in the first session is initially surprising, as a predominant S/W presentation would suggest a more withdrawn presentation. The fact that she was angry could mean that this strategy is already softening, or that another strategy was dominant, or that a trauma response had been triggered within the session. This is discussed further below.

9.2.4 Initial Formulation

9.2.4.1 Developmental Issues–Attachment and Character
It is hypothesised that Molly demonstrates an insecure-avoidant primary attachment style, a presentation which is described by Ogden and colleagues (2006, p. 49; p. 55) in terms of a tendency to withdraw from others, preferring self-regulation, and to minimise attachment needs. There is a tendency to avoid expression of emotions, and an over-regulation of emotional responses. How this can present in the body is varied as some may present as quite rigid in muscle tone and may pull back from others, whereas some may have a more passive structure in their body. This is also similar in presentation and linked to the S/W character strategy, which will be discussed further.
Given our hypothesis discussed above, it is proposed that Molly’s predominant character strategy is S/W, with elements of E/C, and we therefore formulate her case on this assumption while being open to acknowledging the presence of other strategies. As the case information also suggests that Molly’s current difficulties may have traumatic roots, it is important to acknowledge a likely trauma background, which will interact with these character strategies. People who have the S/W strategy tend to be quite isolated, and to withdraw from or avoid social contact (Kurtz, 1990), as discussed above. Molly is single, lives alone, and tends not to socialise much as she finds large groups difficult. This may indicate a tendency to withdraw as she feels unwelcome in groups and may feel like a ‘stranger in a strange and dangerous land’ (Kurtz, 1990, p. 43) when in a group setting. She only felt able to socialise with her housemates when specifically asked to do so, as she did not wish to impose on the group. Molly also felt that she did not ‘fit in’ when working as a classroom assistant. There is further indication of this strategy where she feels ‘stressed’ and ‘exposed’ at university when having to take part in role plays, presentations, and class discussions, which would be particularly threatening to this character strategy which takes refuge in avoiding being seen. Molly does have one long term friend (Eve), but seems to also keep her at distance, talking to her on the phone once a week (although it is not clear whether Eve lives close enough to Molly for regular face to face contact). More recently it seemed like this strategy relaxed a little in relation to Amy, who began working at the library, and a brief friendship began to develop. However, when Molly thought she heard Amy making a comment about her, this would have felt threatening and triggered a return to her default way of being (withdrawing and avoiding). The same withdrawal and avoidance pattern emerged after her encounter with Jack. We would hypothesise that the S/W pattern would manifest in Molly’s body with tension (often within the core) and, with trauma responses (ANS arousal) easily triggered, she may have a tendency in her body to pull away from contact with other people. Her body may physically hold the core belief around ‘holding oneself together’ via the tension and a ‘holding in’ pattern in the whole body. Core beliefs linking with this pattern might be around not belonging or being welcome, or the world not being safe, so it is likely that these beliefs would be present for Molly.

The childhood environment described is also consistent with a need for this adaptive strategy to be developed. Her home life is described as ‘lacking warmth’ and her parents living very separate lives within the same home. It is therefore unlikely that there was much emotional or physical contact between Molly and her parents, and it is likely that she would have had to learn to distance herself from people in order to cope with this environment. It is likely that she would have had many experiences of her emotional needs not being met, which would have left her having to manage these emotions, mainly by shutting them down and learning to manage them by herself. This would then be reflected in her body and muscular pattern, as her body organised itself around containing these emotions. The S/W strategy is often observed in the body as tension, tightness, and appearing to lack emotion and seeming ‘cold’ to other
people (Kurtz, 1990). Fisher and Boreham (2014a) suggest that S/W is characterised by ‘holding and tension’ in the body and the person is ‘internally frightened, extremely sensitive, often suspicious or on guard, finding it difficult to make contact because it feels as if the only safety is withdrawal far inside’ (Fisher & Boreham, 2014b). Indeed, Cotter names this the “Hold Together” personality. A pattern of holding and tension is also likely to affect breathing, so Molly may display a pattern of shallow breathing as well. There may also be a startled or withdrawn look in the eyes (Cotter, 1996).

Emotions may be quite cut-off in someone who has a predominant S/W strategy, and this may be the case with Molly, as she has learnt to not display emotions or needs, because these were not recognised or accepted. This could be observed as tension in her jaw/mouth as she learnt as a child to hold in her emotions rather than to express them. The S/W strategy often withdraws internally into cognitions, and becomes very analytical, splitting off from emotional content. However, there are also various strengths in this strategy, one of which is creativity and analytical abilities, as people withdraw into a world of imagination, theory, analysis, and fantasy (Kurtz, 1990), and in certain circumstances these characteristics can be very useful.

Within therapy, Molly is described as appearing very tense and sitting very still and upright. The phrase ‘pull/keep herself together’ is mentioned three times and is likely to reflect a core belief which could be manifested in the body in a ‘pulling in’ around the central torso area. However, it is mentioned in the context of ‘I should be able to pull myself together’, which may mean that she is finding it difficult to continue with this strategy amongst her current difficulties.

During the first session, it is noted that her gaze fluctuated between the therapist and the door, which is suggestive that a ‘flight’ response had been triggered, and her body, via the ANS, had geared up to quickly leave the situation which was so anxiety provoking for her. We could theorise that the therapy setting is threatening or anxiety provoking because her S/W strategy would not want the therapist to ‘see’ or engage with her, and so this triggers her ANS into hyperarousal. She appears to manage this desire to leave and remains in the session; however, it could be hypothesised that by suppressing her body’s ‘flight’ response, this leads to a ‘fight’ response being triggered. With the ANS arousal high, she may be outside of her window of tolerance and the anger, confrontational, and critical behaviour could therefore be a ‘fight’ response to the perceived threatening situation.

Other perhaps less dominant character strategies, which may be triggered by specific situations, are also indicated within the case description. We will briefly discuss Expressive Clinging (E/C) here as it appears particularly relevant to Molly’s close relationships and her stay on the ward, and may be helpful to the formulation, both to understand her behaviour and predict how she may present at times in therapy. This strategy dramatises and amplifies events and feelings in order to gain attention and to maintain relationships. The desire is to avoid separation and utilises dramatisation to delay ending relationships or conversations (hence the ‘clinging’ part of the term), representing a need for love and attention which has not previously been received (Kurtz,
There are some indications of this E/C strategy being present for Molly, as she is reported to have been seen as “controlling”, “emotionally demanding”, “overly emotional”, “clingy” and “dramatic” by others, particularly when a relationship is under threat of ending. On the ward, the nurses are reported to have experienced her as “histrionic”, and “attention seeking”, which also could have been due to the activation of the E/C strategy as she sought to gain attention from staff members. It is possible that the staff who felt they had established a positive relationship were able to meet some of her needs for attention and consideration, and therefore this strategy was not needed. As mentioned above, it is possible that Molly is pulled between her two main character strategies – one desiring separation and withdrawal to feel safe, the other desiring contact, and maintaining this through drama and ‘clinging’. This could therefore create quite a conflict within Molly, and be confusing to others as she exhibits seemingly contrasting behaviour at different times.

9.2.4.2 Trauma

Whilst there is less information about any traumatic effects of the sexual abuse, it is suggested that Molly has had particular difficulties in sexual intimacy, which we would suggest is linked to her past abuse history. Her reports of feeling “dirty” and worries about sexual intimacy “going too far” suggest that it continues to affect her. Within a body focused therapy it may be difficult for her to focus on her body because of what that might mean for her in relation to the past abuse. It is also possible, however, that she might be re-experiencing physical symptoms of trauma in her body, and may have difficulty regulating her nervous system and physiological arousal levels due to the remnants of past trauma. This might be related to the abuse in her past history, and may be particularly triggered when there is a perceived ‘threat’ of sexual intimacy. The level of trauma-related physiological arousal would be tracked within sessions, particularly when sexual relationships are discussed. It is likely that if unresolved trauma is held in the body then it would need to be processed as part of the therapeutic work.

The formulation would be held in mind whilst working with Molly, but is flexible and open to change depending on new information and insights that might emerge. In addition, the focus of each session would also be negotiated with Molly, and the therapist would have a ‘mini-formulation’ within each session about the current issue being addressed and the possibility of change within that issue.

9.2.5 Intervention Objectives

An essential element in body focused psychotherapy is establishing mindfulness (Kurtz, 1990). This is discussed with the client and taught from the beginning of therapy; the interventions require the client to be mindful (noticing their present
moment experiences) rather than being ‘hijacked’ by the past experience being discussed (Ogden et al., 2006). One of the key differences about this therapy is that we are interested primarily in mindful observation of present moment experience when a difficulty from the past is being discussed. This enables dual awareness, rather than getting caught up in the past, and enables people to learn to stay within the window of tolerance during therapy in order to process past traumas (Fisher, 2011b; Ogden et al., 2006). From first meeting the client, the therapist also engages in mindful tracking (observing) of what the client experiences in the body as we assess how they organise experience through the core elements of body sensation, movement, sensory perception, cognition, and emotion (Kurtz, 1990), and how cognitions and emotions are experienced in the body. The therapist makes ‘contact’ with what they notice, through the use of contact statements (Kurtz, 1990), such as: ‘As you say those words, your leg starts to shake’. The therapist also engages in ‘body reading’, looking for procedurally learnt and long standing physical and postural tendencies that may reflect long held beliefs and patterns of emotion, attachment, and strategies of character (Ogden et al., 2006). Within mindfulness, an ‘experimental attitude’ is fostered, and a variety of experiments are used to explore and work with key issues (Kurtz, 1990). For example, the client might be asked to ‘notice what happens when...’ the therapist or client does or says something (Kurtz, 1990). Objectives of intervention and the process of therapy depend on whether there is a traumatic or developmental focus for the session; we will comment on both here given that both appear relevant in Molly’s case.

9.2.5.1 Trauma

Similar to other trauma-focussed therapies, BCP takes a three-phased approach to treatment. Ogden et al. (2006) label these phases as: (1) Developing Somatic Resources for Stabilization; (2) Processing Traumatic Memory and Restoring Acts of Triumph; and (3) Integration and Success in Normal Life. The aim is to create stability, resources, increase the ability to regulate arousal, and stay within the window of tolerance before traumatic memories are accessed and processed through the body. During Sensorimotor Psychotherapy for trauma, the patient learns to regulate their autonomic arousal and to gain more control over their response to trauma-related stimuli. They also gain greater understanding of how recalling trauma affects their current experience of their body, thoughts, and emotions, and to notice these in the present without judging or interpreting them. In addition, they learn to discriminate more clearly between past and present experience, facilitating an ability to recall the traumatic event without feeling overwhelmed, leading to a sense of the event as being “finally over” (Fisher, 2011b, p. 174).
9.2.5.2 Development & Attachment

The objectives for developmental work are similar in that they are aimed at “addressing the bodily and autonomic symptoms of ... attachment-related disorders, as well as the cognitive-emotional aspects” (Fisher, 2011a, p. 101). For clients with an insecure-avoidant attachment, or S/W strategy, the therapeutic objectives are to increase the ability to engage with others when their arousal is at a higher level than they have previously been able to cope with. Ogden et al. (2006) state that to “practice managing this higher arousal state during interpersonal interaction fosters a wider window of tolerance” (p. 58), acknowledging that a slow paced approach is needed to avoid psychological and physical defences being triggered. For Molly, this would mean that through the process of therapy we would aim to explore and create resources to enable her to tolerate being in social situations more, and feel less like she has to withdraw from them. This would work directly with long held patterns related to her predominant attachment/character style.

The framework for a developmental session is presented in Kurtz (1990, pp. 72-73). Within the therapeutic relationship, mindfulness is established, and a ‘frame’ (focus) for the session created as experience is evoked: “thoughts, feelings, images, memories, sensations, tensions, impulses, and the emergence of the child” (p.72). A variety of techniques can be used to ‘access and deepen into the experience’, and then the session moves into ‘state-specific processing’, where the therapist accesses core material through the body and other core organisers, working with the child state and with strong emotions (which Kurtz sometimes calls ‘Riding the Rapids’). The aim is to use technique to “create the experience that wants to happen” (Kurtz, 1990, p. 72), following which the client experiences a transformation in their body, emotions and/or beliefs. This new experience is then integrated through the body, cognition, and emotion, and ends with ‘completion’ (see below for specific examples of techniques).

In Molly’s case we may work with the trauma process first, as it is likely that she may need to learn to regulate her arousal and stay within the window of tolerance to even enable her to engage with the therapeutic process. We would therefore start with resource-building and stabilisation before working on any traumatic issues from the past abuse. The work with attachment/developmental patterns and character strategies may be interspersed with the trauma work, where appropriate, depending on what is triggered for her, or in the field, at each session.

It is an anticipated part of the process that barriers will emerge during therapy, and indeed Kurtz (1990) recognises a number of possible points at which this may happen. He names these “insight, response, nourishment and completion barriers” (p.170). The ways these barriers emerge are strongly linked to long-held patterns based on early attachments and experiences, and they are acknowledged and worked with as part of the therapy.

It is also anticipated that Molly may have a ‘phobia of therapy and the therapist’ (Ogden et al., 2006; Steele, van der Hart, & Nijenhuis, 2001) which would need initial attention. With her avoidant attachment pattern, it may feel very threatening to
engage with another person in such an intimate way, and it may take a while to build a therapeutic relationship with her for this reason. It may be useful to use experiments around proximity to help her to explore this further (see below).

Mindful observation, therapist tracking, and client report are the main within-session measure of whether these objectives are being achieved. In addition, there may be a transformation which is reached but needs integrating into the client’s life to show whether the process has been effective. Therefore, therapist and client might agree a way for the client to test something out in their life between sessions. Client reports of improvement in their life, their body, cognitions, and emotions are the main ways of assessing therapy progress and effectiveness. In trauma work we would look for less autonomic arousal in relation to the trauma, whereas in developmental work we would look for relaxation of character strategy and therefore greater freedom to act with more choice within their life.

9.2.6 Intervention Plan

Initial sessions would focus on resource building and stabilisation, and would involve considerable psychoeducation about the nature of trauma, the window of tolerance, and how the body is involved in this. Therapist and client would track the body and how it participates in discussion about current and past issues. Mindfulness skills would also be a focus of initial sessions. The therapist should also pay attention to their own physiological arousal levels in sessions in response to the client, and any somatic transference/countertransference which is experienced (Ogden et al., 2006; Rothschild & Rand, 2006). Whilst we would work in therapy with any of Molly’s character strategies that emerged during the process, we will focus here on S/W for clarity and to demonstrate some of the possible interventions we would consider.

In working with the ‘phobia of the therapist and therapy’, experiments using proximity may be helpful. Molly, whilst being mindful, would be asked to observe what happens in her body and other core organisers when physical proximity to the therapist is changed; for example, the therapist moving one step closer or further away from her. In this way, we can explore the body’s reaction to proximity to others, and how this is also experienced in her emotions and beliefs. Finding a distance from which Molly feels comfortable undertaking therapy will help with the ‘interactive regulation’ (Ogden et al., 2006, pp. 58-59; pp. 214-216) of her nervous system, and enable her to stay within the window of tolerance in therapy sessions. It would also enable study of her S/W character strategy, acknowledging where her boundaries lie, and enabling work with them, to help her to tolerate closer proximity and the higher arousal that creates, giving her the opportunity to explore and test this out in therapy before trying it out in situations in her life.

The therapist would need to be mindful of the predominant S/W strategy and adjust their style accordingly; for example, an over empathic therapist may drive an
S/W client to withdraw. It is important to also respect the positive aspects which the character strategy brings and how this has helped the person to survive to this point in time. Molly will have a strong preference for ‘auto regulation’ (i.e., regulating her own feelings and body as opposed to someone else helping her to do this) and so early experiments in therapy may involve seeing whether she can tolerate any ‘interactive regulation’ for even a moment (Ogden et al., 2006, pp. 58-59).

At each session, the focus for the session will be agreed, and the therapist would be aware of whether it is likely to have a trauma or developmental focus.

9.2.6.1 Trauma
Assuming that trauma work is needed, we would begin by developing somatic resources to enable stabilisation and increased ability to regulate body and emotions. An initial aim is to build upon and develop existing resources which are held within the body. This might arise from the therapist noticing a movement which occurs when a particularly resourceful belief is mentioned, for example, or to strengthen the client’s ability to say ‘no’ (Ogden et al., 2006). The movement might be an indication of a resource held within the body which the therapist would draw attention to and strengthen. The therapist would look for hints of somatic resources within Molly’s presentation, and build upon what emerges. There could also be experiments around posture and movement; for example, if Molly presents as very tense and ‘upright’, then she might be encouraged to experiment with movement or relaxing tension, and noticing what happens as she does this. Development of other somatic resources might involve centering exercises (e.g., the client putting a hand on the core and a hand on the heart), grounding (e.g., increasing awareness of the feet on the floor, or the body supported by the chair), breath work (e.g., careful awareness of how the client tends to breathe, and experiments with changing these patterns to regulate arousal), and boundary work (e.g., experiments to enable the client to experience their personal boundaries) (Fisher, 1999; Ogden et al., 2006, pp. 224-223). These somatic resources are practiced and strengthened, then applied to ‘future templates’ (imagining future challenging situations), and then on into the client’s life (Ogden et al., 2006, p. 233).

If trauma responses are still held in the body, or the body is holding an active defence that wanted to happen at the time but could not, then sessions would involve sensorimotor processing of the traumatic experience during the second phase of therapy, or work around reinstating an active defence (Ogden et al., 2006). Sensorimotor Psychotherapy offers one method of processing, called sensorimotor sequencing (described in Ogden et al., 2006, p. 253). Other body focused options for processing trauma are also presented by Levine’s (1997) somatic experiencing therapy, or Rothschild’s (2000) somatic trauma therapy.
9.2.6.2 Development, Attachment, and Character

Developmental sessions would take the form suggested by Kurtz (1990), as presented above. Within this overall structure, it would enable work on the key early memories that led to the formation of core beliefs, as the child ‘map maker’ made sense of how to manoeuvre through the social and physical world (Kurtz, 1990). These core beliefs can be accessed in a number of ways, but a key technique is “going for meaning” (Kurtz, 1990), where core beliefs are expressed in the form of bodily tension, gestures, movements etc. Kurtz (1990, p. 141) describes this technique, where tension in the body is noticed, emphasised, and mindfully observed in detail. The therapist then asks questions such as “If this tension could speak, what would it say?” or “What are you saying with your body when you tense that way?” (Kurtz, 1990). In this way, core beliefs and meanings are discovered, accessing them via the body.

Experiments such as “Taking Over” might also be used. This is where the therapist takes over something that the client procedurally does, to allow the client to experience something different. For example, if Molly was hyper-vigilant and constantly watching the door, the therapist could take that over for her (i.e., watch the door), allowing Molly more freedom to look around the room and ground herself within the environment. If there is a pattern of tension in the body, the therapist might also “take over” this for the client as an experiment (Kurtz, 1990).

Probes might also be used as an experiment during different parts of the process (Rothschild, 2000). Verbal probes are words which are said by the therapist to the client (usually relating to a missing experience that the client has never had), where the client is asked to mindfully observe their response to the words being said, so that they respond rather than react (Kurtz, 1990). A probe which is often used for an S/W strategy is: “You’re welcome here” (Kurtz, 1990), which would likely be an appropriate experiment for Molly given the formulation. She would be asked to notice what happens when she hears those words, in relation to all of the core organisers (body sensation, five senses, movement, thoughts, and emotions) and report what she notices. A reaction is expected, such as a bodily or emotional response, or a thought such as: “I’m not”. Sometimes a probe is used as a way to access and work with a past memory – to evoke an experience to work with at a deeper level. It is quite possible that using this probe with Molly might lead her to access a memory of not feeling welcome, perhaps in a situation from her early childhood. As the early childhood memory is likely to be more linked to ‘core material’, we would work with that memory through the process described by Kurtz (1990): accessing the core material and working with the child state of consciousness, accessing strong emotions and allowing them to emerge, aiming to create the experience that ‘wants to happen’. Kurtz is clear that the adult always remains part of this process as dual awareness is maintained:

“The child and its experiences built the world view and the self-image. The child was the map maker. So, in contacting and working with the child, you have the possibility of changing those maps and the person who is now using them. By just being
there with that child, by talking to it and holding it, and explaining things, by being careful and concerned and patient, just by doing that you change the way that child feels about itself and the world. And in doing that, you can change the adult, too” (Kurtz, 1990, p. 133).

In Molly’s case the missing experience might be to truly feel welcome, and for her child parts to have the experience of feeling welcome too, aiming to create a shift in her beliefs and emotions. However, the process is creative and can utilise various techniques as appropriate; it is therefore difficult to predict exactly what might emerge during therapy with Molly, and which specific techniques might be used, without further therapeutic interaction with Molly herself. Other possibilities are the use of physical experiments (Ogden et al., 2006, p. 49) and ‘Magical Stranger’ (Kurtz, 1990) among others.

In summary, BCP offers a holistic way of formulating and intervening with individuals, considering bodily experience (alongside cognitions and emotions) as central to understanding a client’s difficulties. It is a creative, flexible way of working that is informed by the client’s needs at each session. However, this in itself makes BCP a difficult intervention to research in a randomised way, and the challenges of establishing its effectiveness remain.

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9.3 BCP Formulation: Critical Commentary

In considering this chapter it is very difficult to get to any underlying theory on which the approach is based. Very early on, the authors make the point that the fundamental defining principle of BCP is that we are “bodies”; however, they then concede that most other modern psychological theories agree with this perspective. Furthermore they also rapidly acknowledge that BCP is primarily a repertoire of techniques drawing on a range of influences: Clearly this is an unfortunate position from which to undertake a formulation. Indeed all the more unfortunate in that a coherent account of the phenomenology of human emotional experience also seems to be missing from the approach. Instead, the focus is on physical habits, mannerisms, and “character strategies” (character strategies are essentially a form of personality typology involving eight different ways of relating to the world that are at least “functionally rather than pathologically” labelled). The authors admit that there is very little evidence to support the validity, utility, or efficacy of any of this but attempt to defend their stance by stating that the outcomes BCP practitioners are interested in are “difficult to put into words”.

Despite all this, the authors’ “initial hypothesis” is that Molly’s current issues are derived from the “character strategies” that she acquired in early childhood and consolidated thereafter. The character strategies identified essentially describe Molly’s
avoidance and clingingness, and the approach/avoidance conflict that inevitably arises from these two competing social strategies. The authors also consider the possibility of Molly’s problems having “traumatic roots” (the alleged sexual abuse at the age of 9 years old – the nature of which is currently unknown) and make “assumptions” that this experience has contributed to Molly’s current difficulties with sexual intimacy. At one level, this is a reasonable assumption. However, in practice, when considering the role of the alleged trauma, the focus on the body “in the present moment” causes at least two problems which potentially impair the development of a comprehensive formulation: Firstly, given Molly’s account of a neglectful childhood, she may have been particularly vulnerable to being targeted by others for abuse (as noted above, we do not know anything about the nature of the alleged abuse); secondly, it would imply that the adult relationship/sexual conflicts she reports were not the primary causes of the sexual problems she describes in adulthood. The BCP approach to formulation does not appear to have the flexibility to accommodate these alternative possibilities.

In practice, within the main formulation section, the authors initially put BCP to one side and begin with attachment theory. They describe how an “insecure avoidant attachment style” will be expressed in terms of either a “quite rigid muscle tone” and associated withdrawal or “more passive structures” – such variability in expression, with potential for quite disparate presentations, would presumably make it difficult to interpret the individual’s responses. The authors nevertheless diagnose a primary “Sensitive/Withdrawn” character strategy with elements of an “Expressive/Clinging” (E/C) character strategy. These diagnoses then struggle to account for observable but, from the perspective of BCP at least, conflicting behaviours, such as Molly “relaxing” her character strategies when she meets Amy (at work), and indeed her anger directed at the therapist. Faced with this difficulty, the authors simply change their primary model/terminology and suggest that Molly’s “body may physically hold” core beliefs that account for the conflicting observations. Various other descriptions of Molly’s posture follow before the authors move on to talk about possible interventions. It is unclear how Molly’s body (as opposed to Molly) can hold or express a core belief.

With respect to intervention the authors propose that a “key difference” between BCP and other therapies is focus on “in the moment experience of when a difficulty from the past is being discussed” which enables the client to “learn to stay within a window of tolerance” – essentially a moderate, tolerable level of physiological arousal. Other intervention strategies include focusing on the “autonomic symptoms” of the purported underlying attachment disorder. However, in essence, the process of intervention described here primarily involves an unstructured desensitisation/exposure programme in which attention is drawn to various physical habits and responses. Whether Molly’s body, her brain, or Molly herself is being affected by all this counter conditioning seems largely irrelevant for the practical purposes of BCP – although, seemingly at random, the authors finally suggest that, from a BCP perspective, asking Molly a series of questions around whether she “feels welcome” might be helpful.
Given all of the above it is difficult to see what, if anything, BCP can contribute to either a formulation or intervention that other approaches do not do better, other than increasing client and therapist attention on physical signs of distress. The underlying BCP approach to formulation as articulated here seems to be an eclectic and rather uncritical brew, drawing on a little attachment theory, a measure of personality diagnosis, and a pinch of cognitive structuralism. All these ingredients can be found in other psychological models, some of which also have an evidence-base. Similarly, the suggested BCP intervention strategies also draw on an assorted range of sources (but would seem in essence to be reducible to unstructured covert and overt counter conditioning paradigms). On balance, it would therefore seem that BCP has more in common with so-called integrative approaches, than with evidence-based, theoretically driven approaches. Consequently, I would suggest that clinicians give preference to familiarising themselves with a more coherent and empirically-supported model of human action/intervention, whilst bearing in mind the common sense observation that we should attend to what our clients do as well as what they say.

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9.4 Author response

Writing about BCP in a volume explicitly dedicated to psychological formulation is problematic to say the least. In recent times, it is largely the advocates of behavioural therapies who have most emphasised the notion of formulation, whereas body psychotherapy prefers to explain its therapeutic rationale without using the term formulation at all. Writing from a body perspective in the present volume therefore feels somewhat like playing to an away crowd. And inevitably, in response, the author of the critical commentary musters the stridency that comes from standing on familiar ground.

Primarily, it is important to address the accusation of theoretical inconsistency. The critical commentary suggests that BCP draws on an inadequately bolted together set of theories and techniques. It is asserted that we draw on personality type, then shift to attachment theory, then leap on cognitive constructionism. Nothing could be further from the truth of BCP in practice.

It is true that BCP does draw on a wide range of psychological theory. This is one of its strengths. In a brief chapter it is difficult to elaborate the points of integration between developmental neuropsychology, attachment theory, gestalt psychotherapy, cognitive-behavioural theory, and the numerous other ingredients that make up the consistent flavour of BCP. The task is made more difficult by the fact that many of these conceptual underpinnings are not shared by other contributors to this volume. To convince an audience of newcomers to the approach, more explanation is needed than can be allowed here.
This theoretical diversity however, is not a weakness of BCP, but rather its strength. One of the central commitments of the body centred approach is holism: the view that everything in the human body, mind, and context connect together and influence one another. All formulations by definition take some small slither of this whole for the purposes of making a beneficial intervention, but no formulation captures the entire ecology of the presenting client and her problem. BCP as an approach is therefore deeply committed to not confusing the map with the territory. Just as geographically accurate maps are arrived at through numerous techniques of photography, surveillance, observation, and sampling, so too are accurate views of the clinical situation derived from numerous perspectives, none of which can claim to be the whole truth.

BCP essentially is a critique of the very notion of formulation. The body from this perspective is the formulation: the structural expression of the client’s resources and stresses that, if attended to carefully, directs therapeutic intervention. Far from being a string of boxes and arrows in the therapist’s head, the formulation is the bones and sinew of the client’s body, from which the therapist develops intervention based on the client’s experience as well as theory. It is not a dogmatic formula to be defended, but a living phenomenon to be explored. This lends BCP a singular advantage over the more abstruse constructions of behavioural theory – the advantage of being real and centred upon present moment phenomena.

References


