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What PBSP can teach psychoanalysis

Abstract

In this article, I will first be outlining the theoretical and historical features of psychoanalytic theory and practice which make psychoanalysts reluctant and even dismissive of any consideration of including bodily interventions in psychotherapy. In this section I will focus on the inter-related concepts of gratification, influence and neutrality. I will show how these concepts have been historically linked with the impulse-discharge model of the mind that Freud employed as his working model. I will then outline the shift in contemporary psychoanalytic thought from the impulse-discharge model of the mind to the information-processing, meaning-making model of the mind and the tension this shift has place on the traditional concepts of gratification, influence and neutrality. I will then outline what PBSP says about these concepts and how they could be useful to psychoanalytic thinkers as they attempt to redefine the notions of gratification, influence and neutrality.

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Introduction

Contemporary psychoanalytic theory is in a period of intense growth and turmoil over some its basic concepts. There are many sources for these exciting developments, but for my purposes here I will argue that a primary cause of this turmoil is a shift in the basic paradigm of the mind from one of the mind as an impulse-discharge mechanism to the mind as a meaning-making, information processing system. This shift has meant that the way psychotherapy is thought of has undergone a parallel shift from an emphasis on "insight," or helping the patient to develop ways to control instinctual impulses, to an emphasis on helping the patient to gain new affect-laden relational experiences that allow the patient to understand him or herself, and the world, in new more self-enhancing ways. In this shift some long established psychoanalytic concepts, in particularly, the concepts of gratification, influence and neutrality, are now marked by a great deal of confusion and debate. Within this framework PBSP theory and practice can make a very big contribution.

Consider the following statement made by Heinz Kohut, who in his theories really helped open the doors of psychoanalytic theories beyond the rigid, dogmatic posture of mainstream psychoanalysis common in both the 1950's and 1960's in the United States. In this statement he is introducing the notion of pathological fragmentation, the terrifying experience of feeling like one is "falling apart." He writes:

> There are many people who, in going from adolescence into adulthood, make tremendous steps of adaptation. But they do not break down; they do not become depressed; they do not all turn to security measures like drugs, or touch therapy, or whatever may be involved in order to confirm the fact that they are alive, real, and worthwhile. There are many people who can suffer through normal process and pain of making change from one system of the self to another one. Why do some break down? (KOHUT, 1987, p.32, original work, 1971, emphasis added)

While we can't be sure what Kohut meant by "touch therapy," he does associate it with primitive attempts to hold a fragile sense of self together in a similar way to drug addiction. One doesn't get the sense that Kohut would in anyway welcome some form of touching into the psychotherapeutic process. This impression is buttressed by Kohut's (famous in self psychology circles) example, given some seven years later from the above quote[1], where he described working with a patient who was in a very painful state of despair and depression. Kohut offered his finger for this woman to hold and he said that he envisioned, "the toothless gums of an infant clamping down on her mother's breast." He gave this example to illustrate that armed with theory of self psychology, the analyst might even do things that are considered to be psychoanalytically "sinful" in order to stay empathically connected with a patient. And indeed, even to this day, self psychology is responded to with some scorn amongst some other psychoanalyst as overly gratifying, that is, that it tends not to be a "real" psychoanalytic process but merely masquerades as such while what is really happening is that the self psychologist is "just being nice" to his or her patients.

I say all this to give you some idea about what we are up against, at least in the United States, when it comes to talking about psychomotor therapy to the psychoanalytic community. The basis for its attitudes about touch, stem from its view of gratification, and a more or less related topic of influence in psychotherapy. I will say briefly the place these two concepts have had in psychoanalytic thinking about psychotherapy.

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[1] The example I'm giving here was part of Kohut's last public remarks he made, just days before he died in 1981. I had the privilege to be present at this talk, and in this example I am going by my own memory of it.

Gratification in psychoanalysis

Ghandi once said something like, "you can give a hungry man a loaf of bread or you or you can teach him to fish." Psychoanalysis, and with this PBSP has little disagreement, views the goal of therapy as teaching patients "how to fish." In psychoanalytic theory, "gratifying a patient" means that the therapist is passing out bread and ignoring the task of teaching the patient how to fish; the two processes are seen as mutually exclusive. In psychomotor language, the equivalent concern is that the therapist does not bypass the patient's pilot. The concern that psychoanalysis has over the therapist being simply gratifying is the concern that the therapist does not be simply identified in the patient's mind as the ideal parent with no consciousness of the symbolic nature of interaction.

Clearly neither the psychomotor therapist nor the psychoanalytic therapist wants to do this. In fact, I think a very sound argument can be made that almost everything about the methods of psychomotor psychotherapy is designed to avoid this possibility of confusing literal, contemporary interactions with symbolic historical interactions. Both systems would agree that bypassing the client's ego may feel good to the client at the time, but nothing therapeutic comes of it. What comes of it is establishing a dependence between the therapist and client or patient that is very difficult to break.

Where the very big disagreement takes place between PBSP and psychoanalysis is in the psychoanalytic tendency to define any sort of touching, or any sort of intervention except interpretation, as gratifying in the way I have just outlined. Nowhere is there any prominent provision in psychoanalytic theory of technique for carefully thought out and controlled, ego-enhancing, interventions involving touch of any kind.

The whole topic of bodily interventions remains largely undiscussed because of the old tradition which maintains that touch in psychotherapy is by definition "gratifying" in the sense of always bypassing the patient's pilot. Al Pesso's concept (1991, pp.43f) that touch itself can be ego building, remains the single most radical and challenging position that psychomotor can take from the perspective of psychoanalysis.

Influence and neutrality in psychoanalysis

The problem of influence in psychotherapy goes back to the very beginnings of Freud's development of his theories. Early on Freud stopped using hypnosis, replacing it with free association, in some part because not all patients could attain a hypnotic trance state, but also because Freud was concerned about simply replacing the influence of one parental figure for another. To put this matter very briefly, if a major cause of neurotic suffering is the overly harsh judgment of a superego, this means that a major cause of neurotic suffering is the patients' inability to exercise their own judgments on their own behalf. For instance, if the superego says, "You are a bad person for having such and such sexual desires," keeping in mind that content of the superego is largely inherited from the parent's superego, for the therapist to simply

counteract the superego messages with her own messages means that the patient will only have traded one set of parental messages for another without ever developing a capacity to make ones' own judgments.

Out of this concern, and others, Freud was concerned to limit the therapists' influence in the therapeutic process. This value of developing the patients' capacity of free-will choice on their own behalf is one of the important concerns behind the psychoanalytic concept of "neutrality." The doctrine of neutrality holds that the therapist should think of him or herself like an objective scientist, like a surgeon, as Freud put it once. In part this objective stance was to protect the patient from the subjectivity of the therapist so that the patient could develop his or her own pilot. In this light, any intervention that is directly gratifying, such as the therapist saying things like he likes the patient even if his patient's parents did not, or any intervention attempting to directly influence the patient, such as giving advice or stating what the analyst thought about something, is seen to be a non-psychoanalytic intervention that, more times then not, creates a regressive pull in the therapeutic encounter that at worst destroys the patients' ego and at best simply does not foster psychoanalytic goals.

Impulse-discharge model

Time will not allow me to elaborate on all the reasons for this psychoanalytic position, but certainly a primary justification for viewing any intervention other then interpretation with suspicion was the belief in an impulse-discharge model of the mind. This viewpoint is based on a model similar the operation of a steam engine. Instinctual needs, or drives, were seen to be like the energy of raw, un-captured steam. Like a steam engine, these forces had to undergo a series of transformations so that they could be used productively, which is to say, toward the end of maintaining both the survival of the species and of the individual. The term, "acting out," refers to behaviors that reflect the expression of raw instinctual energies that have not undergone transformation by first going through the structure of the ego. An adolescent, for example, who is angry at his parents and is arrested for shoplifting, would be said to be "acting out." In distinction to this would be the teenager who is angry with his parents and is able to "transform" the anger into something like a productive conversation with his parents, or who expresses the aggressive energy through creating, like composing music with angry lyrics. In this way of thinking the ultimate expression of maturity and mental health is the ability to suspend or sublimate the expression of raw instinctual impulses. The primary marker of this ability is the ability to put ones' impulses into words.

Out of this understanding psychoanalytic treatment entails two movements: One is providing a space where it is ok to reveal any and all desires, and second, the limitation that all desires will only be talked about and not acted on. Any therapeutic intervention that fosters action, or direct expression of instinctual impulses, is looked on as potentially dangerous. Likewise, any

interventions by the therapist that are not entirely verbal are thought to be dangerous in that they potentially foster direct instinctual gratification.

Meaning-making model

This way of understanding the mind, and the subsequent ways of understanding psychotherapeutic interventions, has been largely discredited within the current psychoanalytic scene. Through an explosion in knowledge about the brain, and in actual research on infant development, to name just two of the sources that have pressed psychoanalytic thought to change, the new psychoanalytic vision of the mind is that it is primarily an agent of meaning-making. In this model, the problem of an acting out teenager is not seen as an inability to control instinctual urges. Instead, the problem is seen to be the teenagers understanding, particularly their unconsciously held understandings, of whom they are and how they fit into the world. The shoplifting teenager, for example, might be seen as someone who has an underlying operating principle, or map, that says that the only way she can be heard and responded to is by doing something as drastic as breaking the law. The shoplifting, in other words, maybe an expression of a deeply held belief that the world is not interested in meeting her needs, and the subsequent anger and despair that she finds herself in such an impossible world. Such beliefs, or operating principles, are formed by affect-laden relational experiences. The teenager, for example, had repeated experience growing up that her parents were unable or uninterested in meeting her emotional needs when she very much needed them to be responded to.

Such learning is not bloodless, logical learning, like learning multiplication tables, but learning bound with a high degree of feeling or affect. For example, I can remember clearly the first time I was stung by a bee. My subsequent caution and fear about bees were not merely a logical learning that if some bee stings me it will hurt. The mere sight of a bee recalled the intense, alarming, unexpected pain I felt in my cheek when I was first stung. The sight of a bee subsequently inspired not only logical thoughts, but panic. It took many years of reassurance and examples from my father that in general if you don't surprise bees they have no interest in hurting you before I could remain calm at the sight of a bee.

Following this example, the learning of new meanings which serve as the underlying operating principles to our behaviors, takes place largely by the acquisition of new relational experience. To use the example of my experience of bees, after much risk taking, my map, or my memory images of bees, came to include images of my father reassuring me, while he himself remained perfectly calm, in the presence of bees. As these memory images became more firm, when I then saw a bee I had a different set of memory images to guide my behavior through the encounter. These new memories included not only being painfully stung, but also the memory of many experiences of my father admonishing me remaining calm, while he himself remained calmed, and not being stung. The new learning includes new relational experience, the experience of being calmed by my father's calming attitude.

Turmoil in psychoanalysis

Thus, in the new model of mind, psychotherapeutic interventions in a psychoanalysis have come to emphasize the acquisition of new relational experience. The current rub in psychoanalytic thinking is how to incorporate this new model within the context of concepts that are historically rooted in a totally different way of conceptualizing the mind. How does, for example, a psychoanalyst think about the problem of providing new relational experience within a conceptual framework of neutrality, which historically had meant trying to minimize the impact of the therapist presence in the therapeutic situation? How does the analyst provide new experience without influencing the patient? In short, how does the analyst throw out the bath water of conceptualizations steeped in an impulse-control model of mind, without throwing out the baby of very legitimate concerns also embodied in those concepts? It is at this very point that I believe psychoanalysts would benefit from an encounter with the methods of PBSP.

PBSP, gratification, influence and neutrality

PBSP and psychoanalytic thought agree in their concern that the therapeutic experience does not foster a therapeutic contract – conscious or unconscious – that promises that the patient can expect that the therapist, unlike anyone else in their life, will meet all their needs. Likewise with the other side of the coin, the therapeutic relationship is not about the therapist getting his or her needs met in the therapeutic relationship. KOHUT (1984) gives an excellent example of why a therapy that merely offers the gratification of needs cannot work. The German leader Bismarck had a life long sleep disorder; He couldn't sleep. Eventually he found a physician who cured him of the problem; His physician discovered that Bismarck could sleep if he slept in the same room with him. From the moment of that discovery, Bismarck's physician slept with him. The problem with such a cure is that even if it works, as it did in Bismarck's case, each therapist could only have one or two patients in their life time.

It is not enough for the therapist to identify that the patient is suffering from some need deficit and then simply meets that need. Such a move involves an implicit promise that if the patient needs something like support, nurturance, and so on, then the therapist will meet the need. The real problem is that the therapist is not in a position to honor such a promise. The first time the therapist is not available to meet the patients' need, the patient experiences the relationship as a "negative reconstruction" of their original unsatisfactory experience.

My first experience of this was with one of my first patients I ever worked with as a volunteer therapist in an inner city walk-in counseling-center. The patient's condition was what I would now recognize as a severe borderline personality disorder. His life was lonely and very bleak; no one loved him, he had no friends who truly understood him, he couldn't hold a job because his employers were against him, his parents, with whom he lived, hated him, and so on. One of the first things I offered him was that I could meet some of those needs by being available to him by phone. I gave him my home phone number and encouraged him to call me when

he needed to. Within a very short period of time he was calling me constantly and at all hours of the day and night. Naturally I had to rescind my offer, which met he then experienced me as being just like everyone else. His "old map" which offered him the operating principle that the world and he were such that he could not expect his basic needs to be met ended up being supported and confirmed by my well-intentioned attempt to be helpful.

In psychomotor structures this problem of providing new, truly gratifying experiences without the therapist being identified as the gratifier is worked with in a variety of ways. First of all is the framework of therapy taking place within a structure. By working in the framework of a structure the therapist is implicitly saying that the therapeutic work takes place in a symbolic arena rather then in a literal arena. Winnicott referred to this arena as "transitional space," or "play space." In my own mind I have taken to identifying this space as a "ritual space." Through the process of enrolling and de-rolling, by dividing accommodators into "negative aspects," and "positive aspects," and above all, by enrolling figures of gratification as "ideal" figures, structure space is established as a different order of reality from everyday reality. Obviously, ideal figures exist only on the plane of "as if." The therapist does not offer herself as a literal ideal figure in the life of the patient.

The ability to enter into this ritual space is a skill that if not possessed by the patient must be taught. We unconsciously employ this ability whenever we watch a movie or a theatrical production. I remember once watching the movie, "The Flintstones," with a 4-year-old friend. This friend was terrified by the movie and the video had to be turned off. The child could not view the "world" being created in the movie as a "pretend" world. The slapstick comedy could not yet be viewed as an "as if," "pretend" reality.

I don't often use the word "pretend" to describe this level of reality because it implies that the experienced reality is not really "real." The fact is, as human beings, we live in this so-called "pretend" reality all the time. When I look at an object and identify that object as a chair, I'm living in something of this reality that I've called ritual space. When we identify an object, such as identifying a chair, we are identifying the meaning of that object. The transitional, ritual, play space of a structure experience is the experience of entering into a set-aside psychic area of pure meaning and meaning-making. It's a space where a pillow or other accommodator can be imbued with the meaning of a hated person and destroyed without causing anyone actual harm, and yet the experience can be "real" for us.[2]

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[2] What I'm trying to identify here is that we always exist and operate in a world of meaning. The experience of something as something, such as a "chair," is to identify the human meaning of the object. In a strictly scientific mode the attempt is made to describe objects as if they were devoid of human meaning, i.e., that is, as if humans did not exist. Thus, the chair might become a collection molecules bound together in a certain way. What science sometimes disowns is that its way of looking at things is also serving the needs of the scientist. In a sense, there is nothing "objective" about "objectivity."

The dimension that PBSP psychotherapy adds to this equation is that physical experience can happen on this symbolic ritual arena just as much, and perhaps more so, as verbal experience can. The fact that in structures symbolic meaning is carried by physical means highlights that it is the establishment of the ritual space that is important over any particular symbolic language in establishing such a space. In other words, it is not the verbalization per se which ensures the nonliteral ritual space that all therapy must occur in. Whether verbally enacted or physically enacted, or both, the important step is that a therapeutic, ritual space, be created by the two participants. The important part is that the symbolic ritual space is constructed by both parties and some degree of conscious understanding is established that the therapeutic relationship takes place predominantly within that space. Once this is established the concern that gratification leading to a non-therapeutic regression is very much minimized.

The second way that PBSP psychotherapy deals with the dangers of gratification is matching gratification with the correct developmental sequence. A large part of the problem of gratification is that the gratifications (the meeting of basic needs) that our patients crave are needs that the patient was taught very early in their lives, by experience with their care-givers, that they simply won't be met or will be inadequately met. These unmet needs then come to expression, in the mind, as the need of the original child at the time of the deficit. Young children are utterly dependent on their care-givers to meet their needs. If the parents don't come through the young child and infant has no choice but to cope with life in a state of need deprivation. This state is identified as reality. When this happens, the child is apt to identify their craving for the need as the problem. Everything would be ok if only they could get rid of this pesky need. Therefore, when the need emerges in the therapeutic relationship, the patient experiences their self as a helpless child who needs a parent to take care of them. The need, in other words, is experienced as a specific need for one or both of their actual historic parents to interact with them in a certain way. This means that even if the need is met, the image, or map, of the original need state is not transformed because the need is experienced as a need for a specific parental interaction. A therapist could meet the need for the rest of the patient's life, just as in the example of Bismarck, and it would not change the basic operating principle that, for example, "My needs will not be met because I am unlovable in my parent's eyes."

By creating a ritual space within which the therapeutic encounter takes place it becomes possible to place the new relational experience being gained in therapy "back in time." So, for instance, the experience of being loved by the therapist can become the experience of, "If I had parents who loved me like this when I was three I would have felt about myself and my needs something like I feel now." An experience like this can then become what Al Pesso has called, "a virtual memory." I believe that what such an experience does is open up a kind of pathway in the mind's eye; it allows the ego (the pilot) to identify, "this is who I would have been and what the relationship would have been between me and my needs if I had parents like this." This is similar to actual airline pilots who are taught how to fly a particular plane by first flying in a very elaborate flight simulator. Many of the actual skills needed are developed

in the flight simulator before any actual flying is done. The "as if, pretend" reality that occurs in the ritual space of psychotherapy works in the same way. Whether the need is being symbolically met by an accommodator or symbolically met by an empathically attuned analyst in the transference, by being clear that the needs being met in psychotherapy are the simulated experience of having the needs met when they were developmentally needed, the therapist avoids gratification from becoming literal.

Whenever the gratification happens on a literal level, there is a huge danger of what PBSP calls a negative reconstruction. Because the patient is not literally a child and because the therapist is not literally the patients' parent, any implied promise that the therapist will literally be the yearned for parent will fail. This attempt will not fail sometimes, but always. When the failure happens, it has the impact of strengthening the patient's dysfunctional operating principle (old map).

Influence and neutrality

The PBSP therapist deals with the problem of influence – the problem of helping the patient to become a relatively free adult who can fluidly adapt to changing circumstances in life by making their own judgment calls about what is needed – by making sure that the patient's pilot is always engaged in the therapeutic process. The pilot is that part of the person's self that is the final executer of all decisions. The topic of the concept of the pilot has many complexities. But in practical terms it means that the therapist does not operate from an assumption that he or she "knows what best" for the patient. Respecting the pilot of the patient is not so much a set of discrete techniques as it is an attitude on the part of the therapist. It means things like, the therapist does not say, "You need such and such." Instead the therapist says, "From the way you are gesturing, or the themes of your associations, suggest that you might need such and such, is this true?" I've heard Al Pesso speak to this issue by saying that it is important that the therapist always be one or two steps "behind the client."

The tricky part here is that because the patient frequently is in a mental state of a young child seeking a parent, they want the therapist to be a literal parental figure and tell them what to do. When the therapist succumbs to this pressure, several destructive things can happen: First and foremost is that it destroys ritual space; it implies a contract that the therapist will be a literal need gratifier. Second, more times then not it leads to what I think of as a sado-masochistic enactment. Here, the therapist is elevated, in both parties' minds, to the position of an all-knowing benevolent parent. The therapist then derives emotional gratification from successfully fulfilling this role. This means that the therapist can become frustrated and drained when they can't successfully fulfill this role. This leads to a kind of "force feeding"; "Here, you will eat what's good for you no matter what." The patient thinks of it as their sacred duty to fulfill the therapist by taking on whatever is offered whether it fits or not. The fact that things get worse simply solidifies the therapeutic relationship in these sadomasochistic terms. That is, the

patient feels more helpless and hopeless, and thereby needs the therapist even more and the therapist is further gratified by feeling how much the patient needs their benevolent wisdom. These dynamics occur in any long term therapy from time to time. The goal is to minimize them and not make them a defining characteristic of the therapeutic relationship. The "cure" is for the therapist to always track with the patient's pilot and always keep in mind it's development. A primary manifestation of this, among others, in PBSP psychotherapy is by insisting that the actions of the ideal figures come from the patient. This leaves the patient in charge of identifying what is needed. Where judgment is needed is that this is a skill and not every patient comes into therapy with fully developed pilot. When this is the case, the first order of therapeutic business is to help the patient develop their pilot capacities. Sometimes this can even mean risking a temporary sadomasochism enactment by being a bit more actively suggestive. However, I think that it's appropriate for the therapist to be anxious whenever they risk this because there are real dangers in taking such a position.

Finally, the PBSP therapist deals, above all, with the problem of influence by maintaining what is called, "the possibility sphere." The concept of the possibility sphere has struck me for a long time now as the functional equivalent of the psychoanalytic concept of "neutrality." Just as a country might maintain a position of neutrality in regard to the conflict between other nations in a state of conflict, so too is the psychoanalytic therapist to maintain neutrality in regard to the patient's internal conflicts. Should the patient express their anger or not? Should the patient feel guilty about certain desires they might have? In all such matters the psychoanalyst is to maintain an attitude of neutrality.

As I stated earlier, a primary motivation for this concept, historically, was to protect the patient from the analyst's subjectivity. The goal was for the analysis to help the patient attain a state where they could make their own decisions on such matters, relatively free of ongoing, painful intrapsychic conflicts. The problem with the concept of neutrality, in my view, is that it is based on a notion that it is possible to eliminate the therapist's subjectivity. In the contemporary psychoanalytic scene, it is widely acknowledged that such a stance is impossible to achieve. Even the so-called neutral stance is a subjective stance that influences the patient's therapeutic process. The problem is, again, how to throw out the bath water of the impossibility, and even desirability, of eliminating the therapist subjectivity, while retaining the baby of the necessity of maintaining that it is the patient's growth that is the focus of the therapeutic work. I believe that the whole problem is more easily solved by substituting the concept of the possibility sphere for the concept of neutrality. Briefly, the concept of the possibility sphere is attempting to describe an attitude on the part of the therapist whereby the therapist focuses her awareness on the needs of the patient. The possibility sphere is an interpersonal, emotional space created by the therapist that extends a kind of promise to the patient that "here your efforts to be all that you are will not be thwarted." It acknowledges that the therapist has influence, in fact a lot of influence, in providing an interpersonal setting that maximizes the patient's growth and healing, but also emphasizes the need for the patient to define what

growth and healing is. The concept of the possibility sphere is based on a metaphor of a womb. Just as a womb provides just exactly what the growing fetus needs for its particular developmental needs, so does the therapist endeavor to provide a psychological space that allows and fosters the growth of the patient. This space has to be a dynamic, responsive space to the unique needs of both participants. To mix metaphors, just as a master gardener would notice that certain plants do well in certain conditions while other plants do well in other conditions, so the therapist uses her capacity to influence toward the ends of the particular patient's needs. Likewise, certain gardeners also may require certain conditions to apply their craft. A successful therapeutic relationship requires a fit between the two participants. I wish here to suggest that as an image, the image of providing a womb-like sphere, designed to enhance the growth and potentials of our patients, strikes me as a more user-friendly image then that of an antiseptic scientist. It's an image that I think focuses the therapeutic task without the baggage of the impulse-discharge model of the mind which the concept of neutrality is burdened with. At the same time it preserves the cautions and limits, inherent in the image of neutrality, that the primary therapeutic concern, be that the patient and his or her needs are to be the focus of attention.

To close this section, I have argued that in this time of theoretical upheaval in psychoanalytic thought and practice PBSP theory and practice can offer the psychoanalytic community some help in solving some of its thorniest theoretical dilemmas. First and foremost, PBSP psychotherapy demonstrates that the establishment of transitional, or ritual space does not have to be restricted to non-gratifying verbal exchanges. For example, if the ritual space has been established, even if the psychoanalyst does not employ explicit psychomotor techniques, they need not fear saying things like, "Yes, I love you," to their patients as long as both parties know that the exchange is taking place in a carefully crafted ritual space. Such a space has a kind of "as if" quality to it. The patient understands that if the therapist actually had been their parent the therapist would have been honored to love them in the manner they needed, but in fact she isn't literally going to be their parent. Secondly, the psychoanalyst need not fear their influence on the patient if he or she keeps an attitude of providing the patient with a possibility sphere and constantly monitors the therapeutic relationship for potential breaches in the possibility sphere. Specifically, that the therapist monitor the patient's material for signs that the patient feels like they need to take care of the therapist or that the patient show signs of not receiving sufficient interpersonal nutrients from the therapist to progress therapeutically. This need for therapeutic nutrients will vary from patient to patient. For example, some patients may be upset at any self disclosures from the therapist and others might desperately need such self disclosure.

There is much more that could be said, but for now I will give a clinical example that I think illustrates the points I am talking about.

Clinical example

When I've employed psychomotor techniques with individual cases, my employment of the techniques has happened fairly spontaneously, without much preparation for the patient. For example, one woman in her early 40's came back to see me after a break of eight years. I had seen her for three years, with once weekly sessions, conducted in a traditional psychoanalytic fashion. When she finished, neither of us had any expectation that we would be seeing each other again; that is, she felt finished. She returned because of acute distress she felt over perceiving that she might be parenting her 5-year-old son in a manner that was similar to her own hated upbringing by her own parents. At the same time, her father was terminally ill, and in fact died within a month of her return to therapy.

At the first session of her return she described the vicious inner circle that she had fallen into, which resulted in her feeling an intense fear for her son and intense self-hatred. Her father's work had necessitated that the family move almost once a year to a new location. These moves had been brutal on her and what was especially brutal was her parents' complete lack of empathy for what the moves meant to her. She grew up feeling like her emotional needs had no place in the hearts and mind of her parents and that she literally had no "place " in the world. She was forever being the "new kid on the block" fighting for a sense of acceptance. She adapted to her anxiety's about fitting in by becoming her image of what both her parents and each new school situation saw as a perfect child. In this strategy she was outwardly successful, but inwardly, she felt a perpetual panic that people would find out who she really was and hate her.

She was aware that she anxiously observed her son in school for any signs that he was not being accepted and if she saw any such signs would feel a panic that would result in her desperately attempting to get her son to be more conforming. She recognized that her panic for her son was actually her childhood panic for herself revived and tried as hard as she could not to subject her son to her perfectionistic demands but was frightened that she was not succeeding in this. At the same time her father's apparent impending death, seemed to kick off an intense rage and panic about being abandoned by her father, a state which she experienced in childhood as constant.

As she told me all this, in her first session, she was quickly swept up in her rage and panic. She started crying in a kind of helpless rage and panic both toward her father and toward herself for bringing her own son into the world and creating, she thought, the same conditions for him, that she had grown up with, because she couldn't control her own feelings. Her body, as she cried, started to shake violently, as if her body could not contain the emotions she was feeling. I stayed my traditional psycho dynamic course until she started having difficulty breathing and it was evident that she was descending into ego-less psychotic panic. At this point the PBSP therapist in me kicked in and I suggested to her that sometimes when people are feeling that much emotion that it feels good to have some physical contact and I wondered if she would like me to put my hand on top of her head (just above the forehead to give her resistance to

a rocking motion she was making). With some desperation in her voice she said, "yes, please," and I sat next to her and put my hand on her head. She calmed down just a little bit right away, and continued with a kind of anguished grief over how her father had never been available to her in any way except to make perfectionistic demands on her behavior. As she spoke, I notice that she was embracing herself with her arms. I said that she looked as if she was holding herself and that perhaps she was feeling a childhood urge to be held by her father. She agreed, and spontaneous grasped a pillow that was on my couch and clutched to it. She calmed down a bit more. I witnessed the fact that with my hand on her head and the holding of the pillow she seemed to be calming down, like she was feeling soothed. She agreed. I suggested that she might take the feeling of being soothed and imagine that if "somebody like me," had been back there then when she was little and felt so alone, that she would have been responded to like this. She regained her composure even more.

By the end of the hour she expressed amazement that such simple actions on my part could have such a profound effect. I explained that since the last time we had worked together I had trained in another form of therapy called PBSP and explained a bit about how it worked. That was our first session and in subsequent sessions, at about a once a month frequency, we have done simple pillow structures with me serving as an occasional extension of an ideal parent when she needed to hold a hand or feel some sort of resistance.

For me this single session is a great illustration of how psychomotor techniques can be ego enhancing. I offered both gratification of needs and was actively influential, I think, in response to what her body seemed to be wanting. And far from pulling into a dangerous regression, they pulled her out of a dangerous regression. That is, her pilot functions were in danger of being totally swamped by her intense affect. By offering myself as a containing figure and suggesting she put the feelings she had from my actions back into her memory of herself as a child, she was able to regain her considerable pilot functions. It was clear to both of us that while I was giving her the containment and comfort she craved, it was done on a symbolic or ritual level. She was giving her remembered childhood experiences a symbolic make-over. She was learning who she would have been if she had the parenting she desired.

To close, I have found that my psychomotor background helps me to visualize the shifting dynamics that occur in the conducting of more traditional psychoanalytic psychotherapy. If the therapeutic setting is established as a symbolic, ritual space, and if the therapist is sensitive to how the patient is enrolling the therapist, the way is made clear to safely symbolically gratify childhood needs and for the patient to feel helpfully influenced. When done within these parameters, gratifying and influencing serve to strengthen the development of the executive functions of the pilot. Under these conditions we can teach our hungry patients how to fish.

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