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BODY PSYCHOTHERAPY AND RECOVERY FROM SCHIZOPHRENIA

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Literature Review

There is tremendous controversy with regard to the etiology of non-organic schizophrenia and therefore its prevention and treatment are far from definitive. Whether someone diagnosed as schizophrenic can ever permanently recover is also disputed by many "distinguished scientists" surveyed (APA, 1987; Morgan, 1983). Many clinicians tend to see recovered Person(s) Diagnosed as Schizophrenic (PDS) as having either been misdiagnosed or in a state of remission (Harding, Zubin & Strauss, 1987; O'Keefe, 1994).

This literature review will summarize past and present views on the treatment of schizophrenia and on body psychotherapy. Most reviews on the recovery controversy and on etiological theories would be beyond the scope and purpose of this article. Nevertheless, I will include some of the major theories of causality, particularly those of somatic theorists, as they seem to be most relevant here. The reader interested in etiology may wish to consult one of the comprehensive summaries of schizophrenic research, including those complied by the Group for the Advancement of Psychiatry (1984), Gottesman (1991), or Kales, Stefanis & Talbott (1990).

Etiology

Proponents of the genetic theory of etiology have based their research on clinical population genetics and twin studies. Still, the role of genetic inheritance is unclear. Environmental and psychogenic theorists point to the staggering evidence of neglect and physical, emotional and sexual abuse in the early history of PDS to support their position (Karon & Vandenbos, 1981; O'Keefe, 1994). Some of the more radical theorists, like Szasz (1976), Laing (1960, 1970) and Breggin (1992), have questioned

the existence of schizophrenia as anything more than a socially invented label. Others, like Grof and Grof (1989), Laing (1960), and Lukoff (1975), suggest that schizophrenia can be a form of "spiritual emergency" with potential for great advancement in levels of awareness.

Most somatic (bioenergetic: Fitzpatrick 1983; Lowen, 1975), Reichian (Baker, 1967; Reich, 1992) and Core Energetic (Pierrakos, 1987) therapists see schizophrenia as caused by a rejecting or traumatic pre- and perinatal environment which damages the normal sense of self and leads to its disembodiment. Laing adds that "the seed is thus sown for a persisting running together, mergence, or confusion at the interface between here and there, inside and outside, because the body is not firmly felt as me in contrast to not-me" (Laing, 1960, p. 190).

Lowen (1967, 1975, 1980) supports the claims of the family systems theorists, like Bateson and his colleagues, that children can be driven to insanity by parents who are sexually seductive and rejecting at the same time: the "double-bind" theory. The child is given two opposite messages simultaneously, and the conflict disables children's communication abilities: they become unable to determine what people really mean and subsequently cannot express what they wish to convey.

Reich (1992) had a view of the etiology of schizophrenia similar to Laing's (1960). In the schizophrenic, the character armoring breaks down and the "biosystem" of the person is flooded with deep experiences with which it cannot cope. The " deep experiences" to which Reich refers are the pleasurable streaming sensations associated with intense excitation that is mainly sexual in nature. The schizophrenic cannot cope with these sensations because his/her body is too contracted to tolerate the energetic charge and, unable to deflect the excitation, reduced it through psychotic processes (Lowen, 1980). Having become, As Reich (1992) called it, "homo normalis," PDS betray the acceptance of their natural energetic streamings for the security of being well-adjusted; the alternative is craziness.

The preeminent theory on the causality of schizophrenia today is the diathesis theory, which suggests that this diagnosis develops as a result of a genetic vulnerability to stressful life events and circumstances, such as developmental difficulties, inadequate

support systems, and poorly developed coping mechanisms (O'Keefe, 1994).

In short, there is continuing debate over etiology and no empirical demonstration for the validity of any one theory to date. Treatment modalities remain tied to this continuing debate.

Psychoanalysis and the Body

Among theorists in the field of psychology, Sigmund Freud (1957) addressed the body/mind relationship issue in his structural theory, which posited a central role for the body as the wellspring of instinctual drives and the source of psychic structure. Contemporary theorists (e.g. Greenacre, 1958; Mahler & McDevitt, 1982; and Pierrakos, 1987) have followed suit in postulating the body-self as the substrate for a cohesive sense of self and the essential foundation for interpersonal relationship (Laing, (1960).

In practice, modern psychoanalysts largely ignore the physical side of psychosomatic development and the use of touch in their work. Touching remains one of the greatest taboos in most forms of psychotherapy (Goodman & Teicher, 1988; Montagu, 1971; O'Keefe, 1994; Older, 1977; Scheller, 1993), particularly when it comes to the seriously disturbed. The only exceptions seem to be in dance (Siegel, 1984) and neo-Reichian therapies (Fitzpatrick, 1983; Lowen, 1980; Pierrakos, 1987) for which touch is an integral part of treatment for most client populations. Certain other therapists, who do not consider themselves body psychotherapists, report using touch (Whitaker, Felder, Malone & Warkentin, 1982), but generally there is relatively little written about the use of touch in psychotherapy.

Fitzpatrick states that, at Hanbleceya, " a program of body therapy was designed to enable schizophrenic individuals to become aware of their bodies, their selves, and discover their own boundaries, which would enable them to distinguish themselves from other persons and objects in the world" (Fitzpatrick, 1983, pp. 61-62). Touch is incorporated as a continuous activity throughout the day as part of a culture that encourages physical stroking and holding. Such activities were created out of belief that early relationships develop through touch. Older (1977) argues that there are times when taboos should not be broken,

but recognizes how our therapeutic behavior as linked to cultural prohibitions against physical contact is important in our choosing to act differently (i.e. touch) when it is appropriate.

In part, the body's disenfranchisement in psychoanalytic schools reflects Freud's shift from an id to an ego psychology (S. Freud, 1957; Griffin, 1989). Subsequently, psychoanalysis has become more and more exclusively a science and practice of exploring mental content divorced from physical process. One consequence is the "often circular" nature of analytic thought stemming from a lack of empirical anchoring in observable, somatic phenomena (Griffin, 1989). Several writers also suggest a countertransferential dimension to "talk therapies" neglect of the body. Fain and Marty (1965) suggest that "the inexplicable soma may be a narcissistic affront to the analysts' interpretive powers" (Griffin, 1989, p. 2).

Both orthodox psychoanalysis and bioenergetics agree that the character structure has a somatic component, yet only body psychotherapies recognize this connection in practice as well as in theory. Character structure in psychoanalytic theory refers to an individual's idiosyncratic, automatic style of ego compromise and defense. In Reich's own words:

> **The ego, i.e., that part of the person that is exposed to danger, becomes rigid, as we say, when it is continually subjected to the same or similar conflicts between need and a fear-inducing outer world. It requires in this process a chronic, automatically functioning mode of reaction, i.e., its "character"... as if the affective personality is armoring itself (Reich, 1992, p. 338).**

Character formation thus involves a rigidifying of the ego in the sense of "locking in" early experiences about personal, permissible and impermissible ways of being in the world. People's character structure thus recreates the form of childhood conflicts within their adult relationships. From this, Reich reasoned that clinical observation of the relationship between mental processes, respiration, and muscular tension would reveal client's attitudes. Eventually Reich came to conclude that the psychic character was not only accompanied by but indeed was structured in and maintained by patterns of chronic muscular tension in the body. In *Character Analysis,* Reich (1992) described the essential co

determination of the psychic and somatic attitudes as a "functional unity." Although Reich and most other psychoanalysts later parted ways for a variety of reasons, Reich's views on physical dynamics and character structure were assimilated within the canons of analytic orthodoxy, even for Anna Freud (A. Freud, 1957). After Reich's departure, however, mainstream psychoanalysis rejected the body's therapeutic potential.

Lowen's bioenergetic analysis (1967, 1975, 1980) is an extension of Reichian technique and characterology in which diagnosis from the body and emotionally expressive working through remain important elements. Both Lowen and Pierrakos (1987), with their bioenergetic and Core Energetic analyses, defined pleasure as the primary human motivation that is blocked by energetic stagnation. Psychotherapy is conceptualized in terms of intersystemic conflicts genetically and, for Pierrakos (1987), spiritually related to disturbances in psychosexual development.

Consistent with their Reichian heritage, bioenergetic and Core Energetic therapy emphasize an activist approach to intervention in which the therapist confronts the character armor in order to break through the rigidities that block emotional expression, restrict energetic flow, and encapsulate traumatic memories.

In fundamental agreement with many of the British object relational theorists (Griffin, 1989) Lowen asserts that "every emotional problem has a schizoid core" (Lowen, 1967, p. 18). Thus everyone is schizoid to some extent. He, like the object relations theorists, identifies the threat of annihilation inherent in early maternal rejection as the major etiological factor in schizoidism, of which schizophrenia represents its most extreme form. In the case of the schizoid character type, the mother's rejection and hostility are communicated by the absence of pleasurable physical intimacy and the sustained frustration of the infant's bodily needs (Griffin, 1989; Laing, 1960; Lowen, 1967; Pierrakos, 1987). On the psychological level, this threat produces a diminution of the sense of self typified by the schizoid tendencies toward emptiness, detachment, futility, and depersonalization. Dissociated from the source of his/her own impulses, the child develops a split in self-experience which creates a withdrawal inward and a deadening of the body (Laing, 1960; Pierrakos, 1987).

Schizoidism is viewed in body psychotherapy as defining a continuum extending from health to psychosis, and as present in everyone to a greater or lesser degree. Etiologically, the psychodynamic theorists trace this condition back to a failure of maternal empathy and physical closeness in infancy. Consequently, "the infant's self-experience is split, producing a diminished and impoverished sense of self characterized by dissociations between intellect and affect, impulse and motility, mind and body" (Griffin, 1989, pp. 60-61). Many psychoanalytic authors (Laing, 1960, Lowen, 1967, 1975, 1980; Pierrakos, 1987; Reich, 1992) thus detect a disturbance in highly schizoid individuals' sense of themselves as bodily selves.

The Body and Recovery From Schizophrenia

Relatively little has been written about the possible connection between bodily experience and recovery from schizophrenia. According to Reich (1992), the pioneer of body psychotherapy, the PDS is terrified of being overwhelmed by either being in contact with others or being in contact with his/her own "pleasurable" bodily sensations. Both Baker (1967) and Lowen (1980), Reich's students, noted the PDS's "vacant" eyes, terror of physical contact, and minimal breathing. In working with schizophrenia, Reich believed it was essential to (a) work towards greater contact by treating the PDS with care and respect, and taking the patient's internal experience seriously, and (b) work actively with their bodies through breathing, physical movement, and touch (O'Keefe, 1994), Baker (1967), Fitzpatrick (1983), and Lowen (1967, 1975, 1980) also emphasized the need for the therapist to make meaningful personal contact, guide the client through breathing and physical movement exercises, and to initiate nonsexual physical contact with PDS.

Juhan (1987) notes the dilemma of the professional who believes that touching clients is essential for healing. The prevailing taboo against touching one's patients since Freud's time has already been discussed here. Yet, according to Juhan, touch therapies have made many breakthroughs with PDS who do not respond to conventional therapeutic treatments. Juhan further claims that the PDS's withdrawal from contact with others may create a whole range of difficulties that could be confused with

the primary disturbance caused by physical contact "malnourish- ment."

Podvoll (1990), the founder and one-time director of the Department of Contemplative Psychotherapy at the Naropa Institute and of Maitri Psychological Services and its Windhorse Project, believes that it is essential for the therapist to be aware of the spiritual aspect of psychosis and its close relationship to the body:

> **The body in psychosis is in transition. It begins to manifest a variety of possibilities. Sometimes it is felt to be a spiritual body, a purified body, an invisible body, a body of the other sex, an inanimate body, a machine, a new body endowed with new characteristics and possibilities far beyond the confines of the body left behind (Podvoll, 1990**
> p. 122).

With the Windhorse Project, Podvoll countered the conventional wisdom on recovery and developed an in-home treatment approach that seems to show how authentic recovery can occur without dependence on medications. In his book, *The Seduction of Madness,* Podvoll (1990) points to the importance of the therapist's ability to perceive and protect the "islands of clarity" experienced by the PDS for recovery to occur. He contends that anything promoting body and mind synchronization will further the appearance of these islands of clarity. Furthermore, relating to the PDS both emotionally and physically with kindness and consideration is a necessary part of helping the PDS to develop similar consideration towards his/her own body and mind.

Each PDS's treatment program at Windhorse Project is individually tailored to include live-in family support. Clients either live with their own parents, alone, or in staffed Windhorse households, and significant family members are involved with their respective teams as participants in the healingjourney. The client also takes an active role in designing his/her own treatment plan which continuously adapts to his/her unique situation. Individual and group psychotherapy are included in treatment, but no body psychotherapy per se. Awareness of bodily reality appears to be the only aspect of body therapy used at Windhorse.

Fitzpatrick's treatment approach (1983) at Hanbleceya (now called Project Win) is, at present, the only facility in the United

States that routinely incorporates body psychotherapy into the treatment of PDS. O'Keefe's findings (1994) on the recovery process of 10 "graduates" revealed the importance of such treatment for the recovered PDS.

All of the Hanbleceya graduates interviewed by O'Keefe had been treated by a wide variety of therapeutic approaches, including verbal and somatic therapies, as practiced by both licensed and unlicensed practitioners. The optimum environment found to be most helpful to the participants was that of a therapeutic community which practices the kind of nonexclusionary philosophy proposed by Glass (1989), Podvoll (1990), and Fitzpatrick (1983). Therapists and therapeutic environments which expect full recovery were also found to be essential for the interviewees in their recovery experience.

O'Keefe makes it clear that there is "much more research and discussion needed in the apparently taboo areas of therapeutic use of PDS-therapist physical contact, and the encouragement of the PDS to exist pleasurably in her/his body, including sexual healing and expression" (O'Keefe, 1994, p. 89). It seems imperative, then, that currently accepted treatment practices continue to be evaluated and alternative approaches which show promise be further explored.

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