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Body-to-Body-Communication and Somatoform Disorder in China: A Case Study Regarding Culture and Gender

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Theoretical Study

Abstract

Somatoform disorder and somatic symptom disorder SSD are resistant to traditional medical support. Patients experience a vicious cycle of focused awareness/attention towards distressing bodily sensations. A negative interpretation of these phenomena leads to "worrying, cognitive styles" concerning the body (body-image, which enhances further self-awareness/self-observation) towards unpleasant bodily sensations and hyper-arousal. Body-psychotherapy may be one approach appropriate in dealing with these disorders and syndromes. This article addresses the concept of creative body-work, defines its basic guidelines and aims, demonstrates a practical approach to support patient familiarization with body-self-experience and how to establish a basic contact (relationship) and control the vicious negative cycle. A positive working definition of somatoform disorder would include the following: illness perception and illness attribution; illness behaviour; health-related anxiety; emotional distress; disability; quality of life; doctor-patient-interaction and health care utilisation. This article relates to specific cultural aspects working with patients in China within a one-day professional workshop including clinical observations and analysis. It also refers to the gender perspective. Psychotherapy and psychosomatics more and more also have to consider these perspectives.

Keywords: Body psychotherapy, Somatoform disorder, Body experience, somatic symptom disorder, Medically unexplained symptoms, Cognitive behavioural therapy, Psychodynamic psychotherapy, Gender perspective

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Body psychotherapy in China

Interest is growing in China related to body psychotherapy and psychology. Colleagues want to understand the person in terms of the body and learn how to work with the body in psychotherapy. They want to adapt various concepts, strategies and interventions that were developed in the field of body psychotherapy for several reasons:

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Chinese cultural perspective:

1) Other kinds of psychotherapy, such as psychoanalysis, are based on complex theories but lack systematic practical training in China. It is difficult for the therapist to combine theories and techniques. Furthermore, our colleagues are not often familiar in self-experience. Compared to other forms of psychotherapy, body psychotherapy is relatively easier to study and to learn. The techniques of body psychotherapy seem to be simpler to use. Therefore, therapists in China are attracted by body therapy.

2) Chinese are often not good at expressing feelings due to Chinese culture. If a person, especially a woman, could bear the tough situation silently, she is considered virtuous. Therefore, repression is a common self-defense and somatoform disorders become a common illness. It is difficult for such women to express their feelings and thoughts to other persons. Body psychotherapy can help them access their inner world and explore their emotional level by focusing on bodily feelings. Thus, body psychotherapy could be suitable for Chinese.

For example, the relationship between mother-in-law and daughter-in-law is easily strained in China. The feud between the two female family members is always hard to avoid. And Chinese people treasure 'filial piety' and 'etiquette'. Therefore, if an argument arises between a mother and her daughter-in-law, no matter who was right, the daughter-in-law would be considered as unfilial and ungracious. The son has the same moral anxiety. So, many daughters-in-law choose to suppress their emotion to adapt to the main cultural trend. They hold back their emotions because they fear that the bad emotions cannot be reasonably expressed. This often produces bodily symptoms. Everyone in the family can better handle this unconscious relational conflict because the bad emotions are held back and suppressed whereas the bodily symptoms can be accepted as merely body symptoms. If body psychotherapy could make patients realize the connection between body and emotion, it would help them.

The academic psychology is convinced that China is well developed—economically and socially. And yet, there is a large discrepancy in the field of psychological and emotional development of people. Ordinary people are deeply interested in psychology, in psychological literature, and psychological issues. Media already defines this movement as psychological hype. Psychological issues and questions are communicated like a storm in the social media. More and more, Chinese people are joining psychological workshops to experience themselves in a new way, to explore their personality, and to develop with more joy, curiosity and happiness.

In 2015 a new internet video platform went online offering videos of psychological lectures, conferences and statements processed for an academic audience as well as for ordinary people (www.iepsy.com). Meanwhile, universities and clinics are trying to establish structures for psychosomatic and psychotherapeutic treatment imported from western countries. Colleagues are trained in various psychotherapy methods, with recent political demand for new psychosomatic departments in many hospitals nationwide.

Body psychotherapy (BPT) is a fairly new approach in China. It is convincing insofar as BPT allows therapists to holistically understand the person as a unit. Insofar that BPT understands the person as a functional unit, it understands the person in his/her functional identity—always connected with the body.

This article offers insight into how BPT functions practically, into the understanding of BPT, and into a special increasing field of problems working with somatoform disorder syndrome (SSD). We offer a specific case study for illustration in connection with specific comments/analysis with reference to relevant concepts and guiding ideas of BPT.

Medically unexplained symptoms SSD / MUS

A thirty-two-year old woman involved in a special training-program for physicians complained about regularly occurring, heavy headaches. She has suffered from these headaches for many years. Her headaches were diagnosed as a medically unexplained symptom (MUS). She tried various medications, sports and relaxation exercises. Via her own study and personal experience as a physician, she knew that it would be difficult for her to find proper treatment, nor could she reach a state of deep relaxation and well-being in her life. Nothing helped nor stopped the chronification of her pain.

Chinese cultural perspective:

It may be challenging for patients to accept that there may also be a psychological background for their physical symptoms. The development of psychosomatic medicine in China is immature. Many Chinese, including the doctors in the general hospitals, are not familiar with the concept of "psychosomatic medicine" or of "somatoform disorder". It is easy for patients to accept a diagnosis of organic changes, but if told that there could be a mental or psychological health problem, they feel embarrassed. Stigma is very common among such patients.

China suffers from a serious lack of qualified psychiatrists and psychotherapists. Many patients with somatisation symptoms only go to the hospital for testing and diagnosis; they can't believe that their body has no serious physical problems. They will never choose to see psychiatrists or to get psychotherapy; on the other hand, doctors in general hospitals rarely refer such patients to psychiatrists or psychotherapists.

Therefore, it is important for the therapist to take the physical symptoms of the patients seriously to establish a relationship with the patient. Then the emotion and the physical expression can be treated.

Overall, unexplained medical symptoms are common in primary care settings; there is a high prevalence in primary care (approx. 30%) and in secondary care (approx. 20 %) (Fritzsche, 2015).

"Somatic symptom disorder (SSD) is characterized by somatic symptoms that are either very distressing or result in significant disruption of functioning, as well as excessive and disproportionate thoughts, feelings and behaviors regarding those symptoms. To be diagnosed with SSD, the individual must be persistently symptomatic (typically at least for 6 months)" (American Psychiatric Association, 2013, p.1).

The DSM -V renamed somatoform disorder as somatic symptom disorder (SSD). Clients complain of bodily distress and pain not connected with emotional or psychological complains. Co-morbidity rates are prevalent with other psychological disorders including depression, anxiety, personality disorders, narcissistic and borderline disorder.

We refer to a case in a group of professionals in Shanghai. I met the client in a workshop with other physicians, psychologists, counsellors and social workers in Shanghai at Fudan University. She talked about her pain and the severe headache as well as about her specific life situation, which was characterized by intensively experienced stress especially since she finished her degree as a specialised physician. There was also severe stress in her clinic team related to seeing too many patients by herself and being consciously engaged in adapting concepts of Western medicine.

Chinese cultural perspective:

In China, young doctors like this patient are under much pressure in their work routines and day-to-day lives. The patients only trust the big hospitals in big cities, so the doctors are in great demand in such hospitals. This leads to irrational distribution of medical resources: the big hospitals in big cities, especially in Shanghai, are full of doctors. Only a few young doctors are willing to work at small hospitals in small towns because of the impact on their career development. Thus, qualified doctors go to the big cities. At the same time, there's long-term pressure at work in the smaller cities. Work is burdened because the relationship between patients and doctors is intensely stressed and strained. It quite often happens that doctors are killed by their patients, and at the least, they face a high grade of aggression in the doctor-patient-relationship.

Gender perspective:

Aside from pressure in working environment, newly-graduated female physicians in Chinese big cities, e.g. Shanghai, face also big challenges in their personal life. On the one hand, the high cost of life in those cities can hardly be covered purely with income of a newly-graduated physician. This leads to chronic anxieties due to a constant feeling of insufficient substantial resources. On the other hand, big pressure from work and a lack of leisure time makes it even harder for them to build up an intimate relationship or even start a family. It hasn't been a long history, since the society started to accept that women should have the right to live on and for their own, independent from husband and sons. Many females often find themselves in big conflicts, while struggling to pursue an ideal career. This pursue of successful career may be strongly doubted by their family of origin or even unconsciously by themselves, who deeply believe that no happiness could be gained without a husband and a child. Not being able to start a marriage means for many of those young females not being able to psychologically leave their family of origin, and is thus trapped in this phase of family cycle. They could suffer both mentally and physically from being stagnant, which violates to the basic human nature of being dynamic and developmental.

Although SSD has been discussed for decades, there is still a controversially run debate and still uncertainty regarding the physiology and the roots of SSD. This, of course, is due to the fact that somatisation disorder is often seen as a way to cope with emotional and psychological stress, and is further connected with the client's heightened sensitivity to his own bodily and physical sensations just like stress symptoms and pain.

While talking about and explaining her pain and life situation, the client seemed to be quite balanced though she categorized her pain on a scale between 0 and 100 at approximately 85-90. This was astonishing to me as I realized her gradually changing facial expression while she talked about her pain and life-situation. I did not yet refer to the emotional or psychological part of the complaints. I asked her about how she could handle the pain and integrate such a severe life-situation into her professionally well-done and demanding job. She responded spontaneously to the stress of the present situation following, unconsciously, her habit not to show to someone that she had a headache, that she had chronic pain, and how it felt to have such a severe headache. Instead of this she was silent and smiled a little, unconsciously expressing a message to me that I interpreted as "it`s your turn."

The patient couldn't express her feelings perhaps because of her personality. Forbearance is a virtue for Chinese. Another reason could be that the young doctor does not feel secure in herself. As previously mentioned, young doctors in China are under tremendous pressure. If these young doctors cannot focus on their jobs due to their health-problems, they risk losing their position in the hospital or even the renewal of the contract with the hospital. So, as a young doctor this woman would likely choose to keep silent though she suffered great pain in her body.

And yet, at the same moment, in the here and now of the situation in the group, she, by talking again, addressed the deep bodily suffering that was connected with her headache. But, just for a slight moment, (as later observed this is part of her pattern of behaviour and can be experienced when she is under stress), I had the impression that the rigidity of her habit not to open up emotionally and nonverbally towards somebody else would resemble the intensity of her pain and suffering. Could it be, I asked myself, that this compensation would make it difficult for her to feel herself as a "victim of the pain", as emotionally and psychologically deeply touched and strained by the chronification? Was she feeling pain, sadness, desperation or even anger towards the ongoing torture and the self-torture and not opening emotionally to somebody else?

Chinese cultural perspective:

As affected by culture and the management system, this patient took her "endurance" for granted. Body psychotherapy could help the patient feel the connection between body and emotion, which can offer the patient a new view on her situation, on her symptoms and on what she takes for granted. By this she can realize that her emotions are expressed on the body level, too. This in an important step for the patient to find out that it is possible to try something new. Doing this and experiencing herself emotionally and bodily in the relationship with the therapist opens a new sense of herself and of her life. This is an important step in personal development and change. Even if bodily symptoms still exist, they are no longer considered as important in the patient's life.

Gender perspective:

Women many times find it very hard to unveil some of their physical feelings in front of an opposite gender or in public, especially those that come from body parts, which are not considered to be appropriate to be shown in public. It might bring them too much shame.

Chinese cultural perspective:

The patient's behaviour may be viewed as "psychological resistance". Such resistance cannot be overcome easily by other kinds of psychotherapy, since verbal expression of emotions is difficult for her. Body psychotherapy refers to the bodily expression and the interplay of body, feeling and psyche. This perspective is especially necessary and helpful in China; furthermore, body language may be considered more natural and more intuitive. A body-psychotherapist may be able to more readily work on the resistance of specific feelings and inner-psychic conflicts as well as on the perspective of embodiment of somatoform disorders more efficiently.

Gender perspective:

The pain can also in a way do her something good, by giving an alarm. The headache comes each time when the client feels stressed. This stress may not necessarily be consciously realized. It gives her in time a break, and provokes reconsideration of her situation. And in this way, the pain protects her from further potential harm.

BPT – working with the functional unity of the person

Many psychological and psychiatric theories explain SSD as highly connected with negative, distorted and catastrophic thoughts and reaction of triggering critical live-events. Currently, cognitive behavioural therapy (CBT) is regarded as the most appropriate treatment for SSD (Schröder, 2012). Clients are helped to experience and to regard their own symptoms as not so catastrophic-like as they experience them. To feel relaxation and less catastrophic thinking would, per CBT concepts, reduce the "worsening" of symptoms.

There's another approach and field of scientific research that states that a high proportion of SSD/MUS patients have undiagnosed and therefore untreated mental disorders (Fritzsche, 2015). A much broader concept of treatment and multi-modal therapy is required for the somatic emotional and functional aspects of SSD/MUS.

Body psychotherapy (BPT) offers a needed integrated treatment intervention.

Bioenergetic Analysis (BA), as a specific school, dates to psychoanalysis and movement therapy in the beginning of the last century. It addresses, as does BPT, the interplay of body, emotion, cognition and behavior in an original way. Therefore, it is closely related to psychosomatic medicine. Its concept of functional unity/functional identity of body and psyche is an essential foundation of and orientation towards the understanding of the interdependency of soma and psyche a well as of its practical application.

Chinese cultural perspective:

There is an old Chinese saying:

Only the one who tied the bell knows the way to undo it, meaning that it is better for the doer to undo what he has done. Body psychotherapy is based on depth psychology, so working with the body and the psyche is an integrative approach that helps to feel, to understand and to revitalize the body. This approach may be an appropriate way to work with patients with somatoform disorders. As such, patients are unable to communicate with doctors so it may be necessary to work with the body, the doctor-patients-relationship, and the behavior at the same time. This, of course, is very difficult for doctors in China because they do not have enough time and energy to talk over the details of the discomfort with their patients. Body psychotherapy may be a convenient approach for doctors to treat such patients.

Body psychotherapy begins the treatment with the body and works on the body, which is helpful for the doctor and for the patient. Thus, both the doctor and the patient can feel that they are taken seriously by the other. In this way, good contact within the doctor - patient relationship is created. As the treatment proceeds, body psychotherapy can help the therapist to understand and talk with the patient more about the physical symptoms in relation to the personal experience, their life and their personality. At the same time, the patient begins to appreciate the therapy and can control the situation at the same time. Working on the body, feeling the body and expressing the body helps to accept oneself and the therapy. This is always based, of course, on a body-approach.

Considering that an essential element of psychosomatic disease consists in not being able to perceive and accept one's own emotionality and its underlying psychodynamics connected with the physical symptoms, the popularity of books about BA in Western countries might be understood as an indication that primarily the public of clients, the virtual psychosomatic patient so to speak, has made a first (self) therapeutic step.

The considerable interest in the books about BA from the seventies onward can also be understood as an expression of half-conscious awareness about health and personal well-being. By the clarity found in books by Alexander Lowen or in *The Handbook of Body Psychotherapy* (Marlock & Weiss, 2006) people want to learn how to better understand themselves and live their lives and their relation with their body. This interest is responded to by the resource-oriented, creative concepts of BA: improvement of one's grounding, body awareness, self-experience, emotional presence and self-expression, sense of coherence and finding of one's identity in the sense of a true authentic (body) self as well as training of resiliency and stress resistance.

BPT involves many of these needed criteria to work on the different levels of personality: body-level, level of emotions, cognitive level and functional level. "The body-psychotherapy approach combines verbal with non-verbal strategies with the focus towards emotional processing/expressiveness, movement, behaviour and body/self-perception; it's regarded as advantageous for patients with SSD/MUS since the bodily complaints remain the focus of therapy. The therapy is not aiming to 'eradicate' symptoms but to work with and through the body in respect of mental distress, associated with the symptoms. The interventions do not directly address psychological processes associated with bodily experiences, aiming at a subtler integration of the somatic and psychological aspects" (Rohricht & Elanjithara, 2014).

Chinese cultural perspective:

CBT may support patient changes by changing their illness behavior. Somatoform symptoms may improve after a period of CBT treatment. But if there is no change of the stress events in life or in the patient's coping style, perhaps the inner conflicts of the patients will transform into other kinds of trouble. Compared to CBT, body psychotherapy seems to make use of body experience and of body language as a bridge between doctor and the inner world of patient. It may help the doctor to explore the true feelings of the patient at an emotional level.

It was important for this particular young female doctor to realize that the physical symptom was an expression of stress. It was also important that she began to understand her own posture, which sometimes produced stress. Finally, it was important for the patient to recognize the situation, in which the stress would appear. Body psychotherapy can help the patient to better understand what indicates "new behaviour". Body psychotherapy can also help the patient have sufficient trust in her own personal experience, which the patient can integrate into her everyday life.

Acceptance of the client in the here-and-now

Of course, I didn't talk to her yet about feelings and psychological aspects because she, by herself, had not addressed this issue or perspective of pain symptoms up to that moment. She described the beginning and occurrence of the pain related to the growing intensity of stress in her life and work. Especially then, as she pointed out, she felt a spontaneous impulse, or rigid self-demand, not to give in to this pain but to concentrate more intensely on what she had to do and on her duty to fulfil the needs of others, of her patients, of the clinic and the needs of the next examination, as well the needs of her super ego. And yet, the symptoms, or perhaps it is better to say that her symptomatic reactions to the unconscious experience of more stress were "worsening" the symptoms and her experience of stress. But she remained silent. No complaints but more rigidity in her posture, her back, and the fixed look at me as the therapist.

Chinese cultural perspective:

Per the patient, she attributed the rigid self-demand to her high morality. It seemed that she thought only of others but had never cared about herself. She never mentioned her weakness or her fear. It accords with the Chinese cultural pattern that if one puts the benefit of the group above that of the individual, he/she would be regarded as a person with high moral character. For example, when an Olympic athlete wins the championship, he is interviewed in front of a camera. If he expresses gratitude at first to his family but not to the leadership or to his coach, he would be accused by the society as an ingrate or as morally bankrupt. Many Chinese have the conception that the individual is unimportant. Maybe that was why the patient in this case didn't expose her own feelings.

Gender perspective:

"Never give in" might be a motto of this female client. This strong belief in her own strength and efforts obviously has helped her all the way till this age overcome difficulties and pursue dreams. No matter where she got the motto, it makes her hesitate when receiving an alarm signal of "taking a break". She might feel scared or ashamed to take a break, by thinking that it's a sign of weakness or giving in. On the contrary, her body proves to be so strong that no matter how strong the belief might be, it finally succeeds in showing its existence and attracting her attention.

While talking in detail about her specific situation, she suddenly was touching her upper chest with her right hand to point out that she felt a loss of energy there while being in such a stressful situation. At the same time, she straightened a little bit more yet stayed in this rigid posture. She must have felt very uncomfortable, I guessed in my counter-transference, but she did not express this at all verbally. Her face still showed a slight expression of being touched and a little sad. That was all. Again, I did not refer to her facial expression, her emotionality or the psychological experience/psychological background of the pain because she seemed not yet able to emotionally face this. Especially not yet ready to face this or even talk about it in public, in the group. Though I myself, in the counter-transference, felt the rising and growing pain as well as the rigidity not being able to move. I imagined how it would be for her to experience this so often in her life without being able to talk about her life situation. For a moment, I myself empathized with her pain, her loneliness, and I got a slight impression of the intensity of her unexpressed feeling.

Chinese cultural perspective:

Many Chinese therapists have a sense of frustration when they face patients with somatoform symptoms. They find it difficult to build the emotional relationship with the patient. Maybe body psychotherapy is a more convenient way to feel into the patient and to build a relationship emotional and based on body-to-body-communication. Of course, there is a big difference in terms of interacting with the patient or be aware of the countertransference and/or to feel empathy and to express this in the doctor-patient-relationship.

As mentioned above, it is important that the doctor and the patient communicate about the physical symptoms in the beginning, i.e. they take each other seriously in this way. The patient then feels that her symptoms are taken seriously, and the doctor feels that he is taken seriously by the patient as someone who treated the body. It is an essential feature of trust between doctor and patient when both are taken seriously by each other.

Many clients who suffer from unexplained physical symptoms cling to the believe that their symptoms have an underlying physical cause. Many of the patients are still convinced of a medical or somatic explanation for their symptoms though other approaches of understanding the symptoms are explained by the doctors. Patients with SSD believe that their body is dysfunctional, not that there is an associated personal feeling. They are convinced that there is a somatic/physical illness underlying their problems and pain. It is necessary in BPT, as well as in other therapeutic approaches dealing with SSD, to accept this and not to address the experience and the problems too fast, too early, or on the emotional and psychological level. The therapist points out to the patient that he "believes" this and he also believes that the suffering, the pain, and the herewith connected problems are real. Insofar as the psychotherapist does not oppose the patient's explanations, he tries to enrich the experience and facilitate a new thinking model for the patient via new bodily, emotionally and interactional

experiences. Body psychotherapy with SSD can be compared to the navigation in difficult, new, and unexpected fields of experience. There is some evidence supporting the notion that BPT can be helpful for patients with SSD (Loew et. al., 2006; Rohricht, 2009).

Gender perspective:

In the latest decades, Chinese people tend to belief more and more in personal will power. The attribution of distress to a physical cause may free from the danger of being considered to be weak, of which one should be ashamed. Many Chinese tend to believe that psychological issues are something that could be fully controlled by will power, while physical issues are not. However, this belief could not find its source in traditional Chinese philosophy. Patients, who believe more traditional Chinese medicine, could more easily accept the view, that the body and mind are integrated and interacting parts of one person, and both are not completely under control of will power.

Following this therapeutic strategy, especially in the beginning of the treatment, clients are open for support and improvement of daily functioning, stress-reduction and becoming familiar with the experience that others also suffer from such symptoms. Following this therapeutic strategy, especially in the beginning of the treatment, clients are open for this kind of support if the doctor takes the patient's personal body-experience seriously. The more the client feels respected in this way, the more he can talk about his personal experience and feelings that are connected with the symptoms and with the way he sees himself in his daily functioning. If this can be discussed in a group-therapy-setting, patients also can become familiar with the experience that others also suffer from such symptoms.

Gender perspective:

As mentioned above, Chinese people could feel a strong shame of weakness and uselessness, by admitting that what prevents them from functioning as usual is something emotional. If the therapist shows acceptance and shares universality of this distress, it frees the patients from constant self-blaming.

Chinese cultural perspective:

Doctors in China are required to see numerous patients; they become anxious and get tired. If the doctor-patient-relationship can be improved by body-psychotherapy, which I can imagine looking at this case-study, it could help to improve this relationship. Only when patients feel that they are understood by the therapist, do they consider staying in the therapy. This of course reduces the doctor's anxiety and the stress and strain on the doctor-patient-relationship. It is not enough to only talk about the body; it is important that the relationship between doctor and patient is "embodied", which may be possible by doing special exercises and by communicating about the symptoms.

Scientific approaches in therapy of SSD

Research, especially in the field of cognitive behavioural therapy (CBT), is done to prove how helpful and effective psychotherapy can be, especially in a group setting. Further research demonstrates the effectiveness of psychodynamic psychotherapy as well. There is no doubt in the evidence of psychotherapy in a group setting, connected with some basic relaxation methods.

There has been little comparative research in the field of multimodal treatment looking at the integration of CBT and psychodynamic therapy (Schaefert, et al., 2013, 2015; Schroder, et al. 2012). There is (probably among others) one current related research project planned and in progress that is focused on working with the body in a group setting promoted by the Sino-German Centre for Research Promotion in Beijing in collaboration between China, Germany and Denmark.

Yet, there is a significant difference in approaching clients with SSD problems visa via CBT and/or psychodynamic therapy in connection with relaxation and body awareness methods in comparison to a BPT approach. There are many BPT schools, all of which are characterized by some main similar principles, strategies and interventions. Though all BPT schools distinguish themselves between a variety of specific perspectives and practical approaches and techniques. Some are more related to movement, some more to body awareness, some more to breathing and feeling.

Bioenergetic Analysis (BA) is clearly based on the concept of the unity of all levels of personality including body, feeling, psyche, behaviour and decision making. The person is always addressed simultaneously at his integrated patterned level of feeling, thinking and behaviour (Lowen, 1975). The Swiss psychiatrist Luc Ciompi calls it affect logic (Ciompi, 1998). This means that thinking and feeling (and body) are always circularly interacting in all mental activities. Affect, related to Ciompi, is used as an umbrella-notion that covers all kinds of overlapping emotion-like phenomena variably called emotions, feelings, affects, and moods. The term cognition is defined as the mental capacity to distinguish and further elaborate sensory differences (e.g. between black and white, warm and cold, harmless and dangerous, etc). This term, too, is an umbrella-notion covering different cognitive functions such as attention, perception, memorization, combinatory thought and logic in a broad sense. As Rohricht & Elanjithara (2014) states: "*Almost all of them (BPT) refer to developmental psychology in some way (with emphasis on the importance of body experiences for early ego-foundation). They also refer to the basic concept of embodiment (embodied mind theory), affect-regulation and the phenomenology of body experience (relating to the body as: base line reference for any psychological processes, precondition for psychopathology, subject and object of perception, organ of spontaneity/expression and reference point for feelings) and more recently to findings from (affective) neuroscience*" (p.6).

Working with the ambivalence

All workshop participants completed a pair-exercise to experience the ambiguity between standing on one´s own legs and to push the other person away so that he loses the stable standing position. After the feedback on the group exercise, the client and I were still standing while talking together. She, as I described already, was standing rigidly in an upright position, without too much movement in the body. She was looking at me, with the unconscious message: "it´s your turn. Do something." The meaning of course was not to really touch her emotional state of feeling and being. She nonverbally tried to provoke me to go on talking with her about her pain, her headache, her back pain and so on.

Chinese cultural perspective:

According to the personality of this patient and her low self-esteem, it is understandable that she might have a sense that she was not allowed to express her own feelings. Expressing oneself in public by expressing bodily what she feels might produce heavy, insecure feelings. The reaction of the therapist is very important in the moment. He can start, develop and guarantee a body-to-body communication and by this he is a kind of new role-model. In this session, when the patient looked at the therapist and nonverbally indicated the message, *It's your turn, do something*, the therapist received important information and responded appropriately, with information about the inner-psychic conflict and information about their current working relationship, which helped the therapist react nonverbally, in the same manner that she had addressed him.

Something new happened on the body level for the patient. She felt physically irritated, which enabled her have a new experience. Perhaps this kind of experience was a good starting point for the doctor-patient-relationship to continue with therapy. At the same time, it was not necessary to talk about the feelings with the patient; the important fact was that they could talk just for now.

Gender perspective:

Through grounding exercise, the female client might have connected better to her whole body. Certain physical feelings could be sensed and accompanying emotions triggered. Those feelings and emotions could hardly be bared by the client, so that her body turned even more rigid to prevent her from negative feelings. The rigidity prevents her from any further action, except for an anxious glance at the therapist, as if calling for a distraction of attention from the arising emotions.

Of course, I did so. And yet the fact that she, after the exercise, had shared a little about her pain and had looked at me so intensely helped me to address her to talk about her bodily symptoms. I mirrored what she had shared via my words and my impression of her bodily expression (verbally and nonverbally at the same time).

Chinese cultural perspective:

In this case, the therapist was aware of the requirement of the patient—he chose to talk about the patient's discomfort. This affirmed her sense of trouble. Thus, the patient could have a more secure feeling and be more willing to create a connection with the therapist.

I experienced our contact as quite stable and trustful though still a little tensed and strained. Therefore, while talking about her symptoms, I moved a little from here to there not standing still as she did. Still, of course, influencing her slightly in the way that she, with her eyes, tried to follow my movement. I did so as I had the fantasy that if I were to stand still we would become stuck in a rigid position of therapist-client-relationship. This could induce more rigidity, less emotionality and less chance of improvement. Moving in this state of experience with she following me with her eyes induced a little irritation in her. She tried to control the situation but could not succeed. Of course, she could control her words, her sharing, but could not really control her bodily reaction. Nobody really can do; nor could she control me. The indication of my spontaneous reaction was to mobilize stress in our relationship, to induce more stress and thus mobilizing her own unconscious patterns of behavior. It seemed to be important to make her move by herself, to make her react to me and to make her lose part of her rigid self-control. Our relationship remained safe because we still related at the body level. Nothing else. We had not yet related to her feelings.

Chinese cultural perspective:

The therapist offered the patient a new way to experience herself. Maybe she had a strong impression that the people around her at work or in her routine life never initiate any "movement" if she doesn't make the first "movement". If someone would perhaps take an active role in the relationship with her, she was not used to responding in an appropriate way that means also active and initiative. Her old pattern of being non-active and waiting for the others to be active usually had a negative influence on her relationships; the client will not experience a "good relationship". The therapist tried to do some different things with her; it might make her feel uncomfortable at the beginning because it differed from her behavior pattern. But this attempt could lead to a new experience. This is an important first step to creating a new pattern of behavior.

Doctors often hesitate to start the treatment actively in the beginning as patients have expectations about the doctor's doing and acting. They decide quickly whether to proceed with therapy or not. Patients want doctors to give quick answers and they even need quick answers. The sooner the doctor relates to the body-level (sometimes even to the emotional level), the sooner the patient feels respected, in the beginning unconsciously of course. This is an important first step in implementing the doctor-patient relationship.

Gender perspective:

The female client seems to be in a vulnerable position in front of aroused emotions and other participants. She cautiously tracked with her eyes the therapist's movement, but dared not to make any movement, which could be for her a rather big danger. A slow and regular movement of the therapist might ease the client. For it brings dynamics into the rigid situation and gives the client at the same time a feeling of regularity and safety. A rapid or unexpected move might not be so helpful, for it could elevate the client's stress level

While still talking a little about her experience in the exercise, we consciously addressed her ambivalence. And we addressed her possibility to do something by herself, to stand on her legs and to try at the same time to push her partner away. While talking about this, she experienced that others had done this in another way, of course – everybody does it his own way.

Gender perspective:

By addressing other's feature, the client successfully shifted the attention away from her own arising emotions.

I picked up this aspect and asked her if she would like to do the exercise together with me. She agreed because we still were acting on the body level. And the group functioned as a trustworthy container. I went on irritating her just a little and by that mobilized the ambivalence a bit more. She began to breathe deeper, just for a moment, and stayed in the rigid position right away after that deeper breath. She was activated a little more than before. While we did the exercise, I talked to her, just referring to the body experience and to what happened to her. Still I asked her general questions such as, "What´s happening in your body?", "Where does it happen?", "What changes are you sensing in your body?", "What do you think about right now when this is happening?" and so on.

After some minutes, we stopped, and she had rested to experience the effect of the mobilization of the body via our exercise. She was breathing deeper. Her look was not as fixed on me as before. She showed some changing facial expression and

finally put her hand on the chest and talked about her feeling there of less energy.

Finally, she could talk about feelings. The patient wasn't familiar with change. She didn't believe that her symptoms or her life would change at all. Sometimes it is difficult to think about change abstractly. Often, if something happens or changes on the body-level, this can be more easily experienced by the client. Being consciously aware of this helps the client to realize that a new experience of change can happen. With the changes of body, the patient experienced new changes. Then she could gradually believe that her symptoms and her life might also be changed.

She could experience and observe more of her feelings and emotions. She would thus be braver to express her emotions. As a psychological defense mechanism, the function of somatization would not be as strong as before. She would try to find more psychological and social support and would realize she did not have to face every situation by herself, alone.

Chinese cultural perspective:

It would also affect her intimate relationships. She may remain the same in her work; she may still work too hard and rarely take time off. But she would be more aware of her feelings and emotions so she would deal with them, not evade.

Gender perspective:

When pushing against a male therapist, especially with whom she is not yet so familiar with, the female client might first experience a mixture of shame and fear, which leads to some hesitation. However, the usually firm and tough texture of male hands and the strong and stable male body image could gradually transfer strength to the client, this foreign experience gave her a feeling of being supported and in the end, she felt more energy in the chest, where a lack energy had been reported at first.

I gave her time to experience and to share what happened in her body and what she was thinking about. Then I gave her feedback about how I had experienced her, especially her ambivalence in her bodily expression. Again, I invited her to do a "little exercise", as I usually call it. I typically introduce these follow-up steps, which are often experienced by the client quite unspectacularly. Again, I told her if she wanted to, she could try, and of course she could stop the exercise whenever she wanted to do. She agreed, and I asked to close her eyes for a moment.

Chinese cultural perspective:

The therapist allowed the patient to have the right to choose and to control herself and the situation at all times, which is not common in the Chinese culture but is important for the therapeutic process.

When she closed her eyes, I held one of my hands in a yes-position as if I was giving her something or I was carrying something. My other hand was in a no-position as if rejecting the other or saying stop. I offered two messages in one position: yes and no – a paradox intervention.

Chinese cultural perspective:

It would be hard for her to experience herself as a feeling person. The therapist allowed her from the start to feel not only able to make a choice but also to feel the choice. This is an opportunity for the patient to explore a sense of (self-) achievement. The patient realizes that what happens in the here and now could help her. To experience this on the body-level is a convincing part in the doctor-patient-relationship, which helps to improve the treatment and the process.

She opened her eyes and of course was irritated. The others in the group were at once aware of this, she, too. She moved her body, especially the upper part of her body; her eyes looked here and there. They were no longer fixed, and her hand touched the upper part of her chest and so on. After some seconds, I asked her to close her eyes again to experience in herself, to feel in herself the effect of what she had seen, the effect of this little irritation. And the effect in her body.

After some minutes, she felt much more quiet and showed more facial expression of being touched. Her voice became softer and she talked about the feeling of loneliness and sadness connected with the experience of low energy in the upper chest. She did not cry nor talk much about her life situation. But she did express being touched by this experience, so that I and the others in the group could experience this, too.

I realized her emotional ambivalence and the

fact that this was the first time she had opened up to this feeling and to herself. To make her feel safe, I told her that it would not be important to talk about herself in more detail now, in that moment; maybe later, or another day. It would be, and I pointed this out, more important that she feel inside herself, that she felt herself. I had supported her to have a new experience, which helped her to feel the connection of body and emotionality. To feel herself and still be in control of herself. Insofar as I had the function of a container, a good object, an embodied symbol of trust and a facilitator or better to say a midwife.

This short case study can only offer a small glimpse into the possibilities of a longer therapy process. And yet, it can show some principles of the BPT approach to work with the body in the field of SSD.

Two remaining relevant questions, or better to say issues that need to be addressed are:

- How can a client be touched in the here and now on the body-level, on the level of experiencing his own body related to the physical complaint, the herewith connected feeling and thinking as well as with his patterns of behaviour?
- How can the client experience his body, his symptoms and his complaint under the perspective of functional identity, of body, emotion, psyche and behaviour?

Strategic aspects of BPT

Recent evidence has supported body-psychotherapy as an appropriate approach when working with patients experiencing unexplained medical symptoms and SSD. "The BPT-model offers a fundamentally different approach connecting cognitive and emotional levels with bodily states through enactment and expressive movement exercises" (Rohricht & Elanjithara 2014 p.5).

Röhricht's (2011) manual for group-body-psychotherapy shows exemplarily a concept of practical body-work and understanding body-awareness and body-experience aiming at a deeper, more personal level self-awareness, self-expression, behaviour modification and sensing as well as the relevance of emotional and psychological problem-solving.

It is thus considered important, especially in the beginning of therapy, to stay on the body-level. There is no explicit relating to potentially occurring states of awareness, inner psychic conflicts, hyper-arousal, negative cognitions, and so on. Rather, one works with the here and now level of body-awareness and body-experience and on communicating these experiences.

"The chosen intervention strategy must match with both: The client's expectations and the phenomenology of the symptoms" (mostly bodily sensations) (Rohricht, 2011).

Thus, body-psychotherapy with somatoform disorder symptoms may result in:

- a conscious new awareness and experience of one's own body
- a connected, trustful relationship with the therapist
- a guided, well-contained experience of ambivalence as a way to give up a little control in order to experience an impulse of self-regulation in the body and own`s acting, reacting
- specific feedback, if experienced in a group context, by group members in the role of observer
- a complex variety of other approaches.

Sollmann (1984) conceptualizes BPT as a self-help program and shows guidelines for do-it-yourself exercises. He introduces how to perform the exercises and how to connect the various levels of experience and personality. He implements BPT as a creative method to work with the body and the person in private life. This approach invites people to do the exercises in the beginning, similar to gymnastics or sports. People can explore themselves and become curious about wanting more, having more in life in terms of their feelings, new life-questioning, talking with others about their experiences and so on.

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Chinese cultural perspective:

In China, many kinds of psychotherapy must deal with compliance issues. Psychotherapy is barely (and rarely) covered by medical insurance so treatment is often discontinued due to patient economics. Patients traumatic experiences cannot be effectively treated because of the treatment interruption. Body psychotherapy, via a self-help model then, may enable patients have a different experience every time as they develop the ability to help themselves. Thus, body psychotherapy may be faster, more convenient and more secure to treat such patients.

"Provoking" self-regulation by setting an impulse

Later, I tried to refer to her competence of handling stress and painful situations without complaining in public, doing her job professionally and taking responsibility for the need of others. At the same time, I shared my fantasy that she could not get rid off all those needs and expectations though sometimes this could be good for her. She agreed, of course, but again pointed out how necessary it was not to give in and instead to hold herself up because of all the responsibility she had to face and to follow. ("I would if I could"). By this, she referred unconsciously to some life issues, to some patterns of behaviour that could not yet be touched in detail or be opened up.

Without any specific spoken expectation and stress, I invited her to repeat this little exercise that she had done in the group. She agreed spontaneously and looked quite interested. She probably felt more and more accepted and respected by me (in the group) because I had followed her in the here and now, in the way as she referred to her life-story and showed up by "self-exposure".

Chinese cultural perspective:

There was more self-exploration of the patient in the treatment. The therapist might not know what happed in their inner world, but the patient had the right to choose when she would tell the therapist about her thinking or not. The patient had more of a sense of security, which supports trust in the therapist. As I mentioned earlier, the patient had a feeling of pressure by the surrounding environment; there was some tension between the relationship of the patient and the therapist. But as the treatment was in-depth, the trust was established by them together. Then she could feel relieved in the relationship with the therapist, and she could more easily talk about her emotions and feelings.

Gender perspective:

The therapeutic environment of this case is quite different from those in therapy room. The female client voluntarily fought for a chance to experience her body feelings with male foreign therapist and trainer, whom is often times considered as absolute authority in Chinese culture. This is no way encouraged by traditional Chinese culture. Usually females' efforts of winning attention, especially from males, are negatively seen. Females grew up in this culture are difficult to make this attempt, or to tolerate other females to do so.

Again, I offered her to push away expectations from outside by pushing me away and at the same time to feel strong and stable enough in herself on her own legs. We stood in front of each other, face-to-face, and just held our hands towards the other's hands, just touching. I repeated to her the two rules of the experiment: Stay where you are, keep your stable ground and at the same time try to push me away so that I lose my stable ground.

Suddenly, before we started the exercise, she showed up with a slight impulse to push me away. Nobody could see this, but my hands felt this impulse. She started to smile just for second. Right away, in that moment, we both knew what had happened and enjoyed the exercise. Sharing our experiences in the group helped the group to understand and helped the client to learn a personal lesson. It also started, within the group, a new way of relating to SSD and to the client as a group. The group members shared their own experience and feelings after the exercise. We also discussed diagnostics and indication of (body-) therapy with these clients.

Chinese cultural perspective:

The therapist had realized what had happened—a convincing attribute of a good doctor-patient-relationship and of an effective treatment-process. The patient could experience what happened, especially on the body-level as well on the emotional level and could get an impression of what it means: "Something changed in my body and this can create hope that something in my life can change too." As mentioned above, Chinese doctors and therapists often see somatoform disorder as a hard nut to crack. It is hard to establish a trusting relationship with such patients. The treatment for such patients could not go further easily in most cases. It is almost impossible to talk with these patients about feelings or emotions. They leave therapy very easily even after several sessions. Body psychotherapy can initiate such change, even if the change is slight. It indicates a bright future for therapy and deserves recognition.

A BPT informed experience can induce personal development that starts on the body level and reveals the therapist-client-relationship as trustworthy, which supports the experience of ambivalence on all levels of personality and relationship in the here and now.

Guidelines and rationales of BPT with SSD

To summarize, I offer several guiding principles regarding integrative BPT:

- Human beings are characterized by a complex ambiguity insofar as the embodied Self is subject and object at the same time ("I have a body", "I don't like my body" etc. vs. "I'm this body", "This body is me"). Bodily existence and embodiment and personal experience are characterized by this ambiguity. It is necessary for the patient to explore this and to feel safer in this ambiguity.
- The patient-therapist-relationship is characterized by a specific interactional style of relating to one another and its embodiment. The patient unconsciously reacts also to the nonverbal messages of the therapist. The competence of the therapist is critically judged by the patient (consciously or unconsciously). The patient projects his own ambivalence on the therapist. There is always a tense mood between patient and therapist. BPT must interact via stable contact with the patient. This interaction is one of a body-to-body-communication. The therapist must be empathic. He must register and respect the somatic complaints and the emotional reactions. He talks about the symptoms and works on the body-level with these symptoms. He functions as a living, touching, moving "container". This also makes it possible to verbalize more and more the patient's experience based on his complains and based on the relationship with the therapist, which is connected is another basic principle that can be put into words: "Be your pain and let us listen to what your pain tells us". The main challenge for (body) psychotherapy is the following: "Don't feel good but improve your feeling". This leads to more personal acceptance and integration of the complaint and pain.

Basic strategies and interventions include:

- Activating of resources and supporting self-regulation. This helps to regain partial control of one's own bodily reaction. This also supports a better regulation of hyper arousal and gradually adjusting pain.
- Nonverbal stimulation of bodily self-expression via improvisation of bodily self-expression. It is also supported by the conscious experience of bodily reactions and emotional-affective aspects.
- Movement, motoric self-expression, and bodily reenactment of psychological, emotional and mental states-of-being are used to stimulate conscious experience and half-conscious memories. Insofar this can lead to a corrective emotional body-experience.
- Finally, it is important to experience new re-enforcement styles. This is done by new bodily experiences. The development of awareness to establish new somatic feedback/re-enforcement styles ("bad feeling leads to less bad feeling. This opens up the awareness for better experience, better feelings and more creative, playful experience").

Basic treatment rationales include:

- The improvement of body-awareness, body-perception and experience
- Verbalisation of bodily experiences
- To enable sharing as meaningful experience (within the group)
- Mentalization as sensing one's own and other bodily experience as meaningful
- Connecting cognitive and emotional levels with bodily states through body-experience
- To open to and support the experience of ambiguity.

BPT works with somatic memory and by releasing the restrictions and re-owning the memory a person can dissolve a corresponding pattern of psychological constraint. On the one hand, the pathological dimension is worked through analytically, focusing on the dialogue in the relationship and in a body oriented way. On the other hand, he places support of basic

self-functions in the centre of his work. The unfolding "of self-perception and self-effectivity or creatorship as newly transformed patterns of their organizing principles" occurs as an "embodied dialogue in relationship". Furthermore, the following issues are integrated: experience of boundaries; developing unpleasant feelings; feeling of acceptance as a space for change; and awareness of implicit relational knowledge as agency for the change of patterns of mental organization.

As mentioned above, in Chinese culture "tolerance" and "forbearance" are regarded as virtues, and social pressure is big, especially for the young Chinese people. Many Chinese feel that it is not allowed to express their feelings or emotions. It lacks efficacious methods to treat such patients in China. I often hear complaints from my colleagues about the useless works with such patients. High drop-out rates of such patients and the difficulty of establishing therapeutic alliance with them make many Chinese doctors and therapists lose their interest and patience. As a special art of psychotherapy, body psychotherapy fits the Chinese culture and meets the real-life needs of Chinese patients. It is worth generalizing the use of body psychotherapy in China. More Chinese doctors and psychotherapist should learn the thinking and techniques of body psychotherapy.

Conflict of Interests

Authors have no conflict of interests.

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