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To Whom It May Concern:

It was nearly three and a half decades ago, in 1961, that I first learned of a new kind of psychotherapy that its co-founders, Albert and Diane Boyden Pesso, called "Psychomotor". My informant was Dr. Ellsworth T. Neumann, a friend and neighbor of the Pessos. A physician possessing remarkable (and notably unobtrusive) organizational skills, he was then Administrator of the Massachusetts General Hospital, working in close association with the Hospital's better known General Director, Dr. John Knowles. More than a decade later Dr. Knowles (now deceased) left MGH to direct the Rockefeller Foundation in New York, followed there soon after by Dr. Neumann.

The latter was one of the incorporators of the Psychomotor Institute when it was formed in 1970-71; I was another. During the 1960s I attended some groups conducted by the Pessos, including an "experimental" group of which Dr. Neumann was a member, that met in the Pessos' apartment in Boston. I learned that he had also introduced the work of the Pessos to Dr. Erich Lindemann, Chief of Psychiatry at MGH, who commented, "If the Pessos are doing what I think they're doing, they should be given the Nobel prize!"

This opinion is one I share. Even during the early years -- or I should say especially during the early years -- the Pessos' knowledge of how to "read' emotions and "track" energies by observing bodily movement and positioning struck me as somehow magical and even uncanny. So did their ability to transform a "structure enactor's' emotional state from one of fury or desperation to one of benign peacefulness or blissful satisfaction.

The acquisition of "magical" knowledge

Evidently the Pessos had an unusual grasp of how human bodies register and express emotion. They understood how bodies -- and minds -- might respond to injunctions from parental or other caregivers that had been internalized early in life. And they were aware of how early loss, deprivation or trauma could leave a lasting imprint on bodies' ways of functioning. Much of this knowledge they had gained as dancers and dance educators. Albert Pesso had studied with Martha Graham and Diane Boyden with Jose Limon, among others. Both had spent years in the world of dance before they realized that techniques they had been developing to improve dancers' ability to perform had actually evolved into a new method of psychotherapy.

Twelve years went by following my initial contact with the Pessos before I decided that, like other therapists who by this time had been trained by them, I too might conceivably learn to be a

Psychomotor therapist. During this period -- and up to the present day -- the techniques used by the Pessos to create a safely structured arena for the expression of emotion and for carrying out other essential therapeutic tasks continued to become more clearly defined and systematized. Psychomotor became more teachable and learnable; it no longer seemed to represent 'magic" beyond the learning capabilities of a traditionally trained therapist.

What is now called Pesso Boyden System Psychomotor (PBSP) is still, however, a complex and subtle, as well. as precise and powerful, set of body-based techniques that are often difficult and time-consuming for therapists to master. Trainees sometimes acquire a thorough intellectual grasp of PBSP concepts and formulations, but remain limited in their ability to notice, understand and respond appropriately to what is happening in a client's body. Such trainees tend to focus mainly on verbal expressions and interactions rather than those that involve bodily movement and contact.

The special PBSP kind of interactive role playing by group members (called "accommodation" because it is designed to provide satisfaction of the client's needs) similarly may receive insufficient attention from these trainees. The possible meaning to the client of an accommodator's way of moving his or her body, as well as the meaning of what's going on in the client's body, may thus too often be overlooked. As a consequence therapists who have completed their training sometimes become discouraged about pursuing the further goal of certification by the Psychomotor Institute.

Symbolic interaction; roles

It was the emphasis on interaction, characterizing PBSP from its earliest beginnings, that mainly drew me as a sociologist to become first a devotee and then a practitioner and trainer in this form of therapy. Soon after my first contact with the Pessos I realized that their kind of psychotherapy basically took place on a symbolic level and therefore could aptly be called "symbolic interactionism' -- the name of a sub-discipline within sociology largely based on the contributions of George H. Mead, especially his Mind,-Self and society (1934).

As I see it, Mead's approach in many respects parallels -- and in distinctive ways complements -- that of many psychotherapists. Whereas therapists have been concerned with how and why people behave irrationally, Mead explored how people manage in the first place to become rational in their thoughts and actions. To oversimplify, he held that this was through the social process of learning to communicate with others, and with one's self, on a symbolic level. An essential part of this process is the ability, in his phrase, to "take the role of the other'.

In PBSP it is made clear that interactions between the structure enactor (client) and accommodators occur on a symbolic, not a literal, level. A transition to symbolic reality occurs as the client asks a member of the group to play a specified role and the group member, using ritualized wording, agrees to play that role. When the structure (the therapeutic work involving accommodators) has been completed the accommodators ritually "derole", returning to their places in the room, stating their names and resuming their own identities. This marks the transition back once more to literal, or ordinary, everyday reality.

Meanwhile, during the structure time, certain scenes will have been enacted. After initial conversation with the therapist the client chooses one or more accommodators; the latter's specific placement, actions, words and sometimes voice tone are from this point on collaboratively decided upon by the therapist and the client's "pilot' -- a highly developed part of the ego, or self. The first scene may have to do with a currently difficult situation the client is facing. That scene may then shift to one depicting a remembered, somewhat similar, hurtful experience in childhood. This memory, as now symbolically re-enacted, evokes the pain felt by the client as a child and awakens a partial sense of being that child again.

A concluding scene presents an alternative and contrasting early experience that this child might have had if ideally responsive parents had been available back then. Now -- as symbolic role-played figures endowed with vital emotional reality -- these "ideal parents' are visually, tangibly and audibly present. Following the instructions of their co-directors, they respond in precisely the ways that would have been best for this particular client at just this time in his or her early life. These "parents" convey messages to their 'child" that counteract and correct the pain-inducing of the client's literal past history. By contact they succeed in satisfying needs satisfaction at the earlier period. Both such bodily experiences as being held in parents" can then be internalized by the event or situation that was part words, actions and bodily that had been denied adequate the meaning of words spoken and the arms of two loving "ideal child part of the client. This segment of a symbolic, need-satisfying, alternative past history, taking its place in memory alongside the literal history, can then contribute to the client's development of new, less troubling, patterns of thought and behavior in the future.

Purpose

The basic purpose of PBSP as a form of therapy is not simply to make symptoms of various sorts go away. (Instead, symptoms are welcomed as bearers of significant information, perhaps deriving, one might say, from efforts on the body's part to communicate with the mind.) Nor is it the purpose of PBSP to enable clients merely to understand why and how these symptoms may have come about. (Rather, some sort of movement or action is indicated, together with appropriate interaction involving a symbolically represented other person, that can utilize the energy locked in the symptom.) Nor is the purpose that of getting feelings 'out' in cathartic fashion, nor persuading clients to give nurturant care to their own "inner child". (Both of these lack the essential element of interaction.) Instead nurturance and other basic needs -- for support, protection, limits (or containment) and place -- are seen as universal human needs. During infancy and childhood it is necessary for adequate satisfaction of these needs to be provided by at least one adult (and preferably two), by means of an interactive process.

The purpose of PBSP is to assist the client in constructing on a symbolic level, in ways designed to be internalized and integrated, the need-satisfying interactions that were lacking or insufficient during that client's childhood. The client's own genetically determined patterns of development are then free to find expression in healthy ways that lead, among other things, to rationality rather than to its opposite.

Advantages

Several advantages derive from working on a symbolic level, with a group, and using PBSP techniques of role playing. The therapist does not have to be a principal target of transference on the client's part;

instead such feelings are primarily directed toward the positive or negative roles played by group members chosen to serve as accommodators. The therapist who becomes aware of a client's clear need for a loving mother's -- or father's -- care does not have to struggle against the impulse to be a literal provider of such care, but can use countertransference feelings simply as a source of information about the client's needs. The client, furthermore, does not have to renounce all hope of ever receiving the kind of parental care for which he or she has long yearned.

The dramatic, play-acting form of PBSP structures fully engages the emotions not only of the client but also of accommodators and observers, who often gain vicarious benefit from another person's structure. The playful aspect of the therapeutic work also fits well with the learning style of children, doubtless making it easier for the child part of the client to internalize, at the child level, the interaction that has been experienced. And this same playful quality can produce pleasure for the therapist as well as for members of the group.

Shifting from ordinary reality to symbolic reality, with its partial alteration of consciousness, makes it possible for a part of the client to feel like a child again while another part, in contact with that child, can actively collaborate with the therapist in finding suitable ways to satisfy the child's basic needs. In this process total regression to a child state is avoided while access to the child's feelings, thoughts and perceptions is maintained. Also avoided is the necessity on the therapist's part of serving as the sole arbiter of what the "child's" experience should be. Finally, as the therapist's co-equal in directing the structure, the client feels accepted and respected by the therapist and has a sense of ownership of the work that has been done.

Considerations for the future

With regard to the future of PBSP, the most important current need is for support to the Pessos in the preparation of teaching and training materials. Vast numbers of videotapes of structures Al Pesso has led over a period of many years now exist, as well as videotaped lectures and technical discussions with trainees. He and Diane hope to scan these to select examples of how clients' emotions or states of mind are variously reflected in their bodies, how these may find expression, and what appropriate interactive responses can then be supplied. Together with videotaped examples of Diane's work, Psychomotor exercises led by each of the Pessos, and other material, selections could be made and commented on in new videotapes they would prepare for use as teaching aids.

Trainees can learn much by observing live examples of therapeutic work that occur during their training, but certain topics may be missed, and in the midst of whatever else is going on there may be little chance for comment or discussion. Illustrations and commentary on videotape can be a valuable substitute for or adjunct to live observation, and yields better opportunities for instruction since it can be stopped at any time if questions arise. Videotaped material that can sharpen trainees' awareness and understanding of bodily signs is a prime need at the present time. Videotaped examples are also needed for instructing trainees in how to monitor accommodators and how to assist them, if necessary, in performing their roles. Videotapes dealing with the process of supervision, and with issues confronting trainers, could also be of value to those seeking to advance beyond the practitioner level of PBSP certification.

Another important requirement for the future of PBSP is to secure first the Pessos' and eventually the non-profit Psychomotor Institute's ownership of their property and buildings in Franklin, N.11. These could then serve as permanent headquarters for PBSP training, for maintaining archival records of PBSP writings and videotapes, for preparing training materials, for research, and for sharing new developments and otherwise communicating with people who are interested in the Pessos' work.

As psychotherapists become increasingly hard pressed financially in these days of managed care, the expense of training in PBSP seems difficult for many to afford. The availability of funds to help pay for training would not only meet the needs of therapists already well informed about this mode of therapy but would permit outreach to more ethnically diverse groups than those who have applied for certification training in recent years. (When training began during the 1960s the Pessos took pains to include African Americans among the small number of persons they trained.) Funds to assist in the training of therapists from other countries, who now live in the United States but return occasionally to the land of their birth, could enable training programs to be established in places where relatively few potential trainees are fluent in English. And it might be possible to dub in other languages on some training videotapes.

Meanwhile, to be sure, PBSP has gained a sound footing in a number of European countries, especially in the Netherlands, where PBSP training is sponsored by the North Holland RINO, a government agency that monitors the training of psychotherapists. Training programs also exist in Belgium, Norway and Switzerland, where a number of German as well as Swiss therapists are enrolled. A German translation by Tilmann Moser, combining two books written by Albert Pesso around 1970, and another book of transcribed structures with a psychoanalytic commentary by Moser, have kindled strong interest in PBSP among German psychotherapists. (Sizable proportions of European trainees are psychiatrists and/or psychoanalysts, though this is not the case in the US) Therapists enrolled in all these programs have a sufficient knowledge of English to allow Al Pesso, and less frequently Diane, to conduct their training sessions in that

A cherished long-term dream of Diane Boyden Pesso for the future of PBSP is that high school students throughout the country could have opportunities for doing Psychomotor structures as part of their educational experience. By this means they could be helped to overcome the effects of whatever deficiencies in parenting they had suffered earlier in their lives. (Clearly no real parents can ever be fully "ideal'; it suffices for them to be, in Winnicott's words, simply "good enough", providing enough satisfaction of their children’s basic needs to allow normal development to occur).

Under the guidance of a certified PBSP therapist who would work with groups of students, the effects of their having had insufficient basic need satisfaction in the past might largely be counteracted. During the course of a year students would have a number of structure turns during which they could ask their classmates to accommodate in either negative or positive roles, including the roles of "ideal parents"; the latter would provide symbolic satisfaction of each student's hitherto inadequately met needs. The experience of observing and playing these parental roles would also give these students important knowledge of how to be at least "good enough" parents themselves. A further by-product of this

experience would doubtless be the formation of strong ties of friendship among the members of each group.

As a step in the direction of Diane's dream, a high school demonstration project might someday be set up. Assessments would be made at the beginning of the school year and again soon after its completion, of the mental and preferably also the physical health status of participating students, as well as members of a control group. The status of students who had experienced PBSP could then be compared with that of students who had not. Ideally such a project would be longitudinal, with one or more follow-up assessments some years later which might include evaluations of children born to members of the two populations.

An alternative to this project might consist of providing PBSP training and supervision for the staff of a residential facility for emotionally disturbed adolescents, such as the De Sisto School in West Stockbridge, Massachusetts. (The director of the school, Michael De Sisto, has for many years been eager to incorporate PBSP therapy into its program, and has invited Al Pesso and other trainers to work with students there on a number of occasions). Perhaps research to evaluate this program, if it were established, could follow up and compare the later status of its students with that of another treatment program for adolescents. (The medical director of a therapeutic community for substance abusers, including adolescents, Hoog Hullen in North Holland, has stated that in program evaluations PBSP scores highly, and he emphatically recommends it ‘to all therapeutic communities in the field of addiction and psychotherapy.' He is, by the way, a psychiatrist and a psychoanalyst as well as a trainer in PBSP.)

Other possibilities

I believe that certain videotaped PBSP materials could be of value to sociologists and others who have recently developed a strong interest in emotion, including social influences both on its expression and its control. A Section on the Sociology of Emotion, recently formed within the American Sociological Association, has already attracted a large and active membership, many of whom are also members of the Society for the Study of Symbolic Interaction (SSSI). In addition there is a new Section on Mental Health and a longer established Section on Sociological Practice, with membership overlapping that of the Sociological Practice Association (formerly the Clinical Sociology Association). A number of SPA members have been designated as Certified Clinical Sociologists (CCS) by the Association following an evaluation of their clinical work. Some of the latter might wish to seek PBSP training, while sociologists in related areas may well be interested in evaluative or other research.

Videotaped materials having to do with emotion would no doubt be a valuable resource for many anthropologists and psychologists, and for some holistically inclined psychiatrists and physicians as well as for sociologists. Burgeoning interest in this area is demonstrated by the recent publication of The Nature of Emotion (1994), edited by P. Ekman and R.J. Davidson, and Self-Conscious Emotions (1995), edited by J.P. Tangney and K.W. Fischer. It is possible that members of these and perhaps other disciplines might also want to undertake research utilizing videotaped -- or other -- PBSP materials.

During recent years there has been a groundswell of interest in body-mind relationships that would have been inconceivable a couple of decades ago. Numerous conferences have been held and others

planned to discuss connections between mind and body, often allowing a place also for soul or spirit. (These latter receive attention in PBSP work as well, with the soul seen as residing in the body during each individuals lifetime.) Increasing numbers of psychotherapists describe themselves as "body oriented", "body centered", or (except in the US) "psycho-corporal". Other healers similarly describe themselves as concerned with 'mind-body health", while books, articles and new journals concerned with body-mind relationships continue to multiply. The view that what happens in the mind can influence the body and that bodily movements or other bodily events can affect thoughts and feelings is rapidly gaining acceptance.

Medical ideology

A strong counter belief in the separateness of mind and body currently holds sway, however, in the US, and largely dominates the medical profession. (Big pharmaceutical and medical equipment companies understandably support this belief.) The mechanistic, reductionist mode of thought that most physicians have been persuaded to rely upon has served to advance the science of medicine to extraordinary heights of accomplishment. But this mind set balks at suggestions that anything which cannot be seen to exist in the body can have any influence on the body's functioning, or on its state of health or illness.

In line with this mode of thinking, the existence of strong emotions is acknowledged because they bring about discernible changes in the body. But ideas that can induce or banish, heighten or diminish, these emotions are not granted real existence in reductionists' view. As they see it, ideas lack the 'reality' required if physicians are to grant them causal efficacy, or even take them into account. Ideas thus cannot rank as causes either of disease or of healing. Thoughts, meanings, and beliefs cannot be seen (nor heard through a stethoscope). Neither can social interactions, or social institutions, or cultural traditions, or religious or other spiritual practices. Accordingly conservatively oriented psychiatrists currently tend to focus their interventions on finding the specific medications that will make the bodily changes associated with strong emotion -- not to mention the emotion itself -simply go away.

Non-medical providers of mental health services generally do not subscribe to the view that psychological difficulties are due to causes existing solely in the body, and that they are best treated by organic means. Through their training and clinical experience as social workers, psychologists, family therapists, expressive therapists, psychiatric nurses, pastoral counselors, addiction counselors, or more rarely as sociologists, they know better. It is more likely to be their view that mental or emotional difficulties, often manifested in symptoms, result from problems in living -- or sometimes in thinking -- that need to be solved. And these mental health providers are often very effective in helping their clients arrive at beneficial solutions.

Recent revisions of the Diagnostic and Statistical Manual of Mental Disorders, together with managed care programs requiring DSM's use by mental health providers if they wish to receive third party payments, have been influencing providers to move away from their accustomed humane, problem solving approach. Instead they are being pressed to adopt the medically sanctioned goal of eliminating symptoms and not risk engaging in pursuits that could be found to lack "medical necessity". Somehow I am reminded of a brief -- and true -- cautionary tale from my early training in psychotherapy: A first year psychiatric resident successfully used hypnosis in treating a patient suffering from backache, whereupon

the patient committed suicide. The lesson to be learned concerns the importance of paying attention to the meaning of symptoms. Unfortunately there is little place for meaning in the current DSM. The same seems increasingly likely to be true of nonmedical mental health practice as it becomes subject to the domination of managed care.

Meaning can at least be thought of as located somewhere within the individual patient or client, as being involved somehow in his or her psychological functioning. This, however, is only one step away from the medical model. A further step away from "physicalistic" assumptions concerning causation are influences on health or illness that are located outside the individual, in his or her social and cultural environment.

During the heyday of community mental health in the 1960s and 1703 appreciable numbers of psychiatrists dared to take this second step in distancing themselves from their medical colleagues. This they did by giving serious attention to the impact on mental health and illness of both psychological and sociocultural factors. They saw the latter's influence both on individuals and families, and they gave attention also to communities and to the impact of broader public policies. They were interested in finding ways of intervening at the community level -- or at a wider level -- through programs and activities they believed might prevent or at least reduce the toll taken by mental and emotional disorders in the future.

The 1980s, however, were for many psychiatrists a time of retreat back into the medical profession's biological determinism, and in the '90s this point of view still largely prevails. As for physical illness, it is only quite recently that a few medical practitioners have been persuaded that social or cultural influences could have an effect on processes occurring in the body. The research finding, published in 1989, that patients with metastatic breast cancer, who had been randomly chosen to receive social treatment combined with expressive therapy in a support group, survived about twice as long as members of a control group -- this finding reportedly came as a surprise to the psychiatrist who conducted the research. It would hardly have surprised most non-medical psychotherapists, however, and certainly would not have surprised therapists trained in PBSP.

The latter might even consider a possibility wholly alien to the majority of US physicians. They might suggest that the physical findings to which medical practitioners attribute sole causal efficacy may in their turn have been caused by interactions between parent and child -possibly going back as far as the fetal period -- that failed to provide adequate satisfaction for all of the child's basic needs.