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Taboos in Bonding Psychotherapy

Presentation by Dr. med. Jochen Zimmermann of Frankfurt, Germany, at the 2018 ISBP Conference in Lisbon, Portugal.

Dear Colleagues, dear Guests, dear Friends,

First of all, please allow me to sincerely thank Mr. Domingos Neto and all who were involved in organizing this year's conference in this location, the beautiful city of Lisbon. Also, I am very thankful for the opportunity to stand here today and deliver my presentation on Taboos in Bonding Psychotherapy.

I admit that right now I`m indeed a bit nervous, as this is the very first time that I'm attempting to give a presentation in the English language. Mr. Werner Guss, who prepared the English translation for me, is also here with us today, and he will assist me later on in understanding and answering any questions you may have at the end of this presentation.

Please keep in mind that this pesentation can only be a first approach or introduction to the topic. It is not, and was not intented to be, an all-encompassing scientific study.

My interest in the theme of this presentation, "Taboos in Bonding Psychotherapie" goes back many years to when I first attended a seminar on the topic "Taboos" during one of the annual "Psychotherapy Weeks" in Lindau, Germany. During my more than twelve years of work as psychotherapist in psychodynamic therapy for individuals and groups, as well as in my work as bonding-psychotherapist, I have often been confronted with various forms of "taboos" and "taboo breaches". And that made me want to learn more about taboos: How did or do they come into existence? How do they work? With his presentation, I would like to raise or renew your interest in this subject, and encourage you to explore the workings of this phenomenon in your own therapeutic work.

In my research of relevant scientific literature, I soon realized the tremendous range of the task, as taboos are a subject of interest for quite a number of scientific disciplines, in addition to psychology. For example: sociology, ethnology, theology, philosophy, and social science.

In this presentation, I will address the following aspects:

1. Origin and psychoanalytic background of the term 'taboo'
2. Manifestations and characteristics
3. Functions (general)
4. Breach of taboo (general)
5. Development and change as a result of taboo breaches
6. Distinctive characteristics of bondingpsychotherapy
7. Taboos in bonding psychotherapy

- not necessarily in this order.

The Term "Taboo"
The term 'taboo' stems from the Maori word 'tabu` (spelled t-a-b-u, or also t-a-p-u`), It originally meant `holy`, ùntouchable`, or `forbidden`. The earliest written record of the word 'tabu`is found in a travel account by the English seafarer and explorer James Cook. In seventeen-seventy-seven, after an encounter with the indigenous people of Tonga, he writes - Quote: "None of them would sit

down or eat the food we offered to them. By way of explanation, they shouted ‘tabu`, `tabu`. This word apparently has manifold and complex meanings. In a more general sense `tabu` means that `something is forbidden`”. - End of quote. (Source: Wikipedia).

This of course raises the question as to who is the author of this commandment? Who enacted it? The theory goes like this: In ancient indigenous tribes, such as the Maori in New Zealand or the Aborigines in Australia, certain individual members were accepted as chiefs or leaders based on `mana`. The term `mana`denotes great physical, spiritual, or even supernatural powers. The more `mana` a leader possessed, the more respect, obedience, and privileges he could demand. Privileges, for example in the form of better food, or being the first to be served, and so forth. As a visible sign of respect, this leader would then demand, for example, that no other clan member may touch him, or look him in the eye directly, or speak to him without prior permission. To keep the others at a distance, he would also designate a space around himself, a taboo zone that no other person was allowed to enter. Eventually, many things which the leader deemed to be not good for himself or for the clan, were declared taboo. Initially, the group accepted the taboos as a result of the respect, and fear, and awe they felt for their leader. With time, the taboos became internalized, automatic behaviour, while the reasons and circumstances that had brought them about were forgotten.

In our modern use of the term, `taboo` denotes certain kinds of behaviour, conduct, and issues that are not accepted by society. In other words, all these “don’t do that, and “don`t talk about that” that we all know from our childhood years.

Sigmund Freud already dealt with the subject `taboo` in `Totem and Taboo`, which was published in nineteen-thirteen. Freud believed that all forms of modern civilization and all forms of conforming behaviour that we find in our modern societies have their origin in these early tribal societies. The first part of `Tabu and Totem` is concerned with the incest taboo of ancient tribes, mainly the Australian Aborigines, who he focussed on primarily because of their extensive use of totems. Freud believed that totems were used as symbols for the identification of the various clans or families, and that the main purpose of totems was to prevent sexual intercourse between members of the same clan. For Freud, this is the origin of what he calls “incest taboo”.

To enforce this rule, sexual intercourse among members of the same clan was placed under a powerful spell, in other words, was made taboo. Taboo breakers were sanctioned rigourously: they would loose all honor and respect. Ultimately, they would be expelled from the clan.

So powerful was the taboo that, as in the case of the Australian Aboriginees, taboo-breakers could be made to die, not by physical force, but by the sheer power of the taboo.
Freud was convinced that the mechanism of declaring unwanted things, actions, and behaviour taboo, is standing practice in all societies. On the individual level, all that is taboo is seperated and shut out from the sphere of consciousness and pushed into the subconscious, into that sphere, that is not accessible for conscious thought and reflection. Once certain behaviour is successfully made taboo, the corresponding action is simply removed from a person`s range of behavioural options. You might say, from then on, a person ceases to even think about doing something that is taboo.

However, says Freud, in the subconscious sphere, the original desire or drive remains active, and so creates an ambivalence conflict: on the one hand, the drive must be suppressed, and on the other hand this very same drive still seeks relief. According to Freud, all compulsive neuroses are manifestations of this conflict, and he even names them `taboo-sickness`.

Freud also differentiates between taboos as social phenomena and taboos as causes for compulsive behavioural disorders and neuroses in individuals.

Around nineteen-ninety-five, the ethno-psychoanalyst Reichmayr developed and proposed his model af basic personality strucures. For Reichmayr, taboos, along with rituals and historical

myths, are reflexes and mechanisms that are used by societies for the purpose of creating and maintaing identity and stability.

In ethnology, taboos are viewed as a means for social control and for the achievement of conformity.

In the following I would like to share some thoughts and theories on taboos by Hartmut Kraft (2004):

1. In societies, taboos have the function of suppressing certain unwanted thoughts, actions, or behaviour. Violation of taboos results in shunning and exclusion of the violator.

2. Taboos are subject to change. Social changes may lead to the abondonment of existing taboos, and the creation new ones. Vice versa, the breaking of existing taboos may cause social change.

3. Individuals, as well as society as a whole, often are not aware of existing taboos, once they have been integrated in the subconscious. - According to a well-know German poem and folksong, “Thoughts are free -. . . Noone can know them . . . no hunter can shoot them . . I think what I want, and what makes me happy. . .”, and so forth. (the text and the melody are from a collection of Old German folksongs by Achim von Armin and Clemens Brentano, 1805).
But is that really true? To what extent are our own thoughts already permeated and censored by our own taboos? (self-censoring, the “scissors in our brain”).

4. Taboos have a wide range of manifestations. Taboos may be implicit, subconscious, or non-verbal. At times they may be pulled back into awareness and public discussion. Typical examples of things that are commonly hushed-up and not talked about - often out of a feeling of shame – include certain types of diseases, for example: cancer, certain mental deseases, psychological disorders, alcohol and drug problems, suicide, abortion, extramarital sex, extramarital children, gay and lesbian family members, incest, and sexuality in general.

5. Taboos generally have the function of creating a sense of security, identity, and belonging, often in contrast and opposition to other groups or societies. For many individuals, identity, self-esteem and self-confidence can only be achieved and maintained inside a group that shares the same values: being a part of that group makes the individual person feel more important and better than someone from a different group.

6. Taboos are both an intrapsychic as well as an interpersonal mechanism. When utilized by societies or certain segments thereof, it is generally used in order to create a strong feeling for, and identification with, certain accepted and non-accepted behaviour, attitudes, convictions, beliefs, conventions, and norms which give the group its outward and inward identity. It distinguishes the group from other groups, and ensures cohesion. Accepting and living in conformance with the group’s norms satisfies the individual’s need for belonging and increases the individual’s sense of identity, security, stability, and self-worth. For Kraft, taboos are a mechanism by which certain groups or societies distinguish themselves from other groups, create their own identity, and protect themselves against intrusion of outside influence, which is feared to lead to identity diffusion and identity loss. From a psychoanalytical perspective, this mechanism corresponds with the oedipal symptomology in an individual’s struggle for identity.

7. There is no one common origin of taboos. All societies, ancient and modern, have developped and are still developping taboos in all forms and shapes.

8. Kraft believes that the tendency of an individual to more or less readily succumb to the demands of taboos is deeply rooted in the individual’s personal experience of parental neglect and punishment in early childhood. As babies, we totally depend on the attention, care, and love given to us by our parents. In our early years, any non-responsiveness to our immediate pshysical or emotional needs causes anxienty, stress, agony, and fear of dying.

9. In Kraft's view, children, whose parents frequently subjected their children to varying forms of neglect, for example: witholding of skin and eye contact, withholding of care, love, intimacy, and the like, will in later years more willingly and uncritically accept and internalize taboos than those whose childhood needs were more adequately met. For young children, a parent possesses unlimited, absolute, and magical powers. They have `mana`, just like the prominent members of ancient societies.

10. Additional categorizations of taboos, based on Helmut Kraft:

- Behavioural taboos:

Rules of etiquette. Non-compliance results in avoidance or exclusion.

- Taboos concerning physical contact:

Don't touch persons of higher social rank. Don' touch colleagues and other employees at the work place. Don't touch strangers.

- Religious taboos:

For Christians "Thou shalt not make thee any graven image" (King James Bible).
In the Islamic religions, paintings showing humans or animals are taboo.
Hindus should not eat calf meat. Jews and Muslims should not eat pork.

- Individual taboos:

This concerns all persons who had to live through a traumatic experience, for example, abduction, rape, or torture.
Traumatic experiences may result in reality-splitting and dissociation, whereby the traumatizing content is suppressed into the subconscious and thereby seemingly made non-existent.

- Taboos amongst couples:

Couples know the sore points of their partner and exclude the critical issues from their communication in order to avoid conflict.

- Taboos related to specific groups:

For example: survivors of Nazi concentration camps;
war veterans; war refugees.

- Taboos related to specific locations:

For example, wearing bathing suits is taboo at the opera but not in a public swimming pool.
Examination of the private parts of a patient is not a taboo in a doctor's practice or hospital, but it is taboo in public.

11. Taboos as strategy:

- From a sociological point of view, taboos contribute to decreasing social conflict;

- According to Steiner, the purpose of taboos within a society is the elimination of all potentially disintegrating and disbanding issues, problems, and themes from collective awareness and discussion.

- Hondrich believes that societies could not prevail if all lurking dangers and conflicts were brought to light and that tabooing of lurking evil is an intuitive reaction and attempt which is aimed at keeping societies from falling apart.

- Tabus are often tacitly accepted by individual members of a society, as this relieves them from having to deal with ambivalent and seemingly unresolvable problems and conflicts.

- Highly emotional issues are often tabooed in order to avoid pain.

- Tabooing is one of several strategies aimed at maintaining collective or cultural identity.

12. Taboo breaches.

- Taboo breaches cause emotional turmoil in individuals and groups.
- Taboo breaches are a direct attack against an individual or group.
- Identity change inevitably leads to the breaking of taboos. Vice versa, successful taboo breaches, that is, taboo breaches which led to the alteration or abandonment of existing taboos, invariably cause identity change.
- Since taboo breaches provoke defensive actions and sanctioning from those that are in control, taboo breaches reveal the power structures that exist within a group or society.
- In a family or group setting, exclusion of the undiscerning taboo breaker is the logical consequence.
- Exclusion usually is the end result to a gradual process that begins with isolating the taboo breaker by various tactics, including: no longer inviting the perpetrator to social gatherings, verbal attacks, and isolating the taboo breaker by ending all communication and contact.

13. Taboos and social change:

As stated earlier, taboos are one of the most effective and powerful instruments by which parents, groups, and societies attempt to create, maintain, and preserve identity, unity, cohesion, stability and security. As such, it is a method of scocial control, which in most cases is applied deliberately and for a certain purpose. While it seems that taboos are principally aimed at achieving a positive and life-supporting end, such as: suppressing impulses to hurt or kill, perform sexual acts by force and without the consent of the other person, and so forth, history, on the other hand, has also shown that the very same instrument very often hinders progress and positive change.

Without the determination and resolve of certain taboo breakers like Galileo Galilei, Emily Davison and the suffragettes, Martin Luther King, and hundreds if not thousands of others, modern societies today would not have: women's voting rights, women's access to higher education and professional careers, voting rights for African-Americans in the United States, legal marriage of persons of the same sex, democracy, heart transplantations, and all the other social and scientific achievements.

Many current social and scientific developments are in conflict with existing taboos. I`m thinking of: genetic research, cloning, suicide or assisted dying, organ donation, artificial intellience, to only name a view. Finding adequate solutions for such deeply ethical issues requires free and open discussion and active participation of all segments of society, so that in the end the proposed solutions will be acceptable to the majority. And this cannot be achieved without the willingness to reflect, scrutinize, evaluae, and - if necessary - abandon existing taboos.

In the following, I would like to address taboos related to bonding and some taboos that exist within the bonding organization:

Bonding Therapy in and by itself breaks with exsting taboos

In short, the basic concept of bonding theory is, that in order to initiate a healing process the patient must again find access to, and re-experience, those old traumatic experiences he or she was exposed to in early years, and which at the time were so unbearable and life-threatening, that they had be to erased from active memory and locked away in the sphere of the subconscious. However, since the suppressed content still interferes with the emotional and intellectual reality processing of the adult, and so constantly reinforces and keeps alive the symptoms, therapy must find a method that enables the patient to re-experience the old traumatic content, so that the adult can begin to acknowledge, reflect, and evaluate these old experiences and bring them into line with reality.

It was Dan Casriel who found the method to that end: bonding. In short, Casriel took up Janov's primal scream and combined it with bonding. The bonding routine goes like this:

1. work is in pairs, on a floor-mat

2. the active partner provides shelter by kneeling on top and holding the head and a shoulder of the active partner.
3. the active partner screams

The method works, as we all know from personal experience and from our work with patients.

However, this method is, in and by itself, a violation of taboos.

Firstly, it breaks with a taboo that exists in almost any other psychoanalytic school of thought: the dogma of distance between patient and therapist. In classical psychoanalysis, and in most other forms of psychotherapy, it is a paramount principle that therapist and patient should not touch each other. This includes embracing, hugging, touching body or face, even shaking hands and eye contact during an ongoing session.

Secondly, our method also breaks taboos that our patients have: for them also hugging, touching, and especially the extremely close body contact during bonding work is, at least initially, a taboo.

In my own view and experience, it is exactly this breaking with his own taboos that bonding therapy requires from the patient – close physical contact and screaming - which makes it possible for the patient to break through to the old dramas that are enshrined in the subconscious.

Taboos within the bonding society

The key principles and methods of bonding psychotherapy are based on the principles formulated by Casriel and, at least for the German Bonding Society, by Karl Stauss in his book, “Bonding Psychotherapy - Principles and Methods”. The various regional Bonding Societies have the responsibility to guard these principles, and to ensure that these principles and methods are followed.

For a good reason, most - if not all - of these principles are “engraved in stone”. They are, to pick up the theme of this presentation, “taboo”. Based on my own personal experience, I know that bonding is a highly successful and effective method. I felt it. I`ve seen it. It works. It’s unique. It’s our brand. We should cherish and protect it.

However, in view of many past debates that I have witnessed or been a part of,
for example, debates about whether or not eye contact, or hand-holding, or certain forms of touching could be considered “bonding”, I recommend to differentiate between indisposable taboos that should be upheld and reinforced, which for me is almost, but not quite, the whole package, and only a few which in my opinion should be re-evaluated and possibly qualified or dismissed.

Here are some characteristics which for me belong to the category `ìndisposable`, and which should be enforced:
- bonding means whole body contact. Therefore, eye contact or handholding alone does not constitute bonding.
- bonding should aim at achieving levels 3 and 4 of Casriel’s scale of emotional expression.
- the taboo of sexual contact between therapist and patients should be strictly enforced .

And here are two principles or ‘taboos` which in my opinion should be reevaluated:
- personal relationship and sexual contact between group members.
- bonding is good for all.

Regarding the taboo on sexual contact between group members:

There are very good reasons for the requirement, that patients should not enter into close relationships and should not have sexual contact with other group members. However, bonding brings patients into close physical contact with other group members, for extended periods of time: weekly group sessions and bonding weekends, in most cases over many years. Therefore, the assumption or expectation that sexual contact between bonding patients would never happen seems to me illusionary and unrealistic. In reality, it does happen from time to time.

And when it occurs, I believe the therapist should acknowledge the situation rather than ignore it, and encourage the respective group members to eventually address the situation in the group.

Regarding “bonding is good for all”:

The Bonding Society promotes, and all members are expected to accept, the claim that bonding psychotherapy is an adequate and effective method of treatment for all patients, regardless of the patient’ symptoms or clinical picture. Many within the organization believe, that if our treatment does not show positive results, it is either due to the failure or unwillingness of the patient to overcome his or her resistance, or the failure is a result of the ineptitude or incompentency of the therapist.

Based on solid medical training and experience, I have, during the many years that I have practiced psychotherapy, repeatedly met patients for whom in my opinion bonding therapy was not suited, and in some cases even potentially damaging. Subsequently, I started to research what other professionals had to say about this subject, and found the following:

In his book, “Introduction to emotional group therapy” Abros Wehrli writes:

Quote: “There are people with certain diseases, who should not scream. These are persons in a manic or hypomanic stage, persons with active anabolitic cancer, as well as persons with extreme shortsightedness, whose retina might get detached [as a result of loud screaming]. . . . . Apart from the aforementioned, screaming hurts or damages noone.” End of Quote.

Tschuschke, who, along with Yalom, is an authority in the field of group-psychotherapy, believes that patients with the following indications should be excluded:

- patients with a psychopathic structure
- patients in a state of extreme pain
- patients in a stage of acute suicidality
- patients with certain forms of autism spectrum disorder

L. Greenberg believes patients should not be subjected to bonding therapy if one of the following indications apply:

- psychosis in an acute stage
- impulse control disorder
- acute suicidality
- acute substance abuse
- patients with a highly anti-social personality structure

MacKenzie adds the following counter-indication:

- patients with extremely high defense mechanisms

In accordance with Greenberg, I have established the following routine procedures in order to determine whether I can make a recommendation for bonding therapy:

Candidates are required to complete and send me a questionnaire. I review the questionnaire and make arrangements for a personal interview. If necessary, I may require additional screening: SASB, IPP, SCL-90, RSQ, BDI, DESNOS.

When a candidate cannot arange to see me in person, I may offer a telephone interview in lieue of a personal interview.

I have established the following criteria for not recommending or accepting a person for bonding therapy, in accordance with ICD 10:

- acute psychotic disfunction, acute stage of schizophrenia, F20 – F29
- impulse control disorder
- acute substance abuse F10-F19
- acute suicidality F32.3, F33.3
- anti-social personality structure F60.2
- acute stress reaction (within 4 to 6 weeks as of the event) F43
- mental retardation, from moderately severe upwards F71 – F74

When the following indications apply, I require a preparatory phase prior to accepting a patient for bonding therapy. (In some cases, the preparatory phase may last up to three years):

- complex post-traumatic stress disorder F43.1
- frequent dissociation for extended time periods
- dissociative identity disorder F.44
- organically caused psychic disorder (dementia, delirium) F02 – F09
- affective disorders F30 – F39
- obsessive compulsive disorder F42
- personality disorder F60 – F66 (another possible indication for exclusion)
- autism spectrum disorder F84

Unfortunately, Stauss does not address this issue. Nevertheless, I highly recommend that this issue is revisited and that, hopefully, a recommendation will be made that some kind of screening process should be implemented, similar to the one I just presented.

As I`m approaching the end of my presentation, I would only like to add a few remarks regarding the taboo “sexual abuse of patients by therapists”:

Avoidance of undue familiarity, close presonal relation, and abstaining from sexual contact with patients is one of the basic responsility of psychotherapists. It is prerequisite for all therapeutic work.

Yes, we all know that, and we all strictly abide by this rule, don’t we? Always. No exception.

And yet, according to the German “Ärzteblatt”, Nr. 5, published in February, 2018, there were six hundred reported cases of sexual abuse of patients by therapists, in one year, in Germany alone. More than half of these therapists were middle-aged or older, and quite a few of these also were teaching therapists. It may be reasonably expected that a considerable number of cases did not get reported and are not included in the aforementioned number,

In my own practice, I work with approximately 80 to 100 patients on a continuous basis. I currently treat three patients, two females and one male patient, who have been sexually and emotionally abused by psychotherapists. Of these three ocurrences, two occurred in clinics.

There is no need to address the damage sexual abuse causes for the abused. I do not see the need to allude to the possible legal consequences for the abuser. We all know that.

I have mentioned these facts merely to remind ourselves that in our therapeutic work we may not cease to monitor our own emotions, and that we should, from time to time, reaffirm certain taboos.

Thank you for your attention.

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