

INTERNATIONAL BODY PSYCHOTHERAPY JOURNAL

THE ART AND SCIENCE OF SOMATIC PRAXIS
INCORPORATING US ASSOCIATION FOR BODY PSYCHOTHERAPY JOURNAL

volume sixteen | number one | spring 2017



EABP

EUROPEAN
ASSOCIATION FOR
BODY -
PSYCHOTHERAPY

 **USABP**
United States Association for
Body Psychotherapy
The Hub of Somatic Psychology

International Body Psychotherapy Journal*The Art and Science of Somatic Praxis**(formerly US Association for Body Psychotherapy Journal)*

volume sixteen · number one · spring 2017

The International Body Psychotherapy Journal (IBPJ) is a peer-reviewed, online journal, published twice a year in spring and fall. It is a collaborative publication of the European Association for Body Psychotherapy (EABP) and the United States Association for Body Psychotherapy (USABP). It is a continuation of the USABP Journal, the first ten volumes of which can be found in the IBPJ archive.

The Journal's mission is to support, promote and stimulate the exchange of ideas, scholarship and research within the field of body psychotherapy as well as to encourage an interdisciplinary exchange with related fields of clinical theory and practice through ongoing discussion.

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The IBPJ is available free online.

Print subscriptions: <http://www.ibpj.org/subscribe.php>

Printed single issue Members €17.50, Non-members €20

Yearly subscription: Members €30, Non-members €35

Two-year subscription: Members €55.00, Non-members €60.

Payment through bank transfer, American Express or PayPal.

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Translation The online Journal is published in the English language. Abstracts of articles are to be found on the IBPJ website in Albanian, French, German, Greek, Hebrew, Italian, Portuguese, Russian, Serbian and Spanish.

<http://www.ibpj.org/archive.php>

If an article originally written in another language has been accepted for publication in English, the full article may also be found in the original language.

NB The accuracy or premises of articles printed does not necessarily represent the official beliefs of the USABP, the EABP or their respective Boards of Directors.

ISSN 2169-4745 Printing, ISSN 2168-1279 Online

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Cover image Coming Home, Ofra Syvilia

Spring Issue – Editorial

As body psychotherapists, we cannot help but ponder Reich's life and legacy in these strange, dark days. A man who followed his heart, to no end of trouble, and refused to heel to the powers-that-be of his time. His own moral compass was different than those around him, his search for aliveness never ending, his willingness to speak out awe-inspiring. We all know of his sad demise and the burning of all his works, which is still one of the worst cases of censorship in US history. He suffered great loss fighting for the aliveness he believed in.

It appears we are once again in a time of terrifying political, social and cultural upheaval. Fear grips many; in some cases, it is channelled into hateful words and actions, blaming others for our fate – xenophobia, racism, homophobia, misogyny and war seem to be louder now than ever. Amongst that though, other voices are arising. Voices that say this is not okay; voices that loudly and peacefully stand up for the victims, the less privileged, the minorities. These are embodied voices, of people that hold hope that something will change, and that kindness and inclusivity will once again rise to the fore.

It's a crazy thing, to hold hope. For some it is held in their trust of their God, and their faith brings them hope. For others, hope is held in the actions of everyday people, in kind words and kind deeds, in acts of loving defiance, of standing up and speaking their heartfelt truth, even when the consequences are large.

It is with all of this that we dedicate this issue of IBPJ to hope. As body psychotherapists, we carry Reich's legacy of daring to find aliveness, humanity and hope in times such as these and to embody these qualities as best we can. Within this issue, we present papers that inspire some hope in us.

Shamit Kadosh, who has also now joined our editorial team, presents a bittersweet case study on holding the polarities of theories whilst trying to reconcile this with a heartfelt intersubjective meeting with her client. It brings both pain and hope. Bernhard Schlage writes a beautiful piece on endings in therapy and helps us to think about staying embodied with our own grief. This piece is timely as we say our farewells to Lidy Evertsen and her hard work as the president on the EABP, and we also say goodbye to Jill Van der AA as she steps down as our managing editor, who together with Dr. Jacqueline Carleton, birthed this journal into being.

Sorin Thomas brings together different strands of work and species to look at embodied conflict resolution, something that the world needs a little more of right now. Benedek Tihanyi, in his interesting research, presents us with the prominent value of cultivating body responsiveness for our well being. Curtis Levang, Natalie Slaughter, Timothy Johansson, and Casey Lankow discuss their pilot study designed to validate the Levang Inventory of Family Experiences as a potential therapeutic tool to assist therapists working with the Pesso Boyden System Psychomotor methodology. Our cover picture, the work of art "Coming Home", was created by the artist Ofra Syvilia. It presents her conflictual perspective regarding hope and enlightens the magnitude of coming back home to our inner being

We also have a gift from our editorial team member Nancy Eichhorn as she reviews both the EABP and USABP congresses in her honest and engaging style, and we hope it inspires you to attend the next congresses.

Our wish is that this issue will allow a small bit of hope to take root in your heart. That you can hold another's hand and take strength in holding hope together.

We leave you with this: what happens when you bring an all-round American, some crazy Jews, a loudmouth Australian, a new EABP president and a bunch of Europeans together to make a body psychotherapy journal? Aside from blossoming friendships, much discourse, some casual banter and lots of embodied hope for a better world with space for all our diversities.

IBPJ Editorial Team

Asaf Rolef Ben-Shahar, PhD

Nancy Eichhorn, PhD

Debbie Cotton, MA

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Coming home Ofra Syvilia

It was thirty years ago when I first sought for help. I needed more than my suffering in order to go to therapy. I had to hold buds of hope and know that the vicious cycle of repetitions is not necessarily predestination. I needed to believe that change is an option.

It was after building a rapport with my therapist, that I was taken by surprise when he said to me the words: “There is no hope”.

A twenty- year- old woman, full of hope and desire to build my own bridge to a better world, I was left stunned and confused by his words. Although discussing the issue, I could not fully understand what he meant. I could not relinquish my little hope and I was determined to keep it as my life savior.

Since that day I have had a tangled, conflictual and changing relation to those words with contradictory interpretations.

As opposed to my therapist’s stance, Rabbi Nachman of Breslov , the founder of Hasidic movement, said that there is no despair in the world. While pondering over the issue, I could not find peace regarding the meaning of hope for me with neither of these perceptions.

It was only in recent years that I have given way for a novel insight to burgeon. The words ‘there is no hope’ led me to contemplate the essence of responsibility and guided my way towards my inner being.

At the same time other words have been revealed to me with a deeper meaning. Words like faith, trust, body, spirit, selfhood, femininity and interdependence. They have been all directed towards a delicate listening interweaved with a sober and compassionate insight.

Intertwining those words and insights, the bridge I have been diligently trying to build for so many years, is finally taking shape. It is a bridge of acceptance that passes through my being. It is about being able to see me, just as I am, to stay there, to soften my fears and to compassionately accept my limits. It is about surrendering to my whole being with loving kindness with no need to change anything. Those precious, sweet, relieving ‘no hope’ moments feel like a miracle to me.

Binding the words ‘no hope’ with sweetness and relief may seem paradoxical and unbridgeable. But I believe they do coexist, sometimes in struggle and other times in peace. What an illusion...

I feel that when I try to pursue a warm home feeling, I move away from myself. It feels as if I hold tightly the hope as a promise for something better to happen, while loosening my grip will lead me to devastation.

The phrase ‘coming home’, makes my way back home to my inner being. There are times when being in my inner home feels unsafe and painful, the walls seem to collapse and I just wish to flee in order to save myself from the ruins and ashes of my life. But I have no other choice, but to strengthen the foundations of my own home, because every time I go far from myself, I cannot find an appropriate home for me.

‘Coming Home’ is a work of art that represents my own perspective that espouses and highlights the significance of coming back home to our inner being.

'There is no hope'
Your shaking announcement thrown at me
You cracked all the crystal words
Glittering in the light of the limited hours
Now (years afterwards)
I am cleansing
The 'as if' wishes warehouse
Washing remnants of lead
In a quest for moments of occasional freedom
The horizon stretching in the middle of the word
Shattering moments of past and future
I am a two thousand year captive
I am a Gypsy
Wandering on walls
'The prison of the good hope'
Chanting a song
Scents of bonfire and incense
A veiled gaze
Passing through a barred hatch
Hiding an awakening heart
I am who I am

When the War is Over Dialogues between reality and fantasy, healing and psychotherapy Shamit Kadosh

Received 01 August 2016; accepted 04 October 2016

Abstract

In this paper I describe two sets of irreconcilable binaries in psychotherapy. The first between reality and fantasy, and the second between dynamic psychotherapy and healing. I present my clinical work as a body psychotherapist integrating touch, with Sara, a seventy-one-year-old holocaust survivor. Interweaving clinical experience, psychoanalytic theories and my own biography, I discuss the inevitable tension derived by these binaries and the profound impact of holding them in the therapeutic encounter.

Keywords: body psychotherapy, inter subjectivity, fantasy, reality, touch, healing

International Body Psychotherapy Journal *The Art and Science of Somatic Praxis*
Volume 16, Number 1, Spring 2017 pp 08 - 15. ISSN 2169-4745 Printing, ISSN 2168-1279 Online
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“To see a world in a grain of sand
And a heaven in a wild flower
Hold infinity in the palms of your hand
And eternity in an hour.”

William Blake, *Auguries of Innocence* (1803)

She was born in Auschwitz. At the age of two weeks she was thrown by her mother over the fence with faint threads of hope of someone being there to catch her.

Her body tells her story. Lean, contracted muscles, tightened shoulders; Sara hardly makes eye contact, holds her breath. Six months into therapy, she keeps withdrawing rather than attaching, surviving rather than living. The thrown unloved baby, who grew up in an orphanage, was saved from the atrocities of the Nazis yet abandoned. She became a bitter, angry and hopeless seventy-one-year-old woman, destroying potential relationships in her life. The only thing enlivening her is the war. She keeps living in the war; the war keeps living in her.

I can sense her craving for a mother and her repressed inner yearning. I carefully and slowly try to reach out, but she keeps holding back. From time to time I am drawn forth into helplessness and frustration.

Sara reminds me that children's primary attachment patterns are acquired through affect-laden interactions with their primary caregivers (Ainsworth, 1979), and are encoded as “implicit relational knowing” (Ogden, 2006, p. 45, 2015 p.585). In other words, our early caregiving experiences, encoded as procedural memories, lead to our non-conscious relational strategies. Those interactions encompass somatic exchange, a body to body, brain

to brain dialogue addressed as “affect synchrony” (Schoore, 2003, p.76). When the attuned caregiver responds to the infant’s affective body “language” in a pleasure-enhancing manner, the infant experiences a positive nonverbal communication, which fosters the development of his sense of self and cultivates regulatory abilities (Caroll, 2009; Ogden, 2006).

Winnicott (1963) emphasised the profound importance of a facilitating environment of mothering, the way of holding, responding and perceiving the infant’s internal needs. Bollas (1979) stressed that the mother was experienced as a process rather than an object of transformation, a feature that remained in the trace of this object-seeking in adult life, resulting in a quest of an object that promises to transform the self.

Based on attachment theory, originally developed by John Bowlby (1951) who studied the nature of infant-caregiver relationship, there are four identified attachment patterns: secure, insecure-avoidant, insecure-ambivalent (Ainsworth, Belhar, Waters & Wall, 1978), and disorganized-disoriented (Main & Solomon, 1990). Those patterns correspond with attachment styles in adulthood (Hazan & Shaver, 1994). The main behavioural features of the disorganized-disoriented style are both sequentially and simultaneously contradictory, and stressful. Disorganized and disoriented behaviour is accompanied by movements and postures indicative of freezing and apprehension in relational situations (Main & Solomon, 1986, 1990).

Sara’s biography explains her disorganized attachment style. She expresses confusion and incoherence in our relationship. She craves proximity and contact while withdrawing, freezing and wandering around with labile dysregulated affect and fearful expressions.

Sitting in front of me, Sara tells me about a fight with her neighbour; no one is there for her. She flagellates herself for her aloofness and complains about her loneliness. I can hardly hear her; her words are scattered in the room, and there is only one thing I can feel now. It’s clear and powerful, I can hardly resist it. My hands are tingling, my heart racing, and I certainly know, from the depth of my inner being, that I have to touch her chest. Troubled by this overwhelming unfamiliar sensation, I try to figure it out in terms of countertransference and resonance (Soth, 2005). Is it my craving to mother her? Is it the comforting sense of my hand touching my own heavy chest? My desperate attempts to use my knowledge and clinical experience fail. The only thing that feels right is to touch her chest. Months ago she made it clear, no touch is allowed. My chest becomes heavier; I can hardly breathe while trying to repress my unpredictable urge. A battle is taking place inside of me. A war between knowledge and knowing, between illusion and reality.

Truly, I am a woman of knowledge; I have always been. I valorise science and research; I am trapped in Western scientific scepticism. However, practicing family medicine and later psychotherapy, I am experienced in interweaving knowledge with clinical intuition. While looking at Sara, I can feel in the countertransference the desire to mother her, alongside resistance and fear. Notwithstanding, in this bewildering yet clear moment, my desire to touch Sara feels bigger than anything I have ever felt before. How do I discern between an enactment and a pure intuitive knowing?

Psychoanalyst Christopher Bollas (1983) claimed that by cultivating a freely roused emotional sensibility the therapist welcomes news from within himself, expressed as hunches, feeling states, images, fantasies and imagined interventions. He stressed that neither do we know whether what we experienced was due to that which was projected into us or whether we were having our own idiomatic transference responses to the patient. As I understand, he indicated that the discernment between an enactment and intuitive knowing would be possible only in retrospect. Bollas (1987) punctuated the necessity of uncertainty about how

we feel, and recommended that the therapist gets lost in the countertransference for a long time before making use of it.

So here we are. I want to touch Sara. How do I know to touch or not to touch? Cambry (2011) described moments of complexity in which linear time was resisted, while each potential choice could lead to alternative pathways. While in those moments of uncertainty, we cannot know which paths were optimums. She advised us to attend to intuitions about the quality and flow of complexity, which might provide some guidance. She suggested that such moments often occurred at the onset of enactment in therapy, or when something new was about to emerge beyond the transference/countertransference field. Rossi (1973) wrote:

“A creative moment occurs when a habitual pattern of association is interrupted . . . and introduce a momentary void in awareness. In that fraction of a second when the habitual contents of awareness are knocked out there is a chance for pure awareness . . . This fraction of a second may be experienced as a ‘mystic state,’ satori, a peak experience or an altered state of consciousness “(p. 461).

Looking at Sara, I carefully venture into my inexplicable knowing, while considering the complexity of touch (Asheri, 2009). I introduce her gently to the option of touching her. Her big brown eyes are wide open looking at me. “Sometimes I think that all I need is a big hug, well maybe it’s time,” and then she says, “Let’s go for it.”

I gently put my palms on her chest. I am relieved; she is taking a deep breath. She looks calm. “I like it,” she says. Touching her chest, I sense inside me vulnerability and yearning for a mother. Her contracted muscles start to relax; her head drops on my chest. For a brief moment I can feel my own longing for motherly holding. A wave of sadness expands in my chest, when I hold her, the unwanted baby and child. But there’s something else in this emotionally laden moment I am trying to fight, something bigger than me. My hands are burning and tingling, surges of infinite love are passing through me. Am I allowed to feel it? I surrender, I no longer fight it, and I let it be. I feel how little and limited I am in what I can give Sara and it feels as if I am channelling an endless energy for her, holding infinity in my hands. Her face is calm; her wrinkles look as if they are resting after a strenuous journey. Her body armour melts in my bosom, tears trickling down her cheeks. My whole being resonates with hers, bright light piercing through, illuminating us both, we are breathing together, we have a shared body (Rolef Ben-Shahar, 2014), and we are one.

It is clear to me (and yet confusing) that a substantial part of the work I have done is healing. Is it allowed in psychotherapy? How will it change our relationship? Touching Sara evoked a regressive self-state and ensued an intense parental countertransference. As body psychotherapists we may choose to work with touch interweaving both the symbolic and sub symbolic with the language of touch (Bucci, 2008; Rolef Ben-Shahar, 2014). While touch can be healing (Orbach, 2004; Sinason, 2006; Stern, 1991), it may yield intense transference and regression (Rolef Ben-Shahar, 2014), and we no longer use touch as naively as before in body psychotherapy.

The psychoanalytic literature is full of references regarding the profound therapeutic potential of regression. Winnicott (1954) depicted profound regression as an opportunity to fulfil, in the transference situation, primitive needs that had not been met at the appropriate level of development, hoping for softening frozen situations and ushering adaptation. Bollas (1979) noted that the analytic space might facilitate deeply regressed states to what Balint (1968) called the level of the basic fault. He claimed that the analyst served as a transformational object for the patient.

While carrying reparative potential, regression may hold risks as well (Mitchell, 1993; Totton, 2003). Balint (1968) discerned between benign and malignant regression, describing

the latter as perpetuating maladaptive patterns, increasing dependency between client and therapist and preventing growing in the relationship.

While holding Sara I take upon myself the mother role. Being a mother to my own children is the most natural and fulfilling aspect in my life. However, while playing the mother role in the session, I am aware of a fearful, resisting part in me, which hinders my surrendering to the situation. Growing up being manipulated and lied to, I relentlessly fight illusions and fantasies, and I pursue truth. Being a mother for Sara feels, for a part of me, as if I am deceiving her; whereas, another part of me is eager to give Sara the missing experience and save her. I identify two sets of binaries: the first between reparative regression and an illusional promise; the second between dynamic psychotherapy and healing. I ponder my ability to hold these irreconcilable binaries.

Winnicott (1971) introduced us to the transitional phenomena, where the baby and mother share both an illusory and real experience. He claimed this kind of illusion belonged to human beings and could not be solved. He wrote, “My contribution is to ask for a paradox to be accepted and tolerated and respected, and for it not to be resolved (p.3). . . . The resolution of the paradox leads to a defence organization which in the adult can encounter true and false self-organization” (p.14).

While attempting to understand the oneness, I am reminded of

Bollas’s notion of the aesthetic moment (1978). A moment of deep rapport between subject and object, providing the person with a generative illusion of fitting with the object. It might induce an existential recollection of the time when communicating took place solely through illusion of deep rapport of subject and object, which may correspond with intersubjectivity that takes us both. He argued that such experiences are transformative. Just as in a “good enough” situation when the mother as a transformational object manipulates the environment to meet human needs, so does the therapist.

Researcher Colwyn Trevarthen (2001, 2009) conceived human intersubjectivity as a process that enables subjects to detect and change each other’s mind and behaviour, and emphasised the human need for sharing emotions and feelings. He termed two kinds of intersubjectivity. Primary intersubjectivity referred to the preliminary symbiosis between caregivers and the newborns characterized by mutually regulated interchanges and surrendering, while the newborn had no real choice. At around the age of nine months, the infant is able to integrate a new form of cooperative intersubjectivity (person-person-object awareness), termed as secondary intersubjectivity characterized by surrendering out of choice. Trevarthen stressed that this development was fostered best when caregivers responded with perceptive sympathy to the motives and feelings infants expressed to them (2001).

Sara and I mutually choose being in this fusion. While sharing an aesthetic moment and an illusion of mother holding her baby, I ponder the implications. Although feeling authentic with her, I cannot avoid the feeling of being deceptive, providing her a bite from a cake that can no longer exist. I deeply believe in the healing potential of the therapeutic relationship, and I meet my clients in an authentic and empathic way, listening to them non judgmentally, fully present as far as I am able to. While participating in becoming a transformational object for them, I collaborate in establishing an unreal relationship that might enliven desires and cravings that can never be met in reality. While doing so is part of my job as a psychotherapist, I cannot avoid my ambivalence towards it. In my own therapy, as a client, captured by my own biography, I perceive the therapeutic relationship as a professional one, insisting on and struggling not to go to the realm of fantasy and

illusion. As a therapist I tend to surrender to the illusionary space, hurting each time I shatter the illusion of my clients when I set boundaries of time and money. Winnicott (1965) pointed out that professional work was quite different from ordinary life, and he reminded us that our patients met our professional attitude rather than the unreliable men and women we happened to be in real life.

Segal (2006) discussed the implications of the notion of cure and change that did not rest only on attaining truth but also on the personal influences of the analyst (e.g. his support and comfort). He wrote, "For when the analyst actively takes upon himself the parental role, he invites the patient to live in a lie" (p. 189).

Without belittling the significance of my relationship with Sara, I cannot attribute the healing just to my personal influence. My hands holding Sara were not only mine. Transformative moments, aesthetic moments or what Stern (2004) called "the present moment" are moments of healing. Healing is not something I do, but I can call forth and cultivate. I believe that surrendering to something bigger than me made it happen. My inability to explain it is a comfort, as well as a challenge for me without feeling a fraud. I am reminded of neuroscientist Daniel Siegel's (2010) notion of bottom-up processing, which is based on incoming non-verbal, implicit information, he calls "Beginner's Mind".

Relational psychoanalyst Steven Mitchell (1993) contributed to the subject by referring to the complex relation between reality and fantasy in the therapeutic relationship. He defined this relationship non real, as compared to other real relationships in our personal life. However, the unreal dimensions of the analytic situation enable enlivening of deep experiences, much more than in daily real life. I would like to argue that sometimes there is more reality in therapy for me than in my own personal life, even if it lasts for a fraction of moment.

Sara confronts me with an inevitable conflict. Clients come to therapy and often create intimate relationships with their therapists, while being contained, unjudged and listened to. While this kind of relation is of paramount importance for development and growth, in my opinion it might inspire unreal desires for such relations. Clients perceive us and the co-creation of the relationship as real, while they meet us in a professional attitude blended with transference/countertransference and regressive self-states. Poised on the border of fantasy and reality, I contemplate the advantages and disadvantages, while trying to hold the inevitable tension and reconcile between the two inside of me and between us.

Am I real? Am I a fraud? Who am I? Am I A psychotherapist or a healer? Holding Sara while surrendering to something bigger than me, reminds me of Bion's reverie (1962) and Ogden's analytic third (1994). We are both in a special state of consciousness, creating together as two subjectivities a third unique entity consisting of our thoughts, feelings and bodily awareness. That third heals us both. Psychoanalyst Ofra Eshel (2016) pointed out how client and therapist forge an emergent new entity of interconnectedness – "an emergent two-in-oneness" (p.189). She suggested that this dimension of analytic work engenders new possibilities of being and experiencing.

Sometimes, it seems to me that as psychotherapists we tend to give psychological terms to spiritual phenomena. As a woman of knowledge, I need it to quiet my own fears and confusion.

Pinkas-Samet (2016) referred to bodily reverie as a sleep state of mind of the therapist and the client that allowed understanding shared bodily experiences by tolerating and examining them from the inside. Sara and I co-create the intersubjective space, where our minds are the sum of all we are and we share a wider mind (Rolef Ben-Shahar, 2014). Aligned with the

transformative potential of these moments, I am familiar with my fear regarding merging and fusion (Pinkas-Samet, 2016) and the threat of being changed as a dynamic participant (Rolef Ben-Shahar, 2014).

She opens her eyes looking at me. It seems as if I have met her for the first time; her interpenetrating look leads me into the heart of her soul when she whispers, "Is it possible? Is it really possible that the war is over?"

Seventy-one years of dreadful war subside for a few moments of peace; years of my inner war against the unfathomable depth and mystery of the universe and humankind are transiently over.

Is it real? It will probably not last, but it was felt unforgettably real. Those valuable miraculous moments were derived from a long significant therapeutic relationship, as well as a healing energy channelled through me.

It will only be months afterwards that I will truly let myself believe and appreciate the profound effect of these precious moments for us both. A belief that will not contract my scepticism and cynicism. We will never be the same. Sara will soften; her vulnerability will be painfully exposed; she will open her heart, and for the first time in her life she will truly hug her daughters and grandchildren.

Sara helped me partially retreat from an endless inner war between illusion and reality, to dare to surrender and hold the tension between the edges of fantasy and reality and to regain my faith and hope in the healing potential of relationships. My own ambivalent attachment style that withheld me from holding a transitional space would suspend, the same as Sara's disorganized style. Despite my ambivalence towards illusions and fantasies, Sara gave me the opportunity, as written by William Blake, to see a world in a grain of sand, heaven in a wild flower, and to hold infinity in my hands and eternity in an hour.

In the twilight zone, where illusion and reality interface, where the ineffable and the known engage, where we meet our scant capabilities and surrender to something bigger than us, when the war is over, that is when something new emerges, a looming opportunity for healing, faith and hope.

BIOGRAPHY

Shamit Kadosh is a family physician (MD) and a practicing body-mind psychotherapist in Israel. She has been teaching family practice residents and medical students for the past ten years in Faculty of Health Sciences at Ben Gurion University and in Faculty of Medicine at Bar Ilan University. She headed a training program for residents in family medicine in the Department of Family Medicine in North Israel. Additionally, she is a lecturer in the body-mind psychotherapy program in Shiluv Institute, Haifa University. She is experienced in integrating scientific and clinical writing.

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About a Good End How to end (body) psychotherapy and why this is hardly ever talked about Bernhard Schlage

Received 08 August 2016; accepted 11 September 2016

Abstract

In this article, the author intends to enlighten and engage readers in regards to aspects involved with the last phase of (body-) psychotherapy by introducing potential complexities that impact the last phase of a single session as well as (body) psychotherapy in general. Despite the significance of appropriate closure for client and therapist well-being and emotional health, the author contends it has been relatively neglected in the literature. The author explores this topic starting with a description of challenges therapists may experience then offers ways to address them. He also discusses the impact clients have on therapists within transference-countertransference situations. In conclusion, the author offers propositions to deal with this significant phase of the psychotherapeutic relationship.

Keywords: ending therapeutic relationships, biographical markers of therapists with often broken client-relations, burn-out prophylaxis, katamnesis

International Body Psychotherapy Journal *The Art and Science of Somatic Praxis*
Volume 16, Number 1, Spring 2017 pp 16 - 27. ISSN 2169-4745 Printing, ISSN 2168-1279 Online
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“The initial scene”

Rosenberg (1985) used this term to describe the biographical origin of a psychological habit in the present

“...he sat facing her. He just had noticed that the session was nearing its end. Soon the next client would ring the bell. However, just now, the person opposite him delved into an emotional memory of her childhood of such a sensitive and tender nature that it seemed impossible for him to interrupt. He was aware of his restlessness. In similar situations, before, he sometimes had excused himself with the need for the toilet in order to interrupt in a diplomatic way. Yet, he always scorned himself because of his cowardice. Today he wanted to do it differently. So, he tried to distance himself from the narrating flow of his client and concentrate on the syntax in order to catch a gap into which he could ask a question. But this gap did not appear. He tried to widen his range of consciousness so he could point out a sun beam shining into the room, or to sounds streaming in from outside and in this way get a chance to interrupt the narration of his client. Time stretched out terribly and a strange stillness was in the room: the scene seemed more and more ‘sacrosanct’ to him. Soon it seemed impossible to even clear his throat. When, finally, the bell rang and his client continued to talk as if nothing had happened, he did not dare to get up...”

After 33 years in private body psychotherapy practice and during the work of an ongoing

psychotherapeutic oriented supervision, I realized that several problems arose when my clients (and/or supervisees) and my negotiations involved ending our psychotherapeutic relationship. I have repeatedly tried to find solutions to this tricky phase of psychotherapy. A meta-analysis of publications concerning this topic brought to light that few authors have dealt with this situation. Thus, my motivation to provide information in an article to both enlighten my colleagues and support further research in the (body-) psychotherapy field.

I explore this deficiency of studies in light of psychotherapeutic tradition and in the light of the fact that psychotherapists belong to an especially burdened professional group, i.e., a higher risk of burnout (Abramowitz, 2005, p. 175-186), and a higher risk of suicide (Reiner, et al., n.d., p. 107-114). In conclusion, I offer propositions to improve ways of dealing with the phase of ending psychotherapy to prevent therapist burnout.

Because my colleagues are effected by the lack of research addressing this topic, I chose the participle “us” as a linguistic means to point out my solidarity, working in the field of (body-) psychotherapy myself.

Self perception during the final stage of psychotherapy

Difficulties and challenges exist when ending psychotherapy be it an individual session or the therapeutic relationship developed over time. I have experienced clients who eagerly look at their watch 10 minutes before our ending time and try to bring their talk to an end. Other clients not only arrive late on a regular basis they also open a new topic just when I thought I had skillfully rounded up the session, i.e., “Oh, I still wanted to ask you...”

How do we semi consciously convey that an individual session is nearing its end? Do we look at our watch? Do we clear our throat to allow a break in the interaction? How do we help our clients return from an inner or regressive experience into the presence of limited time?

In my experience, we, as (body-) psychotherapists have varied ways to end a session, some may actually become important rituals that help conclude the process. We may return to the initial phase of the session and validate what has happened in the meantime. We may have fixed seats at the start as well as at the end. We might open and close the curtains, the windows as a ritual, or simply leave the room when the time is over or escort our clients to the door.

Yalom (2002) describes the necessity to allow a few moments between clients to let the last session resonate so that the therapist can become aware of those aspects of the relationship that could not be felt in direct contact because of the transference situation, or do not seem to be describable

This process of clearing our own emotional/mental state is especially helpful with therapies where there is a high density of experiences, or where strong emotional tensions exist on account of traumatic afflictions. This break also gives us the necessary space to recalibrate ourselves for the next client (Brinkmann, 2002, p. 173).

There is also the question of how we ourselves feel when a therapeutic relationship developed over 30 or 40 sessions comes to an end. Are we relieved? Do we feel regret because we will miss the special fragrance of this person or the astute and delicate descriptions of that person?

Questions like these highlight the complexities inherent to ending an individual session or therapy in general and demand further discussion in relation to the impact of our own biography on this phase of closure.

The influence of experiences of separation and parting upon the choreography of the final phase

For psychotherapists, it is evident that all these ways of perceiving the end of therapy (both individual sessions and the relationship in its entirety) reflect what we, ourselves,

have encountered in earlier similar biographic situations. We are convinced that it would be important for our clients to recall memories of farewells or of successful separations from persons of authority during the final phase of therapy. During this time of parting from our client we might reflect just as well on how our own personal experiences influence our ways of dealing with partings from clients.

For instance, we may look at:

a possible connection between the parting from clients and the emotions we felt when we found ourselves alone at home for the first time because our parents had gone out;

our feelings towards clients who end therapy because they move to another city and possibly reflect our emotions when our first best friend moved away;

sensations that arise when a client ends therapy, which may reflect the emotions we felt when our father moved out of the common household because our parents separated;

the influence of the prolonged loss of a dying parent upon the awareness that the therapy with an elderly client is coming to its end;

what we feel when clients leave who are of the same age as our grown-up children.

It has hardly been taken into account that those working in the psychotherapeutic field mostly belong to the oldest or older ones in the constellation of siblings meaning that they take the position of the older sibling towards the clients (Frick, 2006, p. 39ff).

What is the meaning of Perl's empty chair?

Looking at what the elders of our professional group say in response to this question, I noticed in a meta-analysis of Freud's writings only one single place where he generally deals with "reaction to loss of object"; yet, he fails to put this into relation to the behavior of a psychoanalyst towards his/her clients (Freud & Strachey, 1953 – 1974). Novick (1997, p.151) calls this disregard of the importance of the way a therapy ends in early teaching analysis the blind spot of psychoanalysis. Wittorf (1999, p. 19) gives a short overview about the forced endings of analysis by Freud, for instance: the break-up of the therapy with Helene Deutsch to provide time for the client later known as the 'wolf man'. Helene Deutsch herself later ended the analysis of Margaret Mahler stating that she was incapable of analysis.

Even in the textbook, *The Technique and Practice of Psychoanalysis*, (Greenson, 1967), while rich in detail, does not offer a single practical hint about how to deal with the end of psychotherapy.

Fritz Perls once made a statement referring to his teaching analysis that seemed to suggest that not much attention was given to its ending: "I started my analysis with Karen Horney. Then I went to Frankfurt and worked with Clara Harpel until she declared that I was finished, so I went to Vienna to start working under supervision" (Perls & Petzold, 1980).

One might get the impression that Perls' style of therapy - stressing the techniques of the "Here and Now" - left little room for the gradual development of a relationship between client and therapist (Wittorf, 1999, p. 20). This missing relationship is reflected by the 'empty chair', a medium he often used to work with different aspects of personality in his clients. Unconsciously Perls brought the blind spot – the lack of continuity of relationship – into his work by repeatedly returning to the 'empty chair', i.e. the 'missing something'.

Wolfgang Mertens (1993, p.228) in his modern 'Einführung in die Psychoanalytische Therapie' (Introduction into Psychoanalytical Therapy) dedicates one chapter to the ending of therapy. He writes: "For many years, the ending was handled generally on an intuitive basis." Still, in 1966, Rangell expressed his regret about the lack of publications to this topic.

He discusses Freud's later writings concerning the 'finite and the infinite analysis' and he stresses the point that Freud was already 81 years old when he wrote these. He shows how the early idealization of the desire to bring about change in the society and its background in fantasies of therapeutic grandiosity devalues the finite nature of our work (for instance with clients who are terminally ill, or with those who can only afford a short-time therapy).

Finally, Mertens emphasizes the fact that the termination of transference love of the clients upon which Freud insists is not always possible. On the contrary, "post-analytical contact seems to belong to analytical routine "according to a study by Firestein in 1982 (Mertens, 1993, p. 237). Termination of transference love to clients and therapists implies the gradual loosening of expectations, desires, hopes and needs to return to a relationship of an adult nature.

The results of these studies are especially tragic as they show that clients do not return into the state of a healed adult and the therapists concerned bear with them an increasing number of unfinished, incomplete social contacts. This last point has to be stressed especially in the context of the intention of this article. We will return to it later, when we deal with prophylaxis of burn-out among colleagues.

So, the stories of our elders are not really helpful in our present examination. On the contrary, they witness the helplessness and lack of language for the final phase of psychotherapy.

Emotional clearings during the final phase

'Click to delete'. Or, how Facebook changes our ways of dealing with partings and farewells. She came into the practice very upset and was raving about her ex-husband – he was impossible and how could he do this, especially at the same time their daughter was online, and how cold he is and anyway ...it took me some time to reconstruct that the father of her three children obviously had looked for a way out of the squabble of difficult contacts. He had gone onto 'Facebook' and had taken up contact with his children during the times they were with their mother. During one of these virtual meetings the daughter witnessed that he had removed his contact from her site. Troubled, she logged herself onto her father's site and found that she was removed there as well. All the daughter's attempts to reach her father on other internet channels were unsuccessful and finally, very distressed, she turned to her mother. You see how difficult personal emotional clearing is while using these new virtual social media. This especially relates to the end of (body-) psychotherapy.

We cannot turn the wheel back and undo the use of modern social media. We can delay its use, we can limit it, we can tell our children that 'friends' on 'Facebook' are not those with whom they can share their joys and troubles, and we can warn them that everything they share in that forum cannot be made undone. We can offer them guidance to competently use social media and in the end, accept that they will use it and make their own experiences. (Body-) psychotherapists are going to have a new issue in their practices: incomprehensible break-ups of relationships.

Direct talk is not 'in' any more. These complex situations don't happen anymore. There is no more room for a feeling quality of perception to develop. The dynamics of arising emotions and how to deal with them is avoided. And even if we meet in person at all, partings via texting on the mobile, dialogues concerning the relationship via email, or the (non-) communication via Facebook, Parship and others, as described above are an increasingly a part of our daily therapeutic life. We are missing something: we do not comprehend what has happened, why the other person has decided as he/she did. We cannot not perceive the

sound of her voice, not see his posture nor be aware of her smell in the situation, when she parts from us. Or, even worse, we do perceive exactly the sound of his voice in the email and we don't even get the idea that our perception is a fill-in to the written words which – as our projection – could be quite mistakenly dependent upon our present mood. We should be able to make a reality check (Glattauer, 2006). During training, therapists most often asked about which social media channels they should use to stay in contact with their clients: WhatsApp, email, phone or only live contact? Whatever we decide, it changes our ways of relating and each channel brings different possibilities and frustrations. Technology's influence on the therapeutic relationship and the emotional clearing between client and therapist is just starting to be researched.

Facing these changes in communication channels, my sentiments are possibly antiquated. I am challenged by my ability and willingness to react to electronic messages with bonding patterns, understanding various situations and their meaning in this relational context. However, if there is less and less direct communication between human beings and increasing contact merely via technology, the result might be that our channels of perception of our 'social systems' degenerate and finally vanish completely (Ogden & Minton, 2006). Our emotional control system, just like the regulation of our hormonal or gland system, and our immune and cardiovascular system, depend upon neurological regulations that are influenced by our social relationships; that is, by the dealings of our bodies with others of its kind (Juhan, 1987).

I ponder the impact of losing important bonding experiences on the increase of anxiety disorders, cardiovascular diseases and the epidemic development of diseases of the thyroid (Bundesministerium für Gesundheit, 2010). To say it in one line, the use of electronic social media deeply influences our possibilities of emotional regulation at the end of any social contact. We have to think about it; further research about these changes is needed.

Shadow aspects of the therapeutic relationship during the final phase

I now offer a look at what might happen if we are allowed time to announce the end of therapy and to deal with the consequences of this announcement in the relationship.

In her dissertation about the final phase of psychotherapies Susanne Wittorf (1999, p. 44) describes the strange paradox that only few training curricula include the issue of 'ending therapy', while more than eighty percent of the colleagues she interviewed attached special importance to this phase with regard to the success of therapy and the transference of its results into everyday life.

Termination of therapy produces a myriad of responses. Perhaps sympathetic readers may recall their self-awareness trainings and their sensations when their therapist announced the nearing end of therapy. Maybe you were relieved because the closeness of this relationship was coming to an end; or maybe there was a sudden desire to finally bring up some important aspects of the contact; or maybe you felt a deep aggression against the evaluation of the therapy.

In my opinion, clinicians working in middle-class oriented psychotherapy want to choreograph a good ending by reviewing and honoring the process. And yet, in reality, more often breaks and unresolved endings occur. There's a sudden hostility or a "know-it-all manner", therapist hopping even where one contact is being broken while another is already being created. Perhaps the reader catches the note of blame towards the colleague—the underlying assumption is that there surely must have been mistakes made in the analytical situation resulting in these complications.

On account of such blaming, many colleagues do not dare bring up these supposed failings to their supervisor. Not looking upon the question of fault seems to protect against drawing conclusions and having to confront the reasons for one's own failure. However, the pain not acknowledged bears the risk for this colleague to become an obstacle in the final phase of therapy. There is this myth among colleagues that one should stay emotionally distanced towards the clients. And if, in the end, it becomes clear that that is not the case, What then? Perhaps feelings of shame make it difficult for the colleagues concerned to bring up the above mentioned frequent incidents occurring during the ending phase of psychotherapy (Alonso & Rutan, 1988; Hahn, 2001).

But what if the assumption that humans just want to be good to each other are wrong? Already, in the late eighties, our Swiss colleague and Jungian psychotherapist Guggenbühl-Craig (1987, p. 75) points out that evil and destructive energies have to be part of the analytical situation. It seems to follow the attitude of many media that 'evil' is always to be found in the other (the communists, the Nazis, the sexual criminal...). We ourselves may assume ourselves to be free of these drives. However, especially at the end of therapy, these other aspects of our souls appear. This might occur because, when facing the end, the thought comes up that there is nothing to lose; or perhaps we would like to fight off the feeling of powerlessness in view of the end by presenting ourselves great, strong, beautiful (Guggenbühl-Craig, 1987, p. 75).

Guggenbühl-Craig (1987) warns us to be on guard of the archetypical deception of the powerful benevolent therapist and the infantile client, victim to neuroses. This attitude overlooks the fact that therapists can be quite half-baked and blind at times and that there may be a one-sided interest in continuing therapy (for instance for financial reasons...). Too little honor is given to the fact that our clients have a healer inside who presents an inner compass and direction for their life path, and helps them to recognize when and how a therapeutic relationship gets into difficulties or could be ended. Our learning takes place - again and again- near the borders of the (im-)possible.

At the end of therapy, we must look at the transference- countertransference dynamics and process them. We do not merely discharge neurotically ill clients from necessary (body-) psychotherapy. We also support and assist the abilities of our clients to: depart actively; have a good look at us and our failings; give room to the light as well as the dark aspects of our souls, and in this way gain maturity in their ability for relationship and become more themselves in contact and dialogue. The idealistic-normative supposition that a successful end of psychoanalysis means that the client has acquired the ability for self-analysis, implying the internalization of the statements and attitudes of the therapist, is simply not acceptable any more (Stoltzenberg, 1986).

But what can one do if clients do not have an open ear for this evaluation at the end of (body-) psychotherapy, as reported by 30 of 100 colleagues interviewed by Wittorf (1999, p. 134)?

Specific aspects at the end of body psychotherapeutic encounters

It seems to me that in body psychotherapeutic settings specific aspects of transference necessitate another discussion on the topic of touch.

Some of us do touch our clients. We use touch to stimulate. We press specific points along meridians (for instance, in my practice of Postural Integration), and we deeply connect with the tissue of our clients. All these techniques have the effect that, with our own bodies, we have a more intensive encounter with clients than is the case in language-based therapies (Grossmann-Schnyder, 1996).

As body psychotherapists, we offer physical contact in the confrontation supporting the expression of anger (sounding), or by long deep holding in situations of early bonding. We create situations where strong discharges of sexual energy may happen while doing work on the pelvis. We encounter the other person by deep eye contact, reaching to the core of this person: the so-called facing. For weeks, we may find ourselves during therapy sessions on the level of infantile movements while we are concerned with completion of psycho-neurological developments of the peri- and prenatal phases of development.

All these experiences of physical contact and connection bring about a deeper, more intensive therapeutic relationship. The question of how to come out of these contacts has so far not been sufficiently discussed. Imagine what happens, for instance, when we have supported a client to give an intensive expression to her fears for her to allow her 'affect-motor-scheme' (Downing, 1994) to widen and grow, and we then discover how much this work has helped ourselves by giving relief during a personal, existentially fearful situation. Then imagine what happens later, when afterwards, we want to admit that we are thankful for this process. Something significant happens when we are able to go with a client through a deep process of mourning a passed partnership, and when, in the end of this therapeutic work, we realize how mellow our heart is in the presence of this client. And, a last example— we are able to see the change in our relationship when we find ourselves in the dynamic of ordinary relationship and witness an intensive, erotic passion to a client.

The deep impact that these aspects of body-oriented psychotherapy have upon our bodies may result in changes in our neurological structures (Hüther, 2001, p. 53) and challenge our experiences of bonding and encountering.

A repertoire of body psychotherapeutic methods does exist; however, as far as I know no author has written about the actual effect of these techniques on a successful way of separation.

What does remain is our own experience... our sensations...we do feel a yearning for the clients, their scents linger in our clothes following an encounter while the workday continues. In our everyday life we find ourselves pondering the further course of therapy or the particular difficult fate of a client stays on our minds. Let us be clear about the fact that, especially with young and inexperienced colleagues, clients are not merely important for a steady income. With-them and by-them they also leave their marks within our emotional live.

And at the end of therapeutic work, do we have an opportunity to share the impact a client had in our life? Our wordy professional elders advise us to do just that (Yalom, 2002). However, recalling the times when we were clients: do we really want to hear about the feelings of our therapist towards us (Aron, 1996, Chapter 8) ?

Adequate feed-back may emerge out of our intuitively navigated bonding behavior (Bowlby, 1988). It may depend upon the anamnesis and assessment of that biographical phase in which we assume the client's actual conflict to originate. If this phase is from an early preverbal time, we will give feedback to this person that is appropriate to the therapist's role of parenting. To clients with narcissistic disturbances, we will be able to give a more detailed feed-back concerning the effect of their behavior on us/their environment to adjust their self-image.

Karl König (2010, p. 112ff) considers the different needs and difficulties therapists have in this situation per their character types. Referencing classical nomenclature, he describes how a therapist with a schizoid structure nomenclature may view clients as exchangeable because of

his own weakness to have intensive relationships. The depressively structured therapist is prone to problems with separation in her professional as well as in her private life. The obsessively structured therapist might experience the parting as loss of power and does not believe in the client's capability of advancing without therapy.

Keleman (1987) stresses the change of the energetic relationship in the end of body psychotherapy. He describes how in this phase some colleagues begin to passively withdraw inside, and how others actively seem to build up a distance. According to Keleman's observations, others try to build up a special closeness, while a fourth type, whom he calls the bonding type, avoids the actual situation by building up hope for further future meetings in another context (Keleman & Hendrix, 1987).

Everything has its time: our ways of dealing with death and dying as a field of association reflecting into the time of parting

So far we have talked about the phase at the end of (body-) psychotherapy as the phase at the end of one session or the end of a series of sessions in linear time. The ancient Greeks called this understanding of time "Chronos", i. e. the time that can be measured by a watch. They had a complementary understanding of time called "Kairos" (Morgenroth, 2004). Kairos gives justice to the fact that we feel time differently at different times in our life.

In psychotherapeutic settings, this phenomenon is well-known to most of us. The 'original scene' described at the beginning of this text demonstrates how, in the presence of a client, the perception of time changes, sometimes dramatically. I have experienced a sense of timelessness while working with a client suffering from psychosis yet when working with a depressive client time seems to be at a standstill. And the experience of time intensifies dramatically in the presence of terminally ill clients. Because the experience of time with clients can vary during psychotherapy, I ponder the possible ways of facing this intricate experience.

We may be haunted by the hourly intervals of our therapy sessions, or we may become choreographers of time experience during therapeutic work. By being conscious of the change in time quality with ourselves and our clients, we might mention our sensations, choose another pace of speech, or change the clients' quick hopping through different emotions by deepening one single emotion with a grounding practice.

I seek to explore how therapeutic relationships effect the lives of our souls as therapists. How do we handle all the traces these fellow human beings leave in us? Are we burdened by all these life stories that we carry in our memory? Do we suppress this 'lived life' and depose it in the corner of side effects of our profession in the mistaken belief that they will safely remain there (Bund deutscher Psychologinnen und Psychologen, 2008, p. 31)? Do the life stories of our clients contribute to our personal abundance and wisdom? Do they deepen our own life time, or do they give us a feeling of 'lost time' which we could have spent more effectively?

In our professional group, we underlie this special obligation of secrecy and therefore are filled with stories of human fate and are not allowed to share them. Does this tension within us bring about a strong inner resistance towards anything human, or by touching our ability to sympathize does it give us wisdom, a deep, perhaps even spiritual access to life and reality? Do we look at these life stories from a distance as a time-consuming documentation task, or do they bring us into contact with an experience of timelessness, of eternity even, when we feelingly give ourselves to the depth and entanglement of human biographies?

In our work, we keep meeting clients who trigger particular emotions in us or bring us into contact with abilities not known to us before. In the event of transference, it is helpful

to reflect what clients set off within me and where they may touch un-lived aspects of life in me. After parting from these clients, the question remains: what do I do now with these aspects of my personality that I had delegated to this client and that will not vanish when the client departs? Do I accept the legacy of this client and, for instance, consider the trend of art the client was so interested in and sharing it with me brought me closer to my own feeling? Or, at the end of a therapeutic work, do I finally take up creative dance myself after it has been itching in my legs for some time? Or, to choose a last example, do I spend my next vacation on this beautiful colorful island my client used to talk about? We can succeed in transforming linear time spent together during therapy into subjective experienced time, into de-acceleration and openness to new aspects of presence.

By parting from the client do I also part from the access to a new life impulse, or do I really take into possession what had been part of the discourse with this client: do I accept the legacy of this work and thereby honor and respect it in a completely new way?

When we take leave of clients with whom we perhaps have worked for several years, who always came on the same day, at the same time into our practice, how do we feel when this date suddenly is open? Those who have lost someone close to them know this tension in the body, this longing, the search for memories of common experiences. And what do we do with these situations when we become aware of the fact that we miss them (Dobrick, 1989, p. 77)? What do we do when we discover that bonding is not merely a methodical means to keep up a functioning psychotherapeutic working relationship but has an effect on our body experience as well?

Wittorf (1999, p. 123) writes that the definition of psychotherapy as an 'application of methods on clients' is inadequate, since this activity in the therapeutic relationship also influences the therapist himself/herself.

Outlook and preventive measures against burn-out

Concluding a relationship necessitates a review of what has been and a prospect into the future.

Because of the theory of bonding, we know about the importance of sufficient feedback to be able to judge one's impact in a relationship; which might be given by the person next to us, a supervisor, or someone close to us, whom we trust to know us well enough (Guggenbühl-Craig, 1987). As human beings, we need reflection and confirmation. We are in need to be seen. Röhrich (in: Joraschky, 2009, p. 28ff) stresses the influence feedback may have on body image in body psychotherapy. He shows how expressing perceptions of each other, by sharing movements creatively by dancing or painting that, resonate in a more intact physical self-image.

What is taken for granted concerning the client is lost to those colleagues concentrating on distance and neutrality in contact with their client. Consequences are loss of orientation, decline of motivation and initiative. Finally, more and more colleagues are snared into the relationship trap that leads to burn-out because of misunderstood professional ethics.

In specialist literature (Lewis, 1992), the necessity to work with the emotion of grief about the loss of the relationship is stressed. Wittorf (1999, p.62-64), on the other hand, points out that the meaning of experience of relief and release by separation efforts of our clients is marked as well by their biography. Just as we and our clients carry within us undigested experiences of loss of relationships, we also have memories of failed separations in us. Perhaps our mother, because her own neediness, was not able to give space for exploration, or maybe

we were forced into a family tradition that did not allow a decision according to an inner, conscientious maturity etc.

Wittorf (1999, p.167) summarizes the conditions desirable in the final process to bring about a good ending for those working therapeutically:

- In the context of anamnesis, we should thoroughly look into former experiences in therapy the clients might have had. If necessary, we should ask for clinical reports in order to be informed from the beginning about eventual patterns that are repeated during therapies (diagnosis and triage).
- In the last phase, we should give enough time for the completion of mutual perception of client/therapist and be especially open to arising shadow aspects of the relationship.
- Within the framework of supervision, we need to deal with disappointment and failed efforts as well as with validating those therapies that went well (orientation toward resources).
- We should inform our clients ahead of time about a break-up and about the regular ending of therapy and dedicate about ten percent of the sessions to this phase. (Information and professionalisation of the relationship) (Hautzinger., Stark & Treiber, 1994, p. 54).
- In order to avoid a relapse, the number of sessions should be slowly reduced and a special session is arranged for a final review.
- Since 1999 the German law for therapists demands a regulation for vacation: we are officially obliged to name a colleague as stand-in during our vacation. However, the details of this procedure so far remain in the dark.

Finally, we may describe the last phase of (body-) psychotherapy as a transitional phase into a new life period: for our clients as well as for us (body-) therapists. At the end of this article, I wish the readers that this transition may be successful for both sides in the therapeutic setting.

BIOGRAPHY

Bernhard Schlage has given workshops since 1980 in most European countries and has run a private body psychotherapy practice since 1984. He has given lectures at international congresses including San Francisco, Paris and Sydney. In 1986 he co-founded an adult education centre for health care in northern Germany and later was in charge of a mental health centre until 2008. He has been a trainer for Postural Integration since 1999 and an ECP-holder since 2001. Specialised in treating psychosomatic disorders, he is now focusing his work on training the next generation of health care practitioners in body psychotherapy. Bernhard is author of more than 100 articles about body psychotherapy and has written four books.

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Embodied Conflict Resolution: The Use of Body Psychotherapy, Gestalt Equine Psychotherapy, and Aikido to Resolve Conflict amongst Adolescents

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Received 10 October 2016; accepted 11 November 2016

Abstract

This paper describes a clinical experiment integrating body psychotherapy, Gestalt equine psychotherapy, and Aikido principles with a group of adolescents. The project consisted of ten two-hour sessions in which the author's purpose was to generate ideas, explore themes, and create a lasting approach to resolving interpersonal conflict. Participatory Action Research (PAR) was the qualitative method used to gather and analyse data. This study included its participants in the process of problem identification, data analysis, the creation of an intervention to address interpersonal conflict resolution, and the integration of feedback from their community. Findings show that GEP and Aikido supported the participants' exploration of somatic responses to conflict and understanding their physical responses to conflict. Integrating body psychotherapy, GEP and Aikido may help adolescents create a more successful and satisfactory conflict resolution.

Keywords: body psychotherapy; gestalt equine psychotherapy; Aikido; participatory action research; adolescents; conflict

International Body Psychotherapy Journal *The Art and Science of Somatic Praxis*
Volume 16, Number 1, Spring 2017 pp 28 - 37. ISSN 2169-4745 Printing, ISSN 2168-1279 Online
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Adolescence marks a time in life when navigating peer interactions is developmentally significant. During this time period, it is beneficial for teenagers to acquire foundational conflict-resolution skills that will last throughout their adulthood. The purpose of this Participatory Action Research (PAR) study is to utilise Body Psychotherapy (BP), Gestalt Equine Psychotherapy (GEP), and Aikido as the means to facilitate the resolution of interpersonal conflict among adolescents in a residential treatment centre. Adolescent voices are not typically heard or valued in the dominant literature; the participants of this study serve as co-researchers, ensuring that the results include adolescent perspectives and insights. Methods used to facilitate participants' engagement with the project include: body/movement observation and assessment, GEP experiments, Aikido principles, psycho-education, discussion, and creative writing.

Gestalt Equine Psychotherapy (GEP)

Gestalt therapy, developed by Fritz and Laura Perls, became a new form of psychotherapy in 1951 (Mullner, 2014). GEP was developed by Duey Freeman and Joan Rieger as a therapeutic

approach integrating Gestalt therapy and the Equine assisted psychotherapy. It is an experiential therapy facilitating awareness and contact with horses (Kirby, 2010).

One of the core tenets of GEP is I-thou relationship, a concept developed by Martin Buber and inspired by the relationship he had with his grandfather's horse. I-thou relationship is characterized by a mutual presence that is yielding, spontaneous, and direct (Buber, 1958, 2002) in which both sides (whether human and human, human and nature, or human and spirit) are seen as whole and neither is objectified.

Another core tenet is that of the here and now which is synonymous with present-centeredness (Harman, 1996; Kurtz, 1990). Gestalt therapists assert that the most fertile place to focus the work is on the present, because that is where the most impact can be made (Harman, 1996). According to Perls' notion of the paradoxical theory of change, an awareness of the here and now is a change agent that reduces the need for a therapeutic goal other than achieving awareness (Perls, 1969).

Another key concept of Gestalt therapy and GEP is that of figure and ground, based on the work of early Gestalt psychologists Max Wertheimer (1938), Kurt Koffka (2013), and Wolfgang Köhler (1970). Individuals perceive the world in terms of a focus of interest (figure) and a context (ground). They have a tendency to supply any missing information in order to form a more holistic experience or gestalt. Given the same figure and ground, two individuals with different trauma histories will likely form different gestalts. Thus, given a particular context, what an individual focuses on may not always be accurate, beneficial, or healthy in the present moment. The work of Gestalt therapy is to bring awareness to the figure-ground relationship and especially to the missing information that is generated unconsciously and instantaneously to complete the gestalt (Koffka, 2013; Köhler, 1970; Wertheimer, 1938).

Inspired by these concepts, GEP believes in the healing impact of authentic relationships between client, horse and therapist. It emphasizes interconnectedness and an noninterpretive, experiential process fostering an opportunity for experiencing being in an authentic contact (Kirby, 2010; Lac, 2016).

In boundary work, for example, the GEP therapist does not ask the client to "see if you can get it to move out of your space" but rather "how might you communicate to your horse that you need more space". This is a fundamental difference between GEP and Equine Assisted Therapy (EAP), in which the EAP therapist utilises the horse as a tool that tends to objectify the horse (Hallberg, 2008).

The role of the GEP therapist is to support I-thou relationship between clients and horses while clients explore the ways in which they habitually make or break contact with themselves and others. The therapist provides experiments, which disturb the client's habitual ways of interrupting contact and offers new ways of maintaining contact (D. Freeman, personal communication, February 22, 2014). The therapist focuses on developing, deepening and embodying awareness of relational experience and reflective thinking while conducting these experiments (Kirby, 2010). For example, in boundary work the GEP therapist might say, "Your horse is nudging so hard that you are being pushed backwards; does this feel familiar?" If so, the therapist invites the client to place both hands lightly on the horse's shoulder, while stepping one foot back and pulling energy from the ground. Then he might ask the client to engage his core, and push on his next exhalation, using consistent pressure, while imagining creating more space for him until his horse steps back. This type of experiment allows the client to explore contact in non-habitual ways while in a safe space with the therapist acting as guide and witness.

Gestalt Equine Psychotherapy (GEP) and Body Psychotherapy (BP)

Although there is no literature exploring the effects of GEP combined with BP specifically, according to Candice Ford (2013), studies have found that Equine Assisted Psychotherapy (EAP) helps clients to significantly increase their sense of personal empowerment, self-confidence and self-esteem, and effectiveness in creating and maintaining healthy relationships including improved skill with conflict resolution. Studies have also found that EAP helps clients to decrease negative social behaviour including hostility and aggression (Trotter, Chandler, Goodwin-Bond & Casey, 2008).

Aikido and Conflict Resolution

Morehei Ueshiba (O-Sensei), the founder of Aikido in the beginning of the 20th century in Japan writes: “Aikido emerged from a longstanding martial culture which had transformed a system of fighting arts (bugei), devised to inflict injury and death, into marital arts (budo), dedicated to developing self-protection by integrating mind, body, and spirit” (Faggianelli & Lukoff, 2006, p.162). From *ai* meaning harmony, *ki* meaning energy, and *do* meaning way, Aikido has been translated as the way of spiritual harmony or the way of blended energy (Faggianelli & Lukoff, 2006; Ueshiba, 1984) and emphasises peaceful conflict resolution and non-violence (Tapley, 2008).

Faggianelli and Lukoff (2006) suggest that Aikido is a useful tool for psychotherapy because the basic principle of Aikido is conflict and peaceful resolution. Philippe Martin (2004) and others have proposed that Aikido could naturally support and enhance the psychotherapeutic process due to the parallel principles between Aikido and psychotherapy (Rush, 2000). Multiple studies conducted agree that martial arts in general enhance the process of psychotherapy by providing active, physical routes for the discovery and expression of emotions (Weiser et al., 1995; Zivin et al., 2001). Martin (2004) developed a model for conflict resolution comprised of centring, connecting, channeling, and concluding (4Cs) to offer a specific somatic method of working on increasing autonomy via breath, posture, and existential positioning based on Aikido practice and principles.

Participatory Action Research (PAR) with Adolescents

Morsillo and Prilleltensky (2007) describe two types of youth social involvement reported in the literature. The first is civic engagement which does not challenge the societal status quo and the second is transformational involvement which strives to change the conditions that led to the problem. Participatory action research is considered transformational because it recognises the need to both challenge existing social standards and to attempt specific alterations of political structures (Morsillo & Prilleltensky, 2007).

PAR was developed to address practical questions regarding daily struggle and survival. A hallmark component of PAR is that it blurs the distinction between researcher and researched. PAR was developed to study groups and institutions historically distrustful or even completely closed to “outside” researchers. Its methodology facilitates easier entry into the politics of these institutions by maintaining relationships with every level of the group’s hierarchy (Stoudt, 2008). Mutual respect fosters trust and the openness to question some practices or beliefs that may have been previously off-limits and then to work collaboratively toward change. There are different paradigms for producing knowledge and PAR is one alternative in which groups adversely affected by social injustice take it upon them to study the issue and affect a positive resolution (Nygreen, Kwon & Sanchez, 2006; Park, 1999).

Although age is not generally thought of as an area of oppression like gender or race, youth represent a marginalized group in society and most of the participatory research studies focus on projects involving adults despite youth's marginalized status. Recently, however, investigators have been paying increased attention to the meaningful roles that youth, especially marginalized youth of colour, are able to play through their own active participation and civic engagement around social justice concerns. Multiple sources agree that youth participatory action research is coming into its own as a way to promote personally relevant youth engagement. It gives young people a platform for their concerns and promotes local programs and activities that are most relevant to the youth of that community. In this type of youth-focused research, youth are seen to be active, effective collaborators with professionals and powerful agents of social change (Foster-Fishman et al, 2010; Morsillo & Prilleltensky, 2007; Nygreen, Kwon & Sanchez, 2006).

The Project

Context

In the summer of 2013, a rapidly growing, young organization became a licensed residential treatment centre (RTC) in Colorado. By the fall of 2013, it became clear to staff and residents that the old methods of operation were no longer serving their needs and new methods were needed. Communication gaps between administration, direct care staff, and the residents occurred regularly and the residents demanded changes.

A special meeting was called to support the residents' overwhelming feelings of frustration, exasperation, and helplessness. During that meeting, the staff offered the residents the opportunity to create lasting change in the form of an adolescent participatory action research project addressing the issues of conflict and conflict resolution at the RTC. We asked the following questions:

1) How do the residents navigate the somatic effects of conflict as individuals and as a group? 2) How might we co-create embodied conflict resolution?

Participants

For supervision purposes, all residents had to participate in all activities at the RTC. Therefore, the initial ten residents voluntarily and unanimously agreed to participate in the PAR project. For the subsequent eight residents admitted to the RTC after the project start date, however, the project was a mandatory part of their treatment plan. All participants, ranging in age from fourteen to eighteen, were in treatment for addiction and twelve of the eighteen have a dual diagnosis including either anxiety or depression.

Method

This project consisted of ten two-hour sessions that took place over the course of three months. The participants deliberated on whether or not to proceed with the project for the first two sessions before coming to a unanimous decision to move forward. Sessions three, four, five, and six were dedicated to information gathering, in which the primary researcher and a research assistant introduced various body psychotherapy, gestalt equine psychotherapy, and psycho-educational principles to facilitate a deeper understanding of how residents navigate the somatic effects of conflict. Participants created and implemented an action plan to co-create embodied conflict resolution during sessions seven, eight, and nine and gave a presentation to the RTC staff to propose their action plan in session ten.

Findings

In sessions one and two, the primary researcher invited participants to consider whether they wanted to participate in the process of this study. In the face of conflict, many participants disengaged immediately, some attempted to take leadership roles and then collapsed in their bodies when the other participants did not follow, some stood their ground in the face of critical feedback from fellow participants, and others joined the majority to “get it over with”

Phase 1: Gathering information

During the first phase of the project, prompted by the primary researcher, participants identified everything they knew about conflict and the body (tension, shaking, crying, numbness, elevated heart rate, shallow breath, raised voice); conflict and horses (horses learn from pressure and release; they are prey animals and therefore sensitive to congruence and have a propensity for flight; they are herd animals and depend on hierarchy for survival; they communicate with their ears and tails, as well as through contact and boundaries); RTC policies/procedures that support conflict resolution (structure of group therapy, quality of individual/family therapy, inclusion of alternative therapies, enforced diet/sleep/exercise); and RTC policies/procedures that do not support conflict resolution (staff invasion of privacy, staff enforcing different rules differently, group consequences for individual behaviours, staff-staff and staff-resident communication gaps, personality clashes between staff and residents, and not enough unstructured time).

Data analysis occurred by the end of the information gathering phase of the project. Participants were asked to consider all of the data collected, sort it into smaller and smaller groups and name those groups. Participants identified those groups as positive and negative RTC policies and procedures, positive and negative experiences of conflict, and positive and negative outcomes.

In order to begin to understand how conflict resides in the body, participants were asked to list three values. Family, friendship, and love were the most prevalent responses. Participants were then asked to select an object in nature to represent one of their values and create a posture or movement in relationship to that value. Participant F, for example, held a photo representing friendship and love up to her heart and crossed her arms around it in an embrace. Participant B stood ten feet away from a pile of branches representing respect and shook her body back and forth while squinting her eyes and turning away. This exercise was designed to deepen each participant’s understanding of their values by incorporating information gathered from the body.

Next, participants were asked to imagine a situation in which their values clashed with those of a peer or authority figure. Participants were then asked to draw their visceral experiences of the situation on a body map. For instance, participant G drew a scribble over the head labeled “over-thinking”, an X over the mouth labeled “don’t say anything”, another scribble labeled “emotions” over the heart, lines on the left forearm labeled “urges”, and a box around both legs labeled “lazy”. Seven out of eight participants drew some form of scribble or cloud or opaque circle around their heads, hearts, and abdomens. The purpose of this exercise was for participants to gather information about the somatic effects of conflict on their bodies.

Phase 2: Implanting an action plan to co-create embodied conflict resolution

Participants were initially frustrated with the ongoing changes and discrepancies in their daily schedule at the RTC as well as concerned that their input was neither heard

nor welcomed. They expressed irritation and impatience as evidenced by tense and fidgety behaviour. The residents asked the questions like, “Who is in charge?” “Who is at fault?” Feelings of helplessness arose in statements such as: “We’ve tried this before and nothing ever changes”. They also expressed overwhelming feelings, stating that their workload was too large for the allotted time to finish tasks. The primary researcher explained that this project could be an opportunity for residents to examine the culture of conflict at the RTC and create an action plan to support the process of conflict resolution. The process of coming to a unanimous decision regarding the use of PAR to explore the nature of conflict at the RTC proved to be an important step in increasing awareness of individual and group relationships to conflict. For example, Participants A and B became involved in an argument, causing Participant C to shut down, which increased defiance in Participant D and resentment in Participant E. The novelty of making a decision as a group offered space for the residents to notice and comment on the high energy, noise, and tension levels present as well as express personal opinions and ask each other questions. During this phase of the project, participants were not given specific tools to support the conflict; instead they were prompted to engage autonomously. This was done in an atmosphere of tension and frustration. Even though the participants requested that the primary researcher make a decision for them, they were encouraged to resolve the conflict themselves. After four hours, the participants came to a unanimous decision to proceed with the project. The primary researcher congratulated the group. During check-out, the group was asked, “How would you describe your individual response to conflict, your beliefs about conflict, the group’s response to conflict, and the emotional effects of conflict on your body?”

Participant A: The group “learned from experience to be calm”

Participant B: “Conflict is unnecessary and brings more conflict... I try to avoid it.”

Participant C: “I got frustrated once, otherwise I was disengaged.”

Participant D: “I noticed a lot of contradicting behaviour and a lot of neutral behaviour... I felt distracted by my water bottle.”

Participant E: “My individual response to conflict was to take a leadership role, but when that didn’t work I just remained neutral... I’m not a strong leader in conflict situations.”

After participants had figured out how to resolve the initial conflict, the primary researcher began the phase designed to support the acquisition of more effective conflict resolution skills. Participants were invited to observe two horses interacting at mealtime. The horses’ observable actions, such as raising and lowering their heads, were identified as ground, while the participant’s interpretations of those actions, such as “dominating” and “cooperating”, were identified as figure. At the end of the exercise, participants were encouraged to consider what arose for each of them thematically as figure, if that figure typically arises in other conflict situations, and what information was actually missing from this here and now that might have been filled in automatically to create the figure. Relevant themes pertaining to identification of habitual patterns of behaviour in conflict situations included passive-aggressive behaviour, tension, anxiety, and hyper-sensitivity.

In order to ensure safety around the horses, experienced participants were asked to share what they knew about the animals. This activity also served to catch new participants up on the project and provided an opening for the use of Aikido with horses. In Aikido, practitioners are taught to centre themselves, connect with their attacker, channel the incoming energy, and safely conclude the attack. The primary researcher demonstrated how to use these principles and practices to start a horse from a standstill by asking how to move a 1,500 pound

horse's feet if it does not want to move. Another question asked was how to ask for what you need in a conflict situation.

Participants experimented with moving the horses using no physical devices, only touch, energy and voice. Those who used more forceful or dominant methods were less successful than those who "joined with" the horses. At one point the horses walked away from the group and a participant commented that the horses left because they were mad. This prompted a discussion about projections and how they can influence responses to conflict. Then, participants experimented with moving the horses again, this time with the intention of responding to their observations of the horses rather than their interpretations, which were often clouded by projections. The primary researcher noticed a significant increase in participants "joining with" their horses as evidenced by more participants moving their horses without needing devices such as halters and lead ropes.

In session seven, the primary researcher directed participants towards the creation of an action plan. Participants became visibly agitated and expressed feeling unclear about the process, bored, confused, frustrated, and uninterested. The primary researcher explained a way of understanding the action phase, "We have not yet attempted to create change; we were gathering information to better understand what change we would like to effect". The participants wished to manage their own time, so the adult researchers stepped back and let the residents self-organise within the group to decide how they would do that, what resources they would need, what kind of staff support they would need, and what activities would be acceptable. The adult researchers noted that, at first, only three participants were spearheading the effort while the rest (11) talked to their neighbour, slept, or otherwise occupied themselves quietly in their seats. However, as time went by, the leaders began to engage some of those participants and a few others jumped in of their own accord. Eventually, the participants came up with the concept of Personal Productive Free Time (PPFT), in which residents would be supervised by staff for a designated period of time and could engage in schoolwork, de-icing [fulfilling consequences of rule infractions], cleaning, or other enrichment activities. The majority of the participants did not engage in the creation of the action plan although they all signed it once it was complete. Although the participants' action plan did not directly address their initial presenting complaint (scheduling conflicts due to communication gaps), it was indirectly related to scheduling. Moreover, their action plan tended to ignore the need for communication and the participants did not utilise any of the conflict tools taught in the preceding weeks. This is perhaps due to the limitation of rolling admissions (see Limitations and Challenges section below).

Before participants transitioned into Personal Productive Free Time, the primary researcher asked, "Who is holding you accountable to the rules during PPFT?" The participants decided that they would try holding themselves and each other accountable during PPFT and report back in the final session of the project. The adult researchers observed a lot of chaos at the start of PPFT, but after thirty minutes ten out of eleven residents found something productive to do.

Phase 3: Proposing an action plan

In the final session of our PAR project, the participants presented their proposal for a month-long trial of PPFT, to the director of the RTC and key staff. Participants began with an account of the project including the unanimous decision to proceed with the project, hands-on work with the horses involving boundaries, conflict, and communication, and the action plan (PPFT) they wished to propose. During this presentation, participants identified skills

they learned during the project, such as “effective communication”, “awareness of needs”, accountability, and productive time management. They also stated their reasoning for PPFT, “communication between staff and residents was not effective”, residents did not like the schedule flow, PPFT is a chance for residents to have a say in their daily life/schedule, and residents wanted a chance to do productive activities such as cleaning, reading/writing, and “checklist stuff”.

The participants and staff engaged in a question and answer period, at the end of which the director granted the month long trial. Many participants agreed that the presentation went well and expressed feelings such as relief, excitement, and happiness that the group was able to come together and ask for what they needed.

Discussion and conclusion

In this study participants explored their conflict styles using body/movement observation and assessment, GEP experiments, and Aikido principles. They also identified their values and discovered the skills to communicate those values. They discovered their individual and group capacity to co-create conflict resolution and communicated their needs to the director and received a favourable response.

GEP and Aikido were used to support the participants’ exploration of somatic responses to conflict and understanding their physical responses to conflict helped to create a more successful and satisfactory conflict resolution.

Limitations and Challenges

The rolling admissions process at this RTC coupled with the extensive duration of the project due to scheduling challenges is the most significant limitation to this study. For the initial group of residents, participation was voluntary. However, the project became mandatory for incoming residents as a part of the RTC treatment plan. This presented two initial limitations. First, the participants entering the treatment centre after the initial project sessions did not participate in the project voluntarily. Second, residents that were admitted during the action planning phase of the project were not privy to the information gathering portion of the project yet were still expected to contribute to the solution. The limitations of rolling admissions and scheduling challenges significantly contributed to the disrupted flow of the project and the weakened cohesion of the final proposal.

The primary researcher’s assumptions about this clinical experiment and its participants are another considerable limitation. The primary researcher assumed that participants would be invigorated by a project exploring BP tools, GEP experiments, and Aikido principles. Instead, the participants reported initial feelings of exasperation at the prospect of another scheduled activity. The primary researcher was unaware of the participants concern for completing graduation requirements within a schedule that did not allow adequate time. In the end, however, the PAR project yielded a two hour time slot for personal productivity twice a week.

In this clinical experiment, we sought to examine the impact of engaging conflict in an embodied process instead of avoiding it. We wondered if we could identify the underlying problem and find a natural solution. Through the embodied process we found that participants were overwhelmed with the schedule’s demands, felt powerless to communicate to staff that. There was too much rigidity in their schedule, and they needed space to choose how to spend their time. Through their embodied participation in the project participants were able to identify the somatic signs of conflict in their bodies, recognise their habitual responses to conflict, practice

skills to stay in contact with conflict in their bodies, identify what was needed to resolve the conflict, and present those findings as a group in a proposal to staff.

The desired outcome of participatory action research is to change community practice. Conducting the project through the framework of participatory action research meant that the participants discussed and analysed the content of each session along with the author. Transparency allowed the participants to work with the author as co-researchers.. This method allowed the participants to take an active role in the research process, thus empowering them to discover their style of conflict resolution and teaching them about the important role of research within their communities. The participants expressed a new understanding of their relationship to conflict and a sense of empowerment based on their participation in the study.

For therapists working in an environment in which clients are either fighting against the structure and authority or collapsing under it, what is presented here can be a useful model to engage clients in approaching conflicts that arise in treatment from a more empowered and autonomous place. Utilising horses as co-therapists affords therapists a more potent reflection of the non-verbal, which in our experiment helped participants identify their habitual responses to conflict. Aikido principles teach authentic and non-violent responses to conflict, enabling clients to respond with softness and strength even when a tremendous amount of energy is directed at them. Therapists can utilise Aikido to assist clients in responding to conflict without either fighting or collapsing.

The results of this study describe the experiences of the participants at this particular residential treatment centre and although some generalisations may be made to other adolescents in treatment, they cannot be supported by substantial evidence from this narrow study.

BIOGRAPHY

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LIFE Questionnaire Development
Development and factor analysis of the Levang Inventory of
Family Experiences: A new way to operationalize and validate
Pesso Boyden System Psychomotor
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Received 06 June 2016; accepted 04 January 2017

Abstract

It is widely accepted that interactions in childhood have profound effects on the individual well into adulthood. This premise is the bedrock of Pesso Boyden System Psychomotor (PBSP) theory and frames this study. The Levang Inventory of Family Experiences (LIFE) has seven content scales that measure perceived fulfillment of five basic needs plus two socialization constructs that Pesso identified as critical for childhood development. The five basic needs are Place, Nurturance, Support, Protection and Loving Limits. The two socialization scales are the Holes in Roles and the Pilot. To measure these seven PBSP constructs, PBSP subject matter experts first operationalized these terms by developing a 182-item question bank. These items were administered to 75 individuals; responses were provided on a 1-4 Likert scale. Data analysis for inter-item reliability was calculated using Cronbach's alpha (α) coefficient for each of the seven PBSP scales. To revise the LIFE, items were removed following a revision protocol until each scale had either 20 or 10 total questions. This revised assessment of 140-items was then given to a separate pool of 100 individuals. The revision protocol is provided in this paper. An Exploratory Factor Analysis (EFA) was conducted and revealed an underlying factor structure consistent with PBSP theory. Additionally, inter-scale correlations were consistent with PBSP theory: the five Basic Needs scales had inverse correlations with the Holes in Roles ranging between $-.61$ to $-.44$. The Pilot scale also positively correlated with the Basic Needs scales, which is consistent with PBSP theory. This study provides an initial picture of the psychometric properties of the LIFE and shows preliminary construct validity evidence suggesting that the LIFE is a reliable measure of PBSP concepts. Future research should focus on establishing criterion validity, enhancing construct validity, and using the LIFE in longitudinal developmental psychology research studies.

Keywords: assessment, diagnostic tools, childhood development, basic needs, PBSP Theory

International Body Psychotherapy Journal *The Art and Science of Somatic Praxis*
 Volume 16, Number 1, Spring 2017 pp 38 - 55. ISSN 2169-4745 Printing, ISSN 2168-1279 Online
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Introduction

PBSPⁱ is based on the widely-accepted notion that interactions in childhood have a major impact on adult perspectives of the world; this is apparent in research of caregiver attachment

styles (Fraley, Roisman, Booth-LaForce, Owen, & Holland, 2013; Hudson & Rapee, 2001), as well as the increased risk for depression in victims of childhood trauma (Heim, Newport, Mletzko, Miller, & Nemeroff, 2008). Furthermore, for a child's ego to properly develop and for the child to be and become his or her true self, there are essential needs that must be provided by parental figures during childhood.

Pesso referred to these as the Basic Needs, of which he posited five: Place, Nurturance, Support, Protection, and Loving Limits. PBSP theory postulated that the degree to which these needs are met or unmet in childhood had an impact on one's functioning later in life. PBSP suggested that significant unmet needs can lead to depression, anxiety, generalized distress, as well as increased levels of shame – largely due to challenges in realizing one's true self and ill-developed coping skills for navigating the world (Pesso & Crandall, 1991). The Basic Needs are described as:

Place – The provision to a child of a literal Place and then symbolically in the lives, hearts and minds of the parents. That first literal Place being the mother's womb. The provision of Place recognizes the value of the child in having a right to exist and belong in the world. Having a Place means a right to “be” in the universe. It implies the child is being “seen” and valued for whom he/she is. Without Place the individual has difficulty putting down roots and lacks security in attachments.

Nurturance – The act of caring for infants' needs that literally sustain life and keep them alive – such as nursing, feeding, grooming, washing and caressing. When nurturance needs are met, an individual can feel full and satiated inside his or her body, rather than feeling a sense of hollowness and emptiness inside. In later childhood, this translates or transposes into symbolic feeding and grooming in a way that psychologically sustains life such as valuing, appreciating, affirming and admiring.

Support – The act of supporting and carrying an infant that is too young to hold itself upright and move about. The arms and laps of the parents provide this literal Support. In later years, this translates into psychological support, as in “having your back”, or standing behind and being there for the child. When support is given, children and adults learn to trust others can be there for them and they can ask for help.

Protection – The act of literally defending the soft vulnerability of an infant against physical injury is the basic need of Protection. Parents shield their infant from possible contact or impact with hard or dangerous surfaces. In later years, this translates into the parent psychologically defending or protecting their child, as in blocking others' attempts at verbal or psychological injury.

Loving Limits – Through Loving Limits children learn that there are boundaries and limits in life. The parent physically restrains or constrains the infant or older child from doing damage to him/herself or others. The adolescent requires help to contain and navigate their nuclear energies, which are the capacity to create (sexuality) and the capacity to destroy (anger).

It is important to note that Basic Needs are met in a developmental sequence, similarly to Maslow's hierarchy of needs. That is, first there must be satisfaction on a Literal basis and secondarily on a Symbolic level. As these needs become fulfilled by parents or significant caregivers, they become internalized so that the individual can meet his or her own needs in adulthood. Symbolic interactions are imperative as they have an impact on ego development and the child's increasing necessity of knowing how to navigate in the broader world.

In addition to the Basic Needs, there are two additional concepts that frame PBSP's understanding of how childhood and adolescent experiences influence individuals into adulthood. Pesso referred to these as the Holes in Roles and the Pilot.

Holes in Roles - Develops when a child's compassion and imperative for justice is awakened too early without redirection. For example, when a child learns that his or her parent was physically abused as a child, a natural response is to feel compassion and attempt to comfort and heal. However, this is an impossible task for the child; indeed, a young child cannot right the wrong that the parent experienced as a child, and yet the child, without redirection, will continue to psychically attempt to take on this responsibility for their parent's needs. The child's energy is focused away from his/her own appropriate self-development to now taking on the burden of parenting the parent and a longing for justice for the injustice that has occurred. This focus results in an inability to receive caretaking. As an adult, the outcome is over-caretaking where one places themselves in an omnipotent position of feeling that only they can rescue or save others. This leads to feelings of inadequacy and, ultimately, exhaustion.

Pilot - One's ability to think and reason in a mature, reliable and consistent manner. The Pilot detects what one is feeling, thinking, experiencing, and what actions are in their best interest. The Pilot is like a unique, separate aspect of our self that looks upon us and assesses the what and why of our actions. To have a strong Pilot, one needs to have had their inner world of interests, talents, feelings, values, and dreams seen, validated, and acknowledged by parents, caregivers, and loved ones. If this did not occur, then we may not know who we truly and authentically are. This leads to a cloudy or murky picture of our self and prevents us from seeing the world accurately, making good decisions, or being intimate with others.

Current empirical research on PBSP is limited, but promising. In a 2005 study in Prague, researchers used fMRI before and after a two-day PBSP treatment program (Horacek et al., 2005; Perquin, 2004). This pilot study, with only seven participants, lacked a control group. Still, after two sessions of PBSP subjects had an "increase of activation in anterior cingulate and thalamus and decrease in activation of temporal and insular cortex" (Horacek et al., 2005). This finding is important as Hamner, Lorberbaum, and George (1999) suggested that the anterior cingulate is a brain region involved in fear conditioning and serves as an important function to modulate fear responses. Therefore, treatment that can modify exaggerated hyperarousal states connected to negative condition states may be therapeutically beneficial. More specifically, PBSP could prove helpful in the treatment of patients diagnosed with Post Traumatic Stress Disorder (PTSD) as such individuals show a decrease in cerebral blood flow to the anterior cingulate (Hamner et. al, 1999; Lanius et al., 2002; Shin et al., 1999). It should be noted that Eye Movement Desensitization and Reprocessing (EMDR) therapy for PTSD has also shown an increased activation of the anterior cingulate (Bocchia, Piccardi, Cordellieri, Guariglia, & Giannini, 2015; Levin, 1999;) and that it is possible to accurately diagnose PTSD using pre-whitened, resting state fMRI data (Christova, Engdahl, & Georgopoulos, 2015). Clinical testing has also been performed to see the effectiveness of PBSP therapies. In a Norwegian study, 28 outpatients participated in PBSP group therapy (Vogel & Rokenes, 2004). Prior to treatment, the most common diagnosis of the group was depression, followed by personality disorders, and anxiety disorders. The group therapy sessions took place over the course of six months, and were either weekly or biweekly. Researchers found "Significant decreases in psychiatric symptoms and interpersonal problems" by using the following measures: Symptom Checklist-90-revised (SCL-90-R), Inventory of Interpersonal Problems-Circumplex (IIP-C) and the Structural Analysis of Social Behavior-Introject-Version (SASB-Introject)

(Vogel & Rokenes, 2004). Other studies have shown that PBSP produced improved self-concept (Slaninová & Pidimová, 2014a, 2014b) and decreased need for social desirability (Foulds & Hannigan, 1974, 1976).

As a therapeutic tool, then, PBSP would benefit from a reliable methodology that allows therapists to assess Basic Needs, the Pilot, and the Holes in Roles the child assumed responsibility for. Understanding these developmental dynamics serves a diagnostic purpose, operationalizes PBSP concepts, and helps direct specific interventions. At the same time, it provides clients unique insight and understanding of their own history as well as their current quality of life functioning. Thus, a measure of these constructs is necessary.

The Levang Inventory of Family Experiences (LIFE) was created to respond to the need for such a measure and to honor the work of Pessó and Boyden Pessó. It was Boyden Pessó's life goal to bring the theory of PBSP to parents so they might learn to satisfy the basic needs of their children. Such an application is at the heart of the LIFE. Pessó saw great value in the LIFE as a research tool, and he envisioned the LIFE and PBSP as a partnership that could go beyond the clinical setting to impact schools, families, businesses, and even society (A. Pessó, personal communication, April 28, 2016).

Thus, the authors sought to investigate whether the LIFE could reliably measure the foundational components of PBSP, provide therapists with diagnostic data to inform appropriate PBSP interventions, and spur further research.

Method

Participants. The LIFE Questionnaire was developed in three phases: Phase I: Item Development, Phase II: Scale Revisions, Phase III: Test Dimensionality. Phase I, Item Development, included pilot testing of the initial 182-item LIFE. The LIFE was administered to 75 individuals from two data pools: General Population and Clinical Population. During Phase II, Scale Revisions, 100 additional individuals representing both population pools took part in testing to revise the LIFE to 140-items. As Phase III involved only statistical processing, data pools were not required. In combination, 45 individuals were from the Clinical Population and 130 from the General Population. There were 97 female participants and 78 males. Age ranges were 18 to 71 years old. (See Table 1 Participant Demographics).

Test-Development Subject Matter Experts (SME). SME's were selected based on experience with PBSP theory, training, and use of techniques in clinical practice. Potential SME's were invited to participate in the item development at the 2014 annual PBSP trainer's meeting and were known to have expertise in PBSP, along with educational and career backgrounds in the fields of clinical psychology, counseling psychology, human development, marriage and family systems therapy, and psychometric theory and assessment development.

The SME group was led by Curtis Levang, Ph.D. who has 35-plus years of experience in clinical psychology as well as over 30-years training and experience using PBSP techniques in his therapeutic work. Additionally, Dr. Levang received advanced PBSP training directly from Al Pessó, co-founder of PBSP, and Lowjís Perquin, M.D., former lead European PBSP trainer, to become a certified PBSP Supervisor and PBSP Trainer. Dr. Levang consulted directly with Al Pessó and Lowjís Perquin, M.D. who gave feedback and support to the development of the LIFE. Additionally, Jim Amundson, Ph.D., Debbie Wilbur, LCSW, P.A., and Sandy Canfield, LMHC, P.A., all certified PBSP trainers, provided comments and review of the LIFE items.

This expert-level knowledge of PBSP has allowed Dr. Levang and the SME group to ensure that the initial 182 items maintained strong rational fidelity to their intended scale.

Test-Taker General Population. Individuals 18 years and older who volunteered to take the LIFE. Test takers were recruited by researchers and were offered a free interpretation session as an incentive. Test takers were not compensated financially and were informed their results would be kept confidential.

Test-Taker Clinical Population. Clients currently seeking outpatient therapy for a variety of Mood and Adjustment Disorders. Clients were required to have a Global Assessment of Functioning (GAF) score of >60, which placed them in the mild symptomology categories of the DSM-V (American Psychiatric Association, 2013). Clients were recruited by researchers and offered a free interpretation session. Clients were not compensated financially, nor were they charged for a therapy session. Clients were informed their results would be kept confidential.

Materials and Design. The LIFE is hosted by a third-party vendor, CP Consulting & Research, LLC (CPCR), a St. Paul, Minnesota consulting firm specializing in online test administration.

Administration. The LIFE was administered via a HTTPS secured website. Test-takers were emailed a weblink to enter the secure testing session. The LIFE can be administered in an un-proctored setting. An updated internet browser – such as Google Chrome, Internet Explorer, or Mozilla Firefox – and internet connection are required for test completion. Test-takers may save their progress and return to complete the inventory later. There is no time limit to complete the LIFE. The average response time for the 182-item version was 34 minutes; the average response time for the 140-item version was approximately 28 minutes.

Data Collection. Invitation emails were sent from CPCR to test-takers. Response data was collected by CPCR. The data set was prepared by CPCR and provided to the researchers in this study. All test-taker contact information was removed from the data set, thereby ensuring this information was kept confidential from researchers.

Procedures.

Phase I: Item Development. The LIFE was developed by first constructing 26 childhood belief statements for each PBSP domain, totaling 182 items. These items were written by the SMEs.

Item Development. After the initial item creation led by Dr. Levang, the SME group then revised the 182 items for grammar and psychometrically sound item construction, such as eliminating jargon and colloquial wording (Furr & Bacharach, 2008).

Scales were designed to be balanced in scoring, meaning half of the items for each scale were written so an affirmative response (Agree or Strongly Agree) would be indicative of the presence of the construct within the individual. The other half of the items for each scale were written so an affirmative response (Agree or Strongly Agree) would be indicative of the absence of the construct within the individual.

Addition of Response Validity Scale. In addition to the 182 content items, 16 items designed to assess response validity were taken from the International Personality Item Pool (IPIP) research project, an online, open-source, scientific collaborator (IPIP, 2014). The response validity scale measured fake-good response patterns by assessing for over-reporting

of unlikely virtues (Meyer et al., 2001). As reported by the IPIP (2014), average Cronbach's alpha for the unlikely virtues scale was .76 (N=3,325).

Phase II: Scale Revisions. The purpose of Phase II was to revise the LIFE to 140 items. The five Basic Needs scales and the Holes in Roles would have 20 items each, the Pilot scale and the Response Validity scale would have 10 items each. It was determined that given the nature of the Pilot and Response Validity constructs, no additional utility would be gained with 20-items over 10-items. Because the Basic Needs and the Holes in Roles are more complex multi-faceted constructs, they warranted 20-items. The revision was conducted via an initial reliability analysis of the seven LIFE scales and determining the most functional items for each scale.

Item-Reliability Analysis. As a baseline, an initial reliability analysis was conducted using Cronbach's alpha to determine the total-test reliability of the LIFE. The hypothesis was that after following the item-revision protocol, there would be an improvement in the total-test and scale reliability coefficients between the 182-item initial version and the final 140-item version.

Item Revision Protocol. Item revisions were guided by using item-total correlations as indicators of item functioning. Item-total correlations are provided in a Cronbach's reliability analysis for internal consistency using the Statistical Package for the Social Sciences (SPSS) software and following the protocols outlined in Green & Salkind (2009). The following revision protocol was followed:

1. Items with item-total correlations below .200 were eliminated. A total of 13 items were removed in this process, with no scale having more than six items removed.
2. Scales with exactly 20 remaining items after Step 1 (above) were finalized. No scale had remaining items with item-partials below .200 after Step 1.
3. Scales with more than 20 remaining items after Step 1 (above) were further revised by removing items with the lowest item-total correlations until the scale had 20 items remaining. For the Pilot and Response Validity the item count was 10. *Phase III:*

Revised Form Reliability & Dimensionality. The purpose of Phase III was to determine the dimensionality of the LIFE. This was done in two ways:

1. Compare the scale and total test reliabilities from Phase I (N=75) against the reliabilities from Phase II (N=100).
2. Analyze the factor structure of the LIFE using data from Phase I and Phase II (N=175). Note that the factor analysis only included responses from the 140-items of the LIFE.

Reliability Analysis. A second reliability analysis was performed on data collected from Phase II (N=100) to estimate the internal consistency reliability of the instrument. Reliability coefficients increased for each scale and total-test from Phase I to Phase II. The scale and inter-item reliabilities are presented in Table 2 and Table 3.

PBSP Theory and Inter-scale correlations. PBSP theory suggests that the Basic Needs are typically perceived as met in combination, not independently. That is, if a child perceives high Support, he or she likely perceives moderate or high Nurturance, Protection, Place, and Loving Limits. Therefore, inter-scale correlations should be moderate-to-strong among the Basic Needs.

Additionally, PBSP theory allows that the phenomenological etiology of the Pilot and the Holes in Roles are distinct from the Basic Needs. That is, a child could perceive the Basic Needs as met, but may experience less of the Pilot support or be placed in a role of taking

care of a parent when he or she was incapable, i.e., the Holes in Roles. Most developmental theories capitulate to perceptive overlap, however, indicating that the Pilot, the Holes in Roles, and the Basic Needs would all have some statistical overlap. Given this, inter-item correlations between the Basic Needs with the Pilot are expected to be moderate and the Basic Needs with the Holes in Roles to be inverse and moderate.

PBSP Theory and Factor Structure. PBSP theory also purports two underlying mechanisms of the human experience that shape one's perceptions of the past: physical and relational. PBSP suggests that children first develop a sense of their basic needs being met through physical interactions, this is Literal. Secondly, children later gain a sense of basic needs fulfillment through more interpersonal, or Symbolic mechanisms.

The LIFE was designed to measure both a Literal and Symbolic sense of one's basic needs having been met. To examine this psychometrically, an Exploratory Factor Analysis (EFA) was run via SPSS. Best practice guidelines on sample size vary, yet a commonly held minimum threshold is 1:1 ratio of subjects to items (Costello & Osborne, 2005). To obtain a minimally accepted subjects-to-items ratio, data collected from both Phase I and Phase II, for a total of 175 subjects, was utilized in the factor analysis. The EFA included only the 140-items determined after the revision protocol used in Phase II.

The EFA was employed to determine the underlying psychometric structure of the LIFE. The LIFE was designed to be a multidimensional test with correlated dimensions; as such, an EFA with oblimin rotation was selected as the most appropriate procedure (Costello & Osborne, 2005). In PBSP theory there are two primary factors that influence the formation of childhood development memories: Literal and Symbolic influences. An EFA would help establish the theoretical fidelity of the LIFE to PBSP theory.

Secondly, a Confirmatory Factor Analysis (CFA) was run via SPSS. Item Factor Loadings based on the CFA are provided in Table 4.

Results

Reliability. Phase I scale reliabilities for the LIFE content scales ranged from .63 to .76, with a total-test Cronbach's alpha of .71 (N=75). Phase II LIFE content scale reliabilities ranged from .76 to .89, with a total-test Cronbach's alpha of .83 (N=100). The already established Defensiveness scale reliability from Phase I was .78 (N=75) and from Phase II was .75 (N=100). Cronbach's alpha coefficients above .70 are considered an indication of sufficient scale reliabilities (Yan, 2007). Refer to Tables 2 and 3 for the reliability results.

Dimensionality: Inter-Scale Correlations. Inter-scale correlations were consistent with PBSP theory: Basic Needs scales were the most highly correlated scales, with an average person-r correlation of $r=.76$ ($p<.05$). Additionally, the Holes in Roles had an average correlation with the Basic Needs of $r= -.52$ ($p<.05$). The Pilot scale had an average correlation with the Basic Needs of $r=.70$ ($p <.05$). The Defensiveness scale had no significant relationship with any of the LIFE content scales, the average correlation being $r=.01$.

Dimensionality: Factor Structure. The scree plot from the EFA showed two components with eigenvalues above 1.0 and one additional component with an eigenvalue above .80. A fourth component had an eigenvalue of .69. The recommended approach for choosing factors is the Scree test (Costello & Osborne, 2005), which involves examining the scree plot for the natural "break". The scree plot is provided in Figure 1. A three-factor solution was chosen based on the EFA scree test, PBSP theory, and inclusion of

the Defensiveness/Unlikely Virtues scale, which is a construct unrelated to the LIFE content scales.

A 3-Factor Confirmatory Factor Analysis was then run to create an Item Factor Loadings table. Items with no loadings above .30 were placed in an un-factored items category. Table 4 provides the complete LIFE inventory factor loadings.

Conclusion and Discussion

Reliability. When developing an assessment, considerations of test-reliability must be addressed initially. The reliability of the final 140-item version of the LIFE was .83 (N=100). This provides early evidence that the LIFE is a reliable measure. Given the nature of scales, it would be expected that as individuals gain a different perspective on their memories, through therapy or other forms of self-discovery, that scores on the LIFE would change. As such, test-retest correlations would be expectedly lower, particularly when intervals between testing exceed nine months to one year.

Future studies on reliability should focus on establishing reliabilities and norms for various populations, including clinical, general population, young adults (18-29), middle aged (30-49), older adults (50-69), and the elderly (70+). In addition, the LIFE may be a useful measure in longitudinal studies aimed at assessing a variety of developmental phenomena.

PBSP Theory and Factor Analysis of the LIFE. Factor Analysis is largely an interpretive process that uses statistical measures to guide a theoretical discussion: there are few absolutes when exploring the underlying factor structure of an instrument (Costello & Osborne, 2005). The LIFE was developed to assess the extent to which a test-taker perceives fulfillment of the Basic Needs during childhood, to which the Holes in Roles occurred, and to which the Pilot was developed.

There are two factors an individual considers when perceiving the extent to which the Basic Needs are met: Literally and Symbolically. In the literal, an individual remembers childhood experiences of being touched, held, physically supported, and protected. Half of the items on the LIFE are written to measure such literal experiences.

Symbolic perceptions are developed when an individual maintains a more global sense of feeling supported, cared about, loved, and an ability to reciprocate emotionally with others. The other half of the items on the LIFE are written to measure such symbolic perceptions.

Results from the EFA support PBSP's two-factor theoretical framework. The three-factor EFA model provides the most cogent solution to the psychometric structure of the LIFE. The two factors with eigenvalues above 1.0 have items that relate mostly to Literal needs on Factor One and Symbolic needs on Factor Two. A third factor included 16 items relating to response validity, defensiveness, and reporting of unlikely virtues.

The five items with the strongest factor loads on Literal Needs (Factor One) are:

NR I grew up in an environment that nurtured and helped me grow

SP For as long as I can remember, I felt that my parent/caregivers were there for me

PR I liked the sense of security and protection I grew up with

NR My parents/caregivers knew how to talk to me in soothing and comforting ways when I was a child

NR I was well taken-care of by family/friends as I grew up

The seven items with strongest factor loads on Symbolic Needs (Factor Two) are:

-
- SP I feel actively supported by those who care for me
 - SP Balancing the give and take of a friendship is something that comes naturally to me
 - NR I find it easy to care about my family and friends
 - SP I have a strong and reliable support system
 - SP I have the emotional support I need to live a healthy life
 - PB I have a sense of positive meaning and purpose for my life
 - LL I know the difference between my emotions and other's emotions

The factor analysis presents the first empirical evidence in support of the existence of two measurable factors of the Basic Needs: Literal and Symbolic. From a clinical perspective, distinguishing Literal from Symbolic provides greater precision in determining the focus of therapy and applying interventions. The Holes in Roles and the Pilot are inter-relational phenomena and would be expected to load more strongly onto the Symbolic factor than the Literal factor. This is due to the Holes in Roles and the Pilot both being dependent on the development of language, the acquisition of which allows one to create and understand symbols. As the child reaches higher levels of maturation he or she gains the ability to understand roles, process stories, and have a vocabulary for emotions. The EFA supported this theoretical conclusion.

In addition to the factor structure, inter-scale correlations suggest a strong relationship between the Basic Needs scales. This verifies that meeting of one's Basic Needs does not occur in isolation. For example, the child is not just requiring support for success in friendships or schooling, but rather he or she also has needs for loving limits, protection, and nurturance to foster healthy functioning. The inter-scale correlations also corroborate theoretical suggestions that highly effective parents tend to meet the Basic Needs globally.

Secondly, the Basic Needs and the Holes in Roles scales have strong inverse correlations. This supports the PBSP hypothesis that the Holes in Roles are detrimental to healthy childhood development and that inter-relational phenomena affects how one remembers his or her childhood caretakers. Thus, the Holes in Roles has tremendous power over one's attainment of the Basic Needs as this premature awakening of the child's compassion and desire for justice places the focus on others, rather than self. Consequently, the child negatively impacts his or her own development due to an inability to receive or let in the Basic Needs offered by others.

Lastly, the inter-scale correlations show no relationship between the content scales and validity scales. This suggests that state-based defensiveness is not related to the state-based content scales.

Future research. PBSP theory postulates that the degree to which Basic Needs are met or unmet in childhood have an impact on one's later life functioning. PBSP literature demonstrates that deficits in needs attainment can lead to depression, anxiety, generalized distress, and increased levels of shame as one has difficulty realizing their true self and adopting coping skills to deal with life (Perquin, 1998b; Pessó, 1991).

One focus for future research on the LIFE should concentrate on establishing the convergent and divergent validity of the instrument. Results on the LIFE should be correlated with other known measures of psychopathology, attachment style, adverse childhood experiences, and other known measures of mental health and wellbeing.

A second area of focus should be on establishing intervention protocols based on the LIFE. Prior to the development of the LIFE no quantitative measures existed to assess a client's base line degree of unmet childhood needs, to delineate what those specific needs were, or if the need was of a literal or symbolic nature. With the LIFE, interventions targeting Literal or Symbolic deficits can be measured through pre-and-post testing. This would lead to an ability to measure the efficacy of PBSP treatment as well as giving the therapist and client evidence of when to terminate therapy. In addition, use of the LIFE provides the therapist a starting point to assess what PBSP domain requires therapeutic attention (e.g. Nurturance, Place, etc.). For example, understanding the client has Unmet Literal Support Needs would suggest that the therapist rely on literal interventions. Thus, the therapist might say, "Let's enroll this pillow to be a support figure for your back" thereby enabling the client to feel physically supported. By participating in a "literal" intervention, the client can discover that Support is believable and then may be more willing to utilize an "ideal parent" symbolic figure which has more therapeutic power.

A third area of focus should be on utilizing the LIFE results in non-therapeutic settings. The LIFE has practical implications for improving parenting skills, increasing teacher-student relational effectiveness, and for improving work satisfaction and performance. Administration, interpretation, and intervention protocols need to be researched and established for the LIFE in these contexts.

Overall, the research findings demonstrate that the LIFE has strong internal consistency as established by Cronbach's alpha. The EFA indicated an underlying factor structure that is consistent with PBSP theory. As more individuals complete the LIFE and further norm groups are developed, it is recommended to conduct a second factor analysis. Comparing the item-loadings from this study's factor analysis with future factor analysis item-loads results would illuminate a consistent underlying structure of the LIFE and provide additional evidence for the construct validity of the LIFE.

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Table 1
Participant Demographics

Phase	N	Male	Female	Clinical Population	General Population	Age Range	Avg Yrs Clinical Experience
<i>Phase I – SME</i>	9	6	3	--	--	31-85	17.5
<i>Phase II</i>	75	36	39	25	50	18-71	--
<i>Phase III</i>	100	42	58	20	80	21-69	--

Table 2
Phase I Reliability Analysis of Levang Inventory of Family Experiences (N=75).

	Place/ Belonging	Nurturance	Support	Protection	Loving Limits	Pilot	Holes in Roles	Defense
Place/Belonging	.67							
Nurturance	.70	.69						
Support	.71	.64	.72					
Protection	.66	.54	.76	.76				
Loving Limits	.54	.59	.57	.60	.70			
Pilot	.59	.48	.49	.67	.56	.68		
Holes in Roles	-.30	-.42	-.31	-.25	-.21	-.24	.63	
Defensiveness	.01	-.08	-.00	-.10	.07	.02	.08	.78

Note. Inter-scale correlations with scale reliabilities provided on diagonal. Total Items = 182

Table 3*Phase II Reliability Analysis of Levang Inventory of Family Experiences (N=100).*

	Place/ Belonging	Nurturance	Support	Protection	Loving Limits	Pilot	Holes in Roles	Defense
Place/Belonging	.89							
Nurturance	.86	.84						
Support	.85	.89	.86					
Protection	.76	.74	.76	.84				
Loving Limits	.71	.71	.69	.60	.75			
Pilot	.73	.68	.68	.69	.72	.88		
Holes in Roles	-.54	-.57	-.61	-.53	-.44	-.44	.76	
Defensiveness	.18	-.02	-.01	-.07	.03	.05	.07	.75

Note. Inter-scale correlations with scale reliabilities provided on diagonal. Total Items = 140

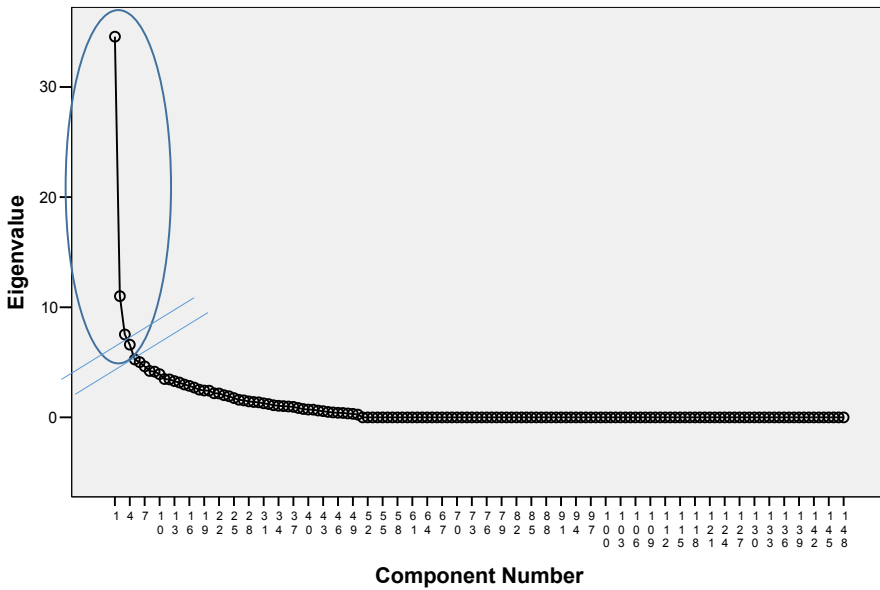
Figure 1. Exploratory Factor Analysis – Scree Plot; 3 Factors (N=175)

Table 4

Phase II LIFE Items Factor Loadings by Three Factor Solution (Literal, Symbol, Response Validity)

Item Key: NR=Nurturance, SP=Support, PR=Protection, PB=Place/Belonging, LL=Loving Limits, HR=Holes-in-Roles, PO=Pilot (N=175)

Factor One – Literal Needs (62 Items)	L
NR I grew up in an environment that nurtured and helped me grow	.819
SP For as long as I can remember, I felt that my parent/caregivers were there for me	.817
PR I liked the sense of security and protection I grew up with	.816
NR My parents/caregivers knew how to talk to me in soothing and comforting ways when I was a child	.806
PO Emotions were not allowed in my family growing up	-.789
NR I was well taken-care of by family/friends as I grew up	.756
PO When I was growing up, I believed my parents knew who I was as an individual	.752
SP As a child, I was not allowed to cry when something upset me	-.747
PB I know I had a place in my parent's life	.733
PO I was given the opportunity to identify my own feelings about things	.725
PR I feel that I have a strong sense of what is safe and what is unsafe because of how my parents/caregivers took care of me as I was growing up.	.719
PO As I was growing up, I learned how to ignore my true feelings	-.709
LL When I was a young child, my parents never made attempts to hold me if I had a temper tantrum	-.709
PO I felt my opinions were respected by my parents, even when they were different from theirs	.699
PO As a child, my family fully recognized and appreciated my uniqueness	.696
PB My parents or caregivers rarely looked lovingly at me when I was a child	-.693
PR As far back as I can remember, my parents/caregivers have worked to keep me safe	.688
PR My parents/caregivers kept me safe and protected as a baby	.688
SP I believe my parents/caregivers held me safely as a baby	.674
P If I felt frightened as a child, I knew my parents/caregivers would protect me	.667
NR There was a lot of comforting and loving touch in my home growing up	.666
SP My parents/caregivers held and carried me as I was growing up	.666
HR I witnessed family members getting physically/emotionally/sexually abused	-.662
NR My mother was warm, comforting and loving when I was a child	.661
PB Growing up, I was told that I was wanted and my birth was planned	.642
PO My parents were not grounded in reality	-.616
LL I was given an opportunity to talk about positive and negative feelings as I was growing up	.614
PR As a teenager, my parents helped me learn how to make decisions by pointing out both the positives and negatives	.608
LL My parents/caregivers helped me identify and name my feelings	.606
PB I feel that my parents had a place in their hearts for me	.605
SP When I was frightened as a child, my parents/caregiver did not comfort me	-.592
PB I feel emotionally safe most everywhere I go in the world	.592
PR I was never forced to show affection or love for people I was not comfortable with or did not know	.590
SP I have had to fight to ensure my needs were met	-.562
PR I don't think my caretakers always knew if I was safe or not	-.550
NR My family never showed affection towards one another	-.547
PO I didn't feel like a real person growing up	-.547
SP As a child, my mother/caregiver took care of me if I was injured (example: scraped knee or elbow)	.534
PB Sometimes I feel like an impostor	-.528
PB My parents were disappointed to discover that I was a boy (or a girl, if you are female)	-.522
NR My father was absent, cold, or uninterested in me when I was a child	-.510
SP When I look back at my life, I feel like I raised myself	-.508
LL In our home, taking your anger out on people or things was okay	-.496
LL In our home, my parents felt uncomfortable with their sexuality and it was a taboo subject	-.484
LL As a child, I was encouraged to learn to be independent	.481
PB Sometimes I feel that I don't have enough roots	-.475
LL My parents/caregivers expressed their anger at me by yelling or screaming	-.475
PB As I was growing up I felt closely attached to 3 or more people in my life	.467
LL I know how to stay calm on the inside when other people are upset	.461
PR I have been physically mistreated by someone or something in my past	-.417

NR I sometimes feel empty inside	-.393
LL As a child, I was encouraged to learn to be independent	.386
HR I was never put in a parent role as a child	.383
NR I was a breast-fed baby	.373
HR As a child, I was far too wise beyond my age	-.357
PR I do not feel any need to be cautious in unfamiliar places	.345
HR I get a lot of pleasure finishing tasks and being organized	-.343
LL My parents/caregivers taught me how to contain my strong emotions	.339
PB My mother's life was stressful and/or chaotic while she was pregnant with me	-.332
SP As an infant, I don't think my mother/caregiver took as much interest in me as most mothers	-.320
HR I feel there needs to be justice for any wrongdoing or mistreatment against me	-.319
LL As I grew up, I felt that I could talk about sex frankly, safely, and appropriately with my parents/caregivers	.315
HR As a young child, my parents/caregivers never expected me to take care of them	.300

Factor Two – Symbolic Needs (45 Items)

	S
SP I feel actively supported by those who care for me	.735
SP Balancing the give and take of a friendship is something that comes naturally to me	.699
NR I find it easy to care about my family and friends	.695
SP I have a strong and reliable support system	.682
SP I have the emotional support I need to live a healthy life	.641
PB I have a sense of positive meaning and purpose for my life	.624
LL I know the difference between my emotions and other's emotions	.622
PB I've been a loner most of my life	-.617
NR I am comfortable being hugged/touched by those I love	.599
PB I have a place in the world	.589
PB I usually keep others at a distance	-.588
HR I do not feel free to live my own life	-.586
SP Friends are not trustworthy	-.583
PB I don't feel connected to the people and places in my life	-.576
NR I prefer to be alone	-.547
LL I feel confident enough to have my own feelings without going along with others	.546
SP I believe that there are people in my life now who are there for me	.529
SP I am comfortable relying on others to help meet my needs	.527
HR I feel a great burden or responsibility to take care of others	-.525
NR I have people in my life who fill me up with love and caring	.521
HR I procrastinate a lot and leave things undone	-.516
HR When I was a child, I was never told stories about our family history	-.508
SP When I was young, I did not need anyone to watch over me and pay attention to me	-.499
HR I'm not always sure of how to take care of myself so that I don't get drained	-.499
PO I am good at articulating all of my emotions and feelings to others	.486
PB I believe that things will work out for me in my life	.480
NR At times, I feel grateful for the love that others show me	.472
NR Those who mistreat people deserve everything that is coming to them	-.453
HR I have a hard time receiving praise from others	-.443
PR Growing up, there were times I felt like I had no one but myself to keep me safe from obvious danger	-.437
NR Those who mistreat people deserve everything that is coming to them	-.433
LL Sex is something that shouldn't be talked about as much as it is	-.425
SP I do not like to rely on others to help me	-.407
HR I'm the first to rescue others no matter what the trouble is	-.406
PR I feel safe and protected in my physical environment	.400
PO Often, I don't take time to think about the root cause of my feelings	-.380
PR People who feel that they need protection from harm are weak	-.367
PB As a child I routinely got angry and pushed others away	-.362
SP I feel it is foolish to let others know you	-.361
NR Generally, I don't care to know other people	-.351
NR I don't like people standing close to me or in my bubble	-.329
LL Some people think I am too rigid	-.295
PR I always carry a weapon of some sort to protect myself	-.293
ASP I don't always keep my feelings in check	-.683

 Factor Three – Response Validity (17 Items)

LL Some people think I am too emotional
 ASP I don't think negatively about anyone
 ASP There are times when I have unfairly held negative opinions about others
 ASP I can always overcome difficulty on my own
 PB I feel comfortable in my own skin
 NR It takes great effort for me to calm down if I get really agitated or worked up
 ASP I have had life troubles where I have needed others' help to overcome them
 ASP I never tell lies
 ASP I always perform up to my highest capabilities
 ASP I have told a lie
 PR I do not think I need anyone or anything to protect me
 ASP I always follow the rules
 HR Nothing is more important to me than taking care of me
 HR I don't have any problem taking responsibility for others
 PB I have had suicidal thoughts in the past few months
 PR I sometimes feel scared, like something larger or stronger than me might get me
 PR I feel like I am big enough, strong enough and smart enough to not need anyone to protect me from harm

 Unloaded Items (n=16)

HR I work very hard to earn what comes to me
 LL There were times when my parents talk of sex and/or sexual behavior left me feeling uncomfortable
 PR As a young child, I was always kept safe from obvious dangers (example: hot stove, electricity, running into the street or a dangerous animal)
 PB I was told that my parents had me in order to save their marriage and keep the family together
 HR I saw my parents/caregivers suffer with disease or frailty
 ASP I am not perfect
 HR I never put the needs of others before my own
 PR I was never forced or allowed to be in an unsafe environment
 HR As a child, I had great compassion for people who suffered
 LL I did not need rules and boundaries growing up
 LL I have been too free and open with sex
 PR I never get startled by loud noises or unusual sounds
 NR I would be fine if I had no family, friends, or acquaintances
 HR I'm the first to rescue others no matter what the trouble is
 LL My parents did not create rules and boundaries for me
 SP I think it's best not to coddle children because I wasn't coddled

Note. Negative item loads indicate reverse coded items. Extraction Method: Principal Component Analysis. Rotation Method: Varimax with Kaiser Normalization. Rotation converged in 5 iterations. All items are under copyright and may not be distributed, copied, or stored in any form without the expressed written consent of Dr. Curtis Levang, LP. ©Levang & Associates, 2016

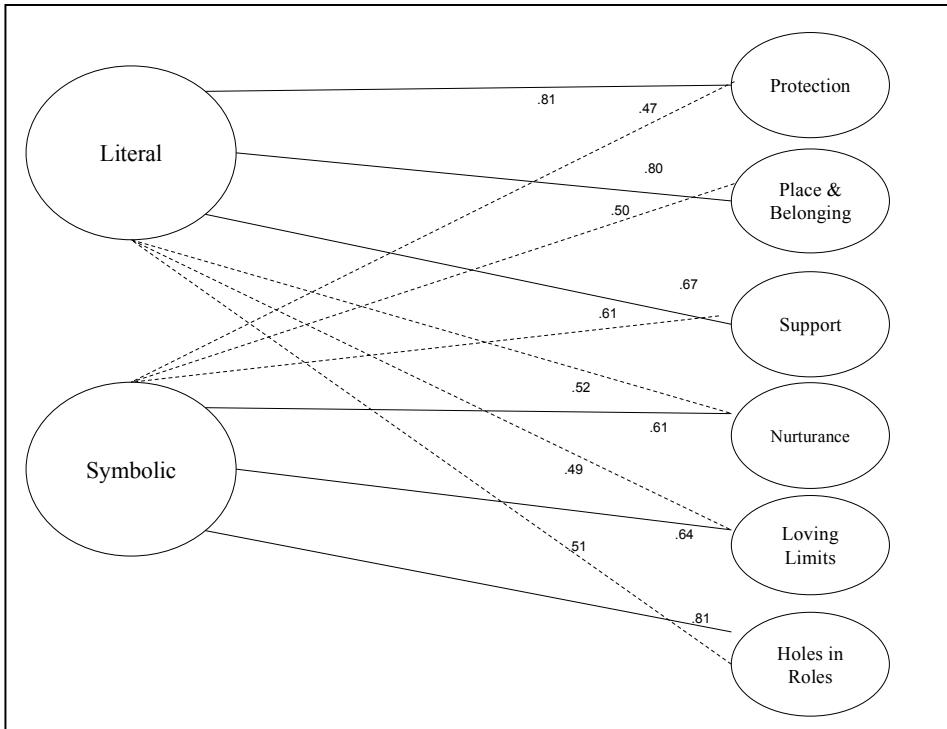


Figure 2. Two-Factor Model for the Levang Inventory of Family Experiences.

ⁱ Imagine the most beautiful dance you have ever seen. As the dancer's body lunges forward into the air you gasp, holding your breath until his toes are safely on the ground. He contorts his body into a shape you barely recognize as human, and it makes you want to cry. Yet another dance, with two dancers intertwined at the hips makes your heart start to race, building a deep lust in your belly. It's this simple fact: that the body and emotion are intertwined, that is the bedrock of Pesso Boyden System Psychomotor (PBSP).

Albert Pesso and Diane Boyden Pesso, trained dancers and choreographers, started working on their mind/body theory in the early 1960s (Howe, 1991). Pesso was the Associate Professor and Director of the Dance Department at Emerson College in Boston, Massachusetts. While there he and Boyden Pesso began to comprehend that the inability of professional dancers to perform certain dance movements were directly related to repressed emotions (Perquin, 1998a). Consequently, they developed therapeutic exercises with the intent of bringing emotions into the conscious mind and forged a new understanding of the interplay between mind and body as an integrated unit (Perquin, 1998a, 2004).

The Boston psychiatric community became interested in Pesso and Boyden Pesso's psychomotor work and subsequent research at McLean Hospital and Boston Veterans Administration Hospital led to further refinements of their theory (Pesso, 1969). As their work grew they began training psychotherapists in the United States and Europe (Perquin, 1998a). With the collaboration of colleagues Louisa Howe, Ph.D., Lowijs Perquin, M.D., Gus Kaufman, Ph.D., and others, Pesso and Boyden Pesso's theory made a lasting mark in the field of psychology. This is demonstrated not only by the elegance of the theory itself, but by the great body of work produced from books and articles, to lectures, videos, and training materials. Of the numerous honors bestowed upon Pesso and Boyden Pesso, perhaps the greatest were his 2012 Lifetime Achievement Award from the United States Association for Body Psychotherapy (USABP) and his work in the Democratic Republic of the Congo as documented in the 2010 film "State of Mind" (Markovitz & Munga, 2010).

Body Responsiveness Questionnaire: Validation on a European sample, Mediation between Body Awareness and Affect, connection with Mindfulness, Body Image, and Physical Activity

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Received 13 August 2016; accepted 04 November 2016

Abstract

Body responsiveness is ‘the tendency to integrate body sensations into conscious awareness to guide decision making and behavior and not suppress or react impulsively to them’. It is assessed by a 7-item tool, the Body Responsiveness Questionnaire (BRQ), which has not yet been validated on the European population. We aimed to translate the original version of Daubenmier’s BRQ, and test its consistency and convergent validity, and explore its connection with positive and negative affect, spirituality, attention-related body sensations, cardioceptive sensitivity, age, and gender. Overall, 402 individuals participated in the research, recruited either through the internet or in a university course. The Hungarian version of the BRQ showed the same two-factor structure as the original version: importance of body in behavior, and perceived disconnection between body and mind. Total BRQ score correlated positively with body awareness, positive affect, mindfulness, spirituality, body-mind practice (e.g. yoga), negatively with negative affect and physical symptoms. NO connection was found between the BRQ scores and cardioceptive sensitivity. According to our mediation analyses, BRQ-total was a significant mediator between body awareness and affect. Our results can inspire future studies investigating somatic psychology or the effectiveness of a body-mind intervention to assess body responsiveness also.

Keywords: body-mind connection, embodiment, mindfulness, positive and negative affect

International Body Psychotherapy Journal *The Art and Science of Somatic Praxis*
Volume 16, Number 1, Spring 2017 pp 56 - 73. ISSN 2169-4745 Printing, ISSN 2168-1279 Online
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Introduction

Embodiment is defined as an ‘experience of connection, attunement and equality between the mind and the body’ (Teall, 2015, p. 8). Regarding the subjectively experienced, interpreted and verbalized embodiment, many dimensions can be conceptualized (Teall, 2015), and using these concepts questionnaires can be constructed, which help to understand and monitor the effect of body-oriented interventions. Body awareness is one of the most widely researched aspects of embodiment and is defined as the ‘perception of bodily states, processes and actions that is presumed to originate from sensory proprioceptive and interoceptive afferents’ (Mehling et al., 2009, p. 4), also referred to as interoceptive awareness (Buldeo, 2015) and somatic awareness (Bakal, Coll, & Schaefer, 2008). Recently, it has been found that there is a significant difference between interoceptive awareness, and interoceptive accuracy, i.e. the capability to

accurately detect bodily processes in objective behavioral experiments (Ceunen, Van Diest, & Vlaeyen, 2013; Garfinkel, Seth, Barrett, Suzuki, & Critchley, 2015). In fact, many previous studies showed no connection between the subjective, questionnaire based assessments of body awareness and objectively measured interoceptive sensitivity (Dunn, Dalgleish, Ogilvie, & Lawrence, 2007; Emanuelsen, Drew, & Köteles, 2015; Khalsa et al., 2008).

Other aspects of embodiment (or disembodiment) were also operationalized (Teall, 2015), e.g. (1) body image dissatisfaction (Cash & Szymanski, 1995), and more widely, (2) body shame (Lamont, 2015; McKinley & Hyde, 1996), (3) alexithymia (Taylor, Bagby, & Parker, 1991), (4) body objectification (McKinley & Hyde, 1996), and, regarding positive approaches, (5) mindfulness, i.e. an intentional, non-elaborative, non-judgmental awareness which focuses on one's emotions, thoughts and sensations (including bodily ones) in the here-and-now (Bishop et al., 2004; Hölzel et al., 2011; Mehling et al., 2009; Zgierska et al., 2009).

Body responsiveness, defined as 'the tendency to integrate body sensations into conscious awareness to guide decision making and behavior and not suppress or react impulsively to them' (Daubenmier, Sze, Kerr, Kemeny, & Mehling, 2013, p. 9), is another important dimension of embodiment. Body responsiveness is assessed using a 7-item questionnaire called Body Responsiveness Questionnaire (Daubenmier, 2005). In the original and some following papers on body responsiveness, the questionnaire was referred to as a one-factor scale (Daubenmier, 2005; Daubenmier et al., 2011; Swami & Harris, 2012). Later the presence of two underlying factors was suggested, namely the importance of body awareness in guiding behavior (I; the four positively-keyed items), and the perceived disconnection between body and mind (PD; the three reversed items) (Clarke, 2008, p. 81; Daubenmier et al., 2013).

A connection was showed between scores on BRQ-total and body-mind practice, like yoga (Daubenmier, 2005; Dittmann & Freedman, 2009; Impett, Daubenmier, & Hirschman, 2006), and contemporary dance (Swami & Harris, 2012). Further results suggests that body responsiveness is connected to increased well-being: positive affect (i.e. feeling enthusiasm, activeness, and alertness (Watson, Clark, & Tellegen, 1988)), satisfaction with the body, the self, and life), and lower levels of maladaptive psychological functioning: negative affect (i.e. experiencing various aversive mood states, like anger, fear, disgust), self-objectification (Daubenmier, 2005; Dittmann & Freedman, 2009; Impett, Daubenmier, & Hirschman, 2006). It was also identified as a mediator between well-being and body awareness, moreover, through improvements in eating behavior (supporting intuitive eating, and preventing emotional eating) it contributes to the decrease of abdominal fat, which is essential in the promotion of physical health as well (Daubenmier et al., 2011). Body responsiveness was also found to mediate the relationship between body shame and the self-rated health, symptoms, and frequency of infections in college women (Lamont, 2015). It is important to note that all the studies mentioned here (1) recruited participants from the USA, therefore the European population was not tested yet, and (2) used either a sample of females only, or included few males, therefore the gender differences regarding BRQ could not be empirically explored. However, women are thought to have a closer relationship with their body, partly because of more intensive and frequent body experiences, e.g. menstruation, partly because of socio-cultural factors (Pennebaker, 1982).

Regarding psychophysiology, in a recent fMRI study body responsiveness and body awareness were found to be connected with resilience, and the least resilient subjects showed higher activation of the insula and thalamus related to an aversive interoceptive stimulus (artificial resistance in airway) (Haase et al., 2016). Regarding non-aversive sensations of breathing, respiratory interoceptive accuracy showed a tendency to correlate negatively with BRQ-PD (Daubenmier et al., 2013). The most prevalent measurement of

interoceptive accuracy, heartbeat detection (Schandry, 1981; Schulz, Lass-Hennemann, Sütterlin, Schächinger, & Vögele, 2013; Whitehead, Drescher, Heiman, & Blackwell, 1977) is yet to be examined in the light of body responsiveness.

Body responsiveness characterizes reactions to conscious body experiences. Body sensations can be brought into awareness by focusing attention on interoceptive inputs that are usually filtered out, causing e.g. tingling, warmth, or pressure (Michael & Naveteur, 2011). The attention-related body sensations were found to be connected to body awareness (Benedek T. Tihanyi, Sági, Csala, Tolnai, & Köteles, 2016), but no empirical research has been published to date to show their connection to body responsiveness.

Mindfulness was connected to higher levels of body-mind unity (not assessed by BRQ) (Kattenstroth, 2009), and mindfulness-based interventions were successful in increasing body responsiveness (Daubenmier et al., 2011). Some of the body-mind interventions are also connected to spirituality and contemplative practices (Brytek-Matera & Koziel, 2015; Totton, 2003, p. 102). Interestingly, no empirical attempt was made to date to investigate the relationships among scores of body responsiveness, mindfulness, and spirituality.

In summary, the construct of body responsiveness assesses an important aspect of embodiment, which is ignored by most of the other body-related questionnaires, and it possibly explains and measures more precisely the health promoting attitude towards one's body-mind, the effect of body-mind methods and other therapeutic, recreational, and preventive processes. In this study, we aimed to develop the Hungarian version of the BRQ, investigate its psychometric properties, and validity. We hypothesized that BRQ would show (1) a positive connection with body awareness, mindfulness, positive affect, spirituality, physical activity, body-mind practice, and attention-related body sensations, (2) a reverse connection with negative affect and dissatisfaction with body image, and (3) positive connection with heartbeat detection accuracy. Moreover, (4) it was assumed that females would show higher levels of BR than males. Finally, (5) it was expected that body responsiveness would (4) mediate the connection between BA and affect (positive and negative). To the authors' knowledge, this research is the first to include enough male subjects to examine gender differences regarding BRQ.

1. Methods

1.1. Participants

Two groups were included in the study. One group ('online group'), was recruited on on-line forums (excluding groups which focus on any kind of body-mind practice), and completed our on-line questionnaire, where we stated that 'the opinions on body experiences (i.e. body awareness) and affective life are investigated'. Another group of participants was recruited from university students ('university group') (for details, see Table 3). Beyond the on-line questionnaire, this group completed a heartbeat detection task as well. The study was approved by the Institutional Ethical Board of Eötvös Loránd University. All participants read and signed an informed consent form before completing the questionnaire.

1.2. Measurements

Body Responsiveness Questionnaire (BRQ) (Daubenmier, 2005) "assesses the tendency to integrate body sensations into conscious awareness to guide decision making and behavior and not suppress or react impulsively to them". A factor analysis indicated the presence of two factors (Daubenmier, unpublished analyses). The Importance of Interoceptive Awareness subscale

(I-subscale) assesses the importance of using interoceptive information to regulate behavior and self-awareness (items include “It is important for me to know how my body is feeling throughout the day,” “I am confident that my body will let me know what is good for me”) and the Perceived Disconnection subscale (PD-subscale) measures the extent of perceived disconnection between psychological and bodily states, including suppressing and reacting impulsively to them (items include “My mind and my body often want to do different things,” “I suppress my bodily feelings and sensations,” “My bodily desires lead me to do things that I end up regretting”) (see Table 1). Since previous Hungarian version was not available the usual method of translation was followed: two experts translated the questionnaire independently from English to Hungarian, then a third expert back-translated the consensus version, which was compared to the original English version by a native English-speaker. Identically to the original version, we used a 7-point Likert scale for the 7-item questionnaire in the Hungarian version (see Appendix 1. also). I-subscale and PD-subscale scores were calculated separately, and for the BRQ total scores, we summed the reversed PD-subscale score and the I-subscale score. For better comparability with previous studies on BRQ, we divided the scores by the number of items, similar to the scores of the further questionnaires. Then the two subscales score were also averaged (similar to every score in Table 3., total scores were divided by the number of items) showed acceptable internal consistency in both the online and the university groups (Cronbach α 0.82 and 0.83 for I-subscale, 0.72 and 0.63 for PD-subscale respectively).

Body Awareness Questionnaire (BAQ) (Shields, Mallory, & Simon, 1989). The questionnaire consists of eighteen statements that measure beliefs about one’s sensitivity to normal non-emotive bodily processes, and the ability to anticipate bodily reactions. Items are scored on a seven-point Likert scale. The BAQ is considered a reliable and valid instrument for measuring self-reported attentiveness to normal bodily processes (Mehling et al., 2009). The Hungarian version showed good validity and reliability in past studies (Emanuelson et al., 2015; Köteles, 2014). In the present study, the internal consistency of the scale was 0.89.

Body Image Ideals Questionnaire (BIQ) (Cash & Szymanski, 1995) is a frequently used questionnaire of body image, which examines 11 physical characteristics, namely height, muscle tone and definition, body proportion, weight, chest size, physical strength, physical coordination, facial features, hair texture and thickness, skin complexion, and overall appearance. Higher scores on the BIQ indicate a greater discrepancy between the actual self and ideal self, and greater importance put on such discrepancy, both indicated on a four-point Likert scale. Reliability of the Hungarian version was appropriate in a past study (Emanuelson et al., 2015; Tihanyi, Böör, Emanuelson, & Köteles, 2016) and also good in the present study (Cronbach α : 0.81).

The Positive and Negative Affect Schedule (PANAS) (Watson, Clark, & Tellegen, 1988) includes two independent scales rated on a five-point Likert scale. The negative affect scale measures the general dimension of subjective distress that contains a variety of aversive mood states (fear, nervousness, anger), while the positive affect scale assesses the extent to which a person feels energetic (alert, enthusiastic). In the current study, the short (5-item) version of the scales was used (Thompson, 2007). The Hungarian version of this scale had acceptable internal consistency (Gyollai, Simor, Köteles, & Demetrovics, 2011). In the current study, Cronbach α coefficients were 0.72 and 0.71, respectively.

Mindful Attention and Awareness Scale (MAAS) (K. W. Brown & Ryan, 2003). The 15-item scale measures the extent to which one is able to focus on the present moment in an open and non-judgmental way. Each of the items is stated inversely using a 6-point Likert

scale (from almost always to almost never) asking the respondents about how often they find themselves acting automatically, inattentively or being preoccupied. The Hungarian version had a good internal consistency (Cronbach's $\alpha = 0.78$) in earlier studies (Simor, Petke, & Köteles, 2013; B. T. Tihanyi, Böör, Emanuelsen, & Köteles, 2016). In the present study, the internal consistency of the scale was 0.86.

Spiritual Connection Questionnaire (Wheeler & Hyland, 2008): This scale assesses an aspect of spirituality that is consistent with religious and nonreligious (e.g., New Age) interpretations of spirituality, namely the importance, experience and beliefs of spiritual connection to e.g. an inner power, interpersonal energy, ultimate force. Participants respond to the 14 items on a 7-point scale, and high scores indicate greater spirituality. The scale was found to be unidimensional, and to have high internal consistency ($\alpha = .97$) and retest reliability ($r = .99$) (Wheeler & Hyland, 2008). The Hungarian version had a good internal consistency (Köteles & Simor, 2013b), Cronbach α was 0.95 in the present study.

Patient Health Questionnaire Somatic Symptom Severity Scale (PHQ-15) is a 15-item scale which measures the prevalence of the most common body symptoms (e.g. headache, stomach ache, feeling tired and trouble sleeping) on a 3-point Likert scale. PHQ-15 was proposed as a diagnostic tool for a broader category of somatoform disorders (Kroenke, Spitzer, & Williams, 2002). The Hungarian version showed good psychometric properties in previous studies (Köteles & Simor, 2013a). Cronbach α was 0.81 in our sample.

Interoceptive sensitivity is characterized most often by heartbeat detection ability. Accuracy in perceiving heartbeats was measured here using a modified version of the Mental Tracking Method (Emanuelsen et al., 2015; Ferentzi, Drew, & Köteles, 2016; Schandry, 1981). Following a 15-second test trial, participants were asked to count their heartbeats for intervals of 30 sec, 45 sec, and 100 sec, with a 10 second break in between the estimates (intervals were arranged randomly). The experimenter counted the participants' actual heartbeats using a Polar watch (model RS-400) with a chest strap. All subjects were asked to breathe at a regular pace during the tracking intervals. Accuracy of heartbeat detection in a given session was calculated using the following formula:

$$1 - |(recorded\ heartbeats - counted\ heartbeats) / recorded\ heartbeats|$$

Interoceptive sensitivity was calculated as the mean score of three (30 s, 45 s, 100 s) heartbeat perception intervals, higher scores indicate higher levels of accuracy. Interoceptive accuracy was measured in the university group only.

Attention-related body sensations: Participants were asked to focus on a freely chosen body part (e.g. hand, ear) with closed eyes and to report on 1-item yes-no question whether the sensation from the chosen area had changed (e.g. tingling) as a result of paying attention to it (Tihanyi 2016). It was only assessed in the online group.

Sport and body-mind activity was assessed by asking questions about the weekly frequency of practice of sport (anything the participant thought to be a physical activity or sport) and body-mind method (defined as any kind of activity where body attention and inner concentration played a role, examples were autogenic training, relaxation, yoga, tai chi, meditation, contact dance), and the duration of one session. These questions were answered only by the online group. Then we calculated, how many hours were spent by sport and body-mind practice in an average week. Since the mental effect of sports and body-mind methods, especially regarding BA was found to be linked to the frequency of practice and not the years spent with practicing (Benedek T. Tihanyi, Sági, et al., 2016), we characterized these activities by the hours spent with practicing in an average week.

1.3. Data analysis

Data analysis was conducted using SPSS v21 software. The Hungarian version's factor structure was investigated using exploratory factor analysis (EFA; principal axis factoring with oblimin rotation). Since age, gender, and most of the psychological measures (BAQ, PANAS, but not BRQ) were non-normally distributed, non-parametric correlations were used to estimate the relationships between body responsiveness and BAQ, PANAS, sport activity, body-mind activity, heartbeat detection accuracy, and the attention-related body sensations. The Spearman rho values between these variables were then entered in a partial correlation analysis which controlled for the effect of age, gender, and group affiliation (Conover, 1999).

Mediation analyses tested whether the connection between body awareness and affect (positive and negative) is mediated by body responsiveness. A bootstrapping method was used, which does not require normal distribution for any variables, but still shows if the regression coefficient between the independent and the dependent variable is significantly changed (decreased) after including one or more (mediating) variable(s) (Preacher & Hayes, 2008).

2. Results

2.1. Sample characteristic

Overall, 402 (64.4% females; mean age: 28.5 ± 11.72 years; range: 18–69 years) individuals participated in the research. Regarding the on-line group, one hundred twenty-four subjects reported to have any body-mind experience, and 68 of them reported to practice some body-mind method presently. For descriptive statistics see Table 3.

2.2. Structure and reliability

The exploratory factor analysis revealed a two-factor structure that was identical to the English version. Correlation between the two subscales was negligible (-0.038) (see Table 1.). The I-subscale showed acceptable internal consistency in the total sample, as well as both the on-line and the university groups, and the internal consistency of PD subscale was acceptable in the total sample and the on-line group, but not in the university group (Cronbach α 0.83, 0.82 and 0.83 for I-subscale, 0.69, 0.72 and 0.63 for PD respectively). The correlation between the items and the total subscale score is showed in Table 2.

2.3. Descriptive Statistics and Convergent validity

The descriptive statistical data of the assessed scales are presented in Table 3. All scales had a non-normal distribution (Shapiro-Wilk 0.899-0.992, $p < 0.05$), except for BRQ in both scale, and BA, mindfulness, spirituality in the student group.

According to the correlational analysis of the total sample (see Table 4.), total BRQ score (BRQ-total) correlated positively with body awareness, positive affect, mindfulness, spirituality, body-mind practice (e.g. yoga), negatively with negative affect, and physical symptoms. No significant correlation was found between BRQ-total score and cardioceptive sensitivity, attention-related body sensations, sport activity, and body image dissatisfaction in the total sample. Regarding the difference of BRQ-total in the two groups, the body image dissatisfaction correlated negatively with BRQ-total of online adults, while positively with BRQ-total among university students. The university group showed higher BRQ-total and BRQ-I than online participants. No other important difference was found between the BRQ-total score's correlation regarding the two groups. Regarding the two

subscales, BRQ-I (positively keyed when counting BRQ-total) and BRQ-PD (reversed when counting BRQ-total, unreversed when used separately) in the total sample, BRQ-I showed a significant positive correlation with body awareness, sport activity, body-mind practice (while BRQ-PD not), and BRQ-PD showed a significant positive correlation with physical symptoms (while BRQ-I not). A discordant correlation (I-subscale and unreversed PD-subscale both showed positive connection) was found in the case of attention-related body sensations and spirituality. Positive and negative affect, and mindfulness showed significant concordant correlation (connection to BRQ-I and BRQ-PD had opposite sign).

Age of online group was not significantly correlated with BRQ, while age among university students showed a positive correlation. Being female was linked to higher scores on BRQ-total and BRQ-I in the online group.

2.4. Mediation

According to the mediation analyses (see in Table 5.) adjusting for age, gender, and group affiliation, BRQ-total is a significant mediator between body awareness and affect, although in the case of both positive and negative affect this was just a partial mediation, since the direct connection between body awareness and positive affect remained significant. Mediating effects calculated for the two subscales separately were not significant.

3. Discussion

The Hungarian version of the Body Responsiveness Questionnaire (BRQ) showed the same two-factor structure as the original version: importance of interoceptive awareness in guiding behavior (BRQ-I, positively keyed when counting BRQ-total), and perceived disconnection between body and mind (BRQ-PD, reversed when counting BRQ-total). Both subscales had acceptable internal consistency. Convergent validity was found to be good: based on the correlational analysis of the total sample, total BRQ score correlated positively with body awareness, positive affect, mindfulness, spirituality, body-mind practice (e.g. yoga), negatively with negative affect and physical symptoms. In the case of body image dissatisfaction, attention-related body sensations and spirituality, both BRQ subscales showed a positive connection, thus they neutralized each other's effect when calculating the total score. However, no significant correlation was found between any of the BRQ scores and cardioceptive sensitivity. According to our mediation analyses adjusting for age, gender, and group affiliation, BRQ-total is a significant mediator between body awareness and affect (positive and negative).

The two subscales of BRQ were not correlated in the present study, which suggests that this construct covers two independent factors: (1) the tendency to integrate body sensations into conscious awareness, and not to suppress or react impulsively to them (reversed PD-subscale), and (2) the tendency to let body sensations guide decision making and behavior (I-subscale) (Daubenmier et al., 2013). It is still an open question, if the lack of connection found here reflects a real conceptual difference, or origins from other biasing factors, e.g. response set (Herzberg, Glaesmer, & Hoyer, 2006), since now all PD-subscale items are reversed, while all I-subscale items are positively keyed. Based on our findings on the factor structure together with the different correlational pattern found in our convergent validity analysis, we recommend that future researchers examine the two subscales separately. Our results suggest that the ongoing education of the university group

on sport, health and recreation and physical trainings of these students might increase year-by-year BRQ, and cease gender differences. While in the mixed online sample, closer to the average population, BRQ is lower, not connected to age, and women showed higher scores on BRQ-total and BRQ-I.

According to the embodiment paradigm, most content of the mind can resonate and be felt somehow in the body, and analogously, every body sensation or process can evoke an emotion or thought in the mind (Gendlin, 1984). Still, BRQ clearly uses a dualistic language (talking about body and mind separately), which is nevertheless understandable, since presently that is a more dominant paradigm, and therefore more comprehensive for most of the subjects. Body awareness (as assessed by the BAQ) showed a moderate positive correlation to BRQ-I, but not to BRQ-PD. This means that, in our sample, those who reported themselves to be able to perceive, interpret, and predict body states and processes reported to let more of this bodily information guide behavior, but did not report stronger unity between body and mind. This result is plausible since subjects using a disembodied, dualistic paradigm to describe themselves can still report that their body and mind (although experienced as separated entities) can interact strongly in both direction, i.e. the body is perceived precisely by the mind, and the mind is guided heavily by the body. Interestingly, BRQ-PD covers rather the attitude to radically favoring the mind (against the body) as an aspect of the self which is wiser, more trustful, more true, although the opposite attitude (favoring body over mind) would be a disconnected, dualistic and not-embodied attitude again, involved unclearly in the PD-subscale.

The lack of connection between BRQ and heart-rate detection ability in our study suggests that those who can monitor and perceive the cardiac activity accurately will not necessarily trust their own body and experience a connection between body and mind. Even the connection of interoceptive sensitivity and self-reported body awareness is questionable (Ainley, Maister, & Tsakiris, 2015; Emanuelsen et al., 2015). As well as the intention to define body awareness as based on interoceptive stimuli, since somatic experiences are also shaped by top-down processes (Pennebaker, 1982), moreover, perceiving a body sensation is possible even without any interoceptive input (H. D. Brown, Kosslyn, Delamater, Fama, & Barsky, 1999; R. J. Brown, Brunt, Poliakoff, & Lloyd, 2010), for example by the means of the as-if-body neural loop within the brain (Bechara & Damasio, 2005). This raises the possibility, that the term 'body' in the expressions of body awareness and body responsiveness could not only mean the organic, physical part of oneself, but also a projective surface where mental processes (emotions, thoughts) can be manifested.

Our results are in accordance with previous findings showing a significant correlation between BRQ and affect (Impett et al., 2006). Moreover, body responsiveness was a significant mediator of the connection between body awareness and affect. This finding suggests that those who stated to be more sensitive to body sensations and attend to them more regularly were found to report more positive emotions (e.g. feeling energetic, proud, strong) and less negative emotions (e.g. afraid, nervous, ashamed), and this connection was mediated by BRQ. This is in line with former suggestions, namely that a higher awareness of body sensations, together with a stronger perceived connection (and coherence) between body and mind and a behavior taking account of body signals, supports behaviors which satisfy more psychophysiological needs, which leads to a better mood (Farb et al., 2015; Fogel, 2013). However, the causal link might not just start from body awareness towards positive affect, it can also be directed the other way round, or a circular causality can also be hypothesized. For example, positive emotional states, especially feeling safe was found to support body awareness, while negative emotional states, especially fear was found

in cases to dissociate body from mind, close the interoceptive pathways and allocate attention to the outer world (Fogel, 2013). Other variables which could mediate the connection between body awareness and positive affect at least partly independently from body responsiveness are body posture, basic respiratory pattern, health behavior (e.g. sport and body-mind activity, nutrition, sleep hygiene), social support, traumatic experience, perceived body symptoms and diseases. On the contrary, BRQ mediated completely the connection between body awareness and negative affect, which means that all the possible mediating variables were covered by the construct of body responsiveness in our sample. The finding that the correlational coefficients tended to be higher between I-subscale and positive affect, and PD-subscale and negative affect might reflect on the use of reversed items in the case of PD-subscale.

In the on-line sample body image dissatisfaction was not connected to I-subscale, but was connected positively to PD-subscale, supporting the notion that in average sample body disconnectedness and dissatisfaction are connected. Surprisingly, in the case of the university sample, higher body image dissatisfaction appeared together with higher importance of body signals to guide behavior, but was not connected with disconnectedness. This could mean that in this sample, taking into account body sensations and bodily intentions was motivated partly by dissatisfaction or shame.

In the case of attention-related body sensations, measured only in the online sample, a discordant connection was found, i.e. both BRQ-I and BRQ-PD had a significant positive correlation with it. It is easy to interpret, that those who regularly use body signals to guide behavior can connect more easily to subtle body sensations, or 'evoke' them by focusing attention on the body (Benedek T. Tihanyi, Köteles, et al., 2016). The positive connection between perceived body-mind disconnectedness and attention-related body sensations might be caused by a lack of or lowered actual interoceptive input, which gives space to top-down processes (evoking body sensations by attention, imagination) and as-if body experiences, or might be understood by noticing that attention-related body sensations had been also linked to discharges caused by anxiety and other negative emotions, or a numbness to cover body sensations from mind (Benedek T. Tihanyi, Köteles, et al., 2016). Spirituality showed a similar discordant correlation with the two BRQ subscales. The connection between I-subscale and spirituality could possibly reflect to a general experience of interconnectedness, between body, mind, other beings and objects. Regarding the positive connection between perceived disconnectedness and spirituality, since the correlation was the strongest with the item 'My mind and body often want to do two different things', it might suggest that those with higher spirituality are more sensitive to moments when body and mind seem to disconnect and disagree; PD-score does not show if a subject can manage such perceived disconnection and reconnect and integrate body and mind. It is important to note, that body responsiveness total score showed no or weaker connection with body image dissatisfaction, attention-related sensations, and spirituality, since I-subscales and PD-subscales correlations neutralized each other when the two subscales were summed, which highlights the usefulness of examining the two subscales separately in future studies.

The aspects of body responsiveness were integrated in other scales since the publishing of BRQ, e.g. a multidimensional scale of body awareness (MAIA) (Mehling et al., 2012), and mindful self-care, representing the "daily practice of being aware of the physical and emotional needs, and behaving to meet these needs", has also inspired a scale, whose psychometric validation is under process (Webb, Wood-Barcalow, & Tylka, 2015). Body intelligence was also assessed by a self-report questionnaire, defined as "the awareness and

use of bodily sensations to (a) support health and well-being, (b) supply information about environmental safety and comfort, and (c) enhance personal and spiritual development over a lifetime” (Anderson, 2006). Even a multi-dimensional questionnaire of experienced embodiment was conceptualized, which involved the connection with the body, agency and functionality, attunement and self-care, experience and expression of desire, and inhabiting the body as a subjective site (Teall, 2006). Future studies might examine the relationship between these constructs, and might create a multidimensional scale for body responsiveness, analogous to the one for body awareness (Mehling et al., 2012).

The most important limitation of the present cross-sectional study is that it could not reveal the causal direction of the reported connections. During the correlational analysis numerous statistical tests were performed, therefore a correction (e.g. Bonferroni) could help to clarify which coefficients’ significance were likely not just by chance. Moreover, our sample was not representative, thus the generalizability of the results is limited, even though the effect of gender and age was controlled. Participants completed the questionnaire online, therefore the conditions of answering were not controlled, although the mode of data collection was controlled in the analyses. Furthermore, as a self-report questionnaire, the BRQ can assess the self-perceived importance of body signs in guiding behavior and the disconnectedness, which would be interesting to compare with scores given by outer observers of the subjects.

In conclusion, our findings are in accordance with previous results, and together they suggest that higher body responsiveness is connected to (1) higher self-regulation: not just recognizing (body awareness), accepting (mindfulness) inner needs, but also integrating, and satisfying them, (2) increased positive affect and decreased negative affect, (3) increased self-acceptance, self-care (sport activity and body-mind practice), decreased body dissatisfaction, (4) connectedness to others and the universe (spirituality) (Daubenmier, 2005; Fogel, 2013). Our results can inspire and support future studies investigating the body-mind interaction, somatic psychology, assessing the effectiveness of various body-mind interventions (somato-psychotherapy, bodywork, sport) and follow body-related psychiatric patients (body image disorder, alexithymia, somatoform disorders) to include the BRQ.

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Appendix 1.

The Hungarian version of the Body Responsiveness Questionnaire (Daubenmier, 2005)

Testi válasz-készség skála

értékelés: 1 (*egyáltalán nem igaz rám*) ... 7 (*teljesen igaz rám*)

1. Biztos vagyok abban, hogy a testem (szervezetem) tudatja velem, hogy mi a jó nekem.
2. Testi vágyaim olyan dolgokra sarkallnak, amiket végül megbánok.
3. Az elmém és a testem gyakran két különböző dologra akar tenni.
4. Elnyomom a testi érzéseimet és érzeteimet.
5. Odafigyelek a testemre, hogy tanácsot adjon nekem, hogy mit tegyek.
6. Fontos számomra, hogy tudjam, hogyan érez a testem a nap folyamán.
7. Élvezem, amikor tudatába kerülök annak, hogyan érez a testem.

I tételek: 1, 5, 6, 7.

PD tételek (BRQ totál pontszámhoz megfordítandó): 2, 3, 4.

Tables

Table 1. Factor matrix of EFA (principal axis factoring with oblimin rotation)

Item (subscale)	1st factor	2nd factor
1. (I) I am confident that my body will let me know what is good for me.	0.53	
2. (PD) My bodily desires lead me to do things that I end up regretting.		0.63
3. (PD) My mind and body often want to do two different things.		0.85
4. (PD) I suppress my bodily feelings and sensations.		0.52
5. (I) I 'listen' to my body to advise me about what to do.	0.78	
6. (I) It is important for me to know how my body is feeling throughout the day.	0.91	
7. (I) I enjoy becoming aware of how my body feels.	0.74	

Table 2. Corrected item-total correlation for the two subscales (I and PD)

	Corrected item-total correlations
Items of I-subscale	
1.	0.49
5.	0.68
6.	0.78
7.	0.67
Items of PD-subscale	
2.	0.52
3.	0.59
4.	0.41

Table 3. Descriptive statistics (mean, standard deviation) of the variables for the two groups separately. N.M.: not measured

	On-line group (n = 242)	University group (n = 160)
Gender ratio (females)	78.7%	42.5%
	Mean ± std. deviation	Mean ± std. deviation
<i>Age (years)</i>	32.9±13.21	22.0±2.81
<i>Body responsiveness</i>	4.6±0.91	4.7±0.78
<i>BRQ-I</i>	4.5±1.24	4.9±1.04
<i>BRQ-PD (unreversed)</i>	3.4±1.27	3.6±1.09
<i>Body awareness</i>	4.8±0.85	4.8±0.70
<i>Body image dissatisfaction</i>	6.1±1.87	6.6±2.30
<i>Positive affect</i>	3.6±0.62	3.5±0.86
<i>Negative affect</i>	2.1±0.72	1.9±0.71
<i>Physical symptoms</i>	1.5±0.33	1.4±0.33
<i>Mindfulness</i>	3.9±0.74	4.0±0.60
<i>Spirituality</i>	4±1.65	3.8±1.29
<i>Sport activity (hours/week)</i>	6.3±17.45	N.M.
<i>Body-mind practice (hours/week)</i>	0.7±1.96	N.M.
<i>Interoceptive sensitivity</i>	N.M.	0.6±0.23
<i>Attention-related body sensations</i>	0.6±0.49	N.M.

Table 4. Spearman correlation coefficients with significance between BRQ-total, BRQ-I and BRQ-PD subscales and variables controlled for age, gender and group affiliation, in total sample, online sample and university sample. N.M.: not measured

	<i>BRQ-total</i>			<i>BRQ-I</i>			<i>BRQ-PD</i>		
	<i>total</i>	<i>online group</i>	<i>university group</i>	<i>total</i>	<i>online group</i>	<i>university group</i>	<i>total</i>	<i>online group</i>	<i>university group</i>
<i>Group affiliation</i>	0.15***			0.20***			0.01		
<i>Age</i>	0.41**	0.03	0.27***	0.29*	-0.01	0.22**	0.11	-0.07	-0.24***
<i>Gender</i>	0.06	0.11*	0.11	0.03	0.11*	0.08	-0.05	-0.05	-0.06
<i>Body awareness</i>	0.39***	0.42***	0.34***	0.46***	0.47***	0.45***	-0.07	-0.10	-0.02
<i>Body Image Dissatisfaction</i>	-0.02	-0.12*	0.13*	0.1*	0.03	0.21**	0.17***	0.25***	0.05
<i>Positive affect</i>	0.23***	0.28***	0.2**	0.2***	0.19**	0.24**	-	-	-0.07
							0.19***	0.27***	
<i>Negative affect</i>	-0.27***	-0.3***	-0.21**	-0.1*	-0.09	-0.09	0.33***	0.37***	0.25***
<i>Physical symptoms</i>	-0.17***	-0.15*	-0.17*	-0.02	0.03	-0.08	0.27***	0.31***	0.21**
<i>Mindfulness</i>	0.27***	0.34***	0.15*	0.11*	0.15**	0.01	-	-0.4***	-0.24**
							0.34***		
<i>Spirituality</i>	0.24***	0.25***	0.22**	0.41***	0.45***	0.32***	0.12**	0.15*	0.08
<i>Sport activity</i>	0.12	0.11	N.M.	0.16*	0.14*	N.M.	-0.02	-0.03	N.M.
<i>Body-mind practice</i>	0.24***	0.23***	N.M.	0.27***	0.25***	N.M.	-0.03	-0.04	N.M.
<i>Interoceptive sensitivity</i>	0.05	N.M.	0.03	0.10	N.M.	0.04	-0.01	N.M.	0.01
<i>Attention-related body sensations</i>	0.03	0.03	N.M.	0.15**	0.14*	N.M.	0.11*	0.10	N.M.

*: $p < 0.05$, **: $p < 0.01$, ***: $p < 0.001$.

Table 5. Descriptive statistics (mean, 95% confidence intervals, standard error) of the indirect effect of body awareness (independent variable, IV) on dependent variables (DV) mediated by body responsiveness, and the coefficient and significance of the direct effect, calculated from 1000 bootstrap samples for the two mediation analyses. Total sample involved, effect of age, gender, and group affiliation was controlled for.

<i>Dependent variable</i>	<i>Mediator</i>	<i>Mean of the Indirect Effect</i>	<i>95% CIs</i>	<i>SE</i>	<i>Model summary (R-Direct effect of IV on DV)</i>	
<i>Positive affect</i>	<i>BRQ</i>	0.036	0.013 - 0.635	0.013	0.084***	0.085**
	<i>BRQ-I</i>	0.019	-0.011 - 0.053	0.016	0.06***	0.101***
	<i>BRQ-PD</i>	0.004	-0.005 - 0.016	0.005	0.085***	0.118***
<i>Negative affect</i>	<i>BRQ</i>	-0.058	-0.086 - -0.035	0.013	0.12***	0.013
	<i>BRQ-I</i>	-0.016	-0.046 - 0.018	0.016	0.06***	-0.03
	<i>BRQ-PD</i>	-0.007	-0.028 - 0.012	0.01	0.16***	-0.04

*: $p < 0.05$, **: $p < 0.01$, *** $p < 0.001$.

Sexuality, Spirituality and the Body: The Art and Science of Somatic Psychotherapy A Review Nancy Eichhorn

International Body Psychotherapy Journal *The Art and Science of Somatic Praxis*
Volume 16, Number 1, Spring 2017 pp 74 - 76. ISSN 2169-4745 Printing, ISSN 2168-1279 Online
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Sexuality and spirituality are not typically spoken about in the same stance, even less so in the psychotherapy room. Talking about clients' religious and spiritual beliefs and using them as a therapeutic tool remains controversial. Freud considered exploring a client's religious/spiritual beliefs potentially beneficial in the same vein as one explores fantasies and illusions—to move from the unscientific analysis of what's occurring in a client's mind to accessing the more scientific/deeper truths of the psyche (Kersting, 2003). While Oxhandler, Parrish, Torres and Achenbaum (2015), in their recent study on the value of religion/spirituality in the therapeutic process, learned that 80% (of the therapists interviewed) responded that it was useful only a minority said they used it in practice.

As well, sex is still an uncomfortable topic for many clients, and, in fact many therapists, to address (Harris & Hays, 2008; Weaver, 2012). It's not necessarily clear "what constitutes sexual issues (considering there is a wide range of acceptable sexual behaviors, experiences, and attitudes in the modern world), and possibly a lack of guidelines for how to address sexual issues that may be occurring in client relationships" (Weaver, 2012). At times, as well, clients may confide sexual concerns, whether regarding their own sense of sexuality or sexual dysfunction, but most therapists are not trained in this field of study; perhaps lost in their own discomfort and confusion with the topic, therapists may refer their clients to specially trained "sex therapists".

Yet, The United States Association for Body Psychotherapy's Summer 2016 conference boldly focused on Sexuality, Spirituality and the Body: The Art and Science of Somatic Psychotherapy.

Attendees—152 in total—traveled from as far as Japan to network with colleagues in the fields of somatic psychology and body psychotherapy. The conference offered participants the chance to experience a sense of coming together on diverse topics to find common ground as well as to promote this field of study and give body psychotherapy a bigger voice worldwide. Both USABP President Beth Haessig and USABP Vice President Dan Mingle, MBA acknowledged the association's positive position as the "hub of everything somatic". They noted the Association's growth citing membership (including institutional memberships), their new administrator Linda Heck (who did an excellent job putting the conference together and running it in Rhode Island) and their redesigned website.

The three-day conference integrated body based activities (such as bio energetics and yoga) with keynote addresses and workshops ranging from sensual and sexual experiences to sexual and spiritual messages in the body and integrating spirituality in body psychotherapy. Workshop titles included (but were not limited to): healing the trauma of sexual abuse through the synergy of talk and touch; sexuality and the sacred; the heart of integrating sexuality and spirituality; sexual

pleasure in light of intersubjectivity, neuroscience, infant research, relational psychoanalysis and recognition theory.

There was also space for poster presentations and discussion, and professional recognition. Denise Saint-Arnault, PhD, RN shared her research on mind-body and culturally-tailored-interventions to promote mental and physical health for women from a variety of cultures. Robyn Flaum Cruz, a professor of expressive therapies and a dance/movement therapy instructor, was honored with the Alice K. Ladas Research Award, and Eugene Gendlin received the USABP Life Time Achievement Award, which Ann Cornell Weiser accepted on his behalf.

Three Keynotes

Dr. Barratt challenged the audience with his philosophical perspectives on the significance of “bodymind” visioning for the profession and the planet. A self-proclaimed “radical” currently teaching/living in South Africa, Dr. Barratt was quite clear that too many diverse perspectives on what healing is as well as far too much divisiveness in our movement (body psychotherapy) perplexed our system. We need a unified vision, he said. Per Dr. Barratt, few health care practitioners know what healing is, mistaking it as manipulating or changing something—adapting to the environment. Healing, he said has an inner meaning. It is holistic and addresses the irresolvable concepts of life and involves movement of subtle energy.

He discussed cultural impacts and cultural divisions (i.e., class, race, social economics) and the impact of subjugation and domination on the healing process—I’m here to heal you (the “otherness” inherent in the language alone). Denial is not the answer—it only serves to perpetuate the imbalances already in place, he said, then explained that life is suffering and we will not escape suffering because of our egotism, our dividedness. Our need to dominate perpetuates suffering, he said. We can’t abolish the differences between cultures; we cannot homogenize cultures any more than we can deny differences between species, between the sexes, between children and adults, he said. He stressed that our focus must be on how to relate to differentiation, not only in healing but also across our profession.

Joan Borysenko arrived late and exhausted due to an airline crisis yet shared such pertinent information with such passion that she received a standing ovation (and some hands-on energy work at the end of her session). Dr Borysenko’s career started in science and research. Intrigued by the nature of the mind and body, she joined others investigating mindfulness and the concept that the mind and body are embodied and embedded in our relationships. She discussed traits/qualities that facilitated healing relationships, including empathy and love and then offered the impact of stress on the body/mind (noting the ACE Study—adverse childhood experiences— conducted by Kaiser Permanente in the late 1990s). She spent much time on what she considered the biggest news of the decade in the field of bodymind science—the mighty microbiome.

According to Dr. Borysenko, we have three genomes: our parents, our epigenome and our microbiome where our genetics/genes are present in gut bacteria. In fact, “three pounds of beasties have an ecosystem (in our gut) that function to”: keep our gut lining intact (leaky gut syndrome can result in autoimmune diseases); regulate our weight and our immune function; reduce inflammation, and regulate mood by making neurotransmitters. She shared information about new uses of “poop” and the new medical practice of using “poop donors” for fecal transplants to cure C-Difficile. According to Dr. Borysenko, when babies are born via C-section, they do not get the transfer of bacteria from the mother, which leads to mental health problems—the bacteria are important to our neurotransmitters.

Dr. Borysenko indicated that diagnoses of anxiety and depression are increasing in our culture because the food we eat changes the bacteria in our gut. We must talk with our clients about the food they eat, she said, because gut microbes shape human behavior. As an example, she recounted her and her husband's experience when they became "fundamentalist low fat vegans" because her husband's lipids were high. Calling the 'food' they endured for 14 months "organic cardboard", she said that they were so strict with their veganism they both became sick/sicker. Her concluding point was that no one diet fits all people—each body responds to food in its own way—and that as clinicians it is essential that we become aware of the interplay between nutrients and health (mental, physical and spiritual).

Michael Mannion discussed Wilhelm Reich, his work and his life. Per Mannion, Reich was "a pioneer in the scientific study of Life Energy" who "took this concept out of the realm of metaphysical and philosophical hypothesis and gave mankind a fundamentally new understanding of Life Energy as physical, demonstrable, measurable and usable." Mannion said that Reich's "study of energy—in the microscopic, macroscopic and cosmic realms—forced him to transcend the artificial barriers separating these disciplines." Mannion also offered that Reich coined the term 'Sexual Revolution' to describe the human struggle to create natural healthy love lives. Further, Mannion said that Reich fought for women's political and economic equality and reproductive rights, including contraception and abortion on demand. He advocated for sexual education for adolescents and their right to full sexual love lives.

In Conclusion

While the keynote addresses did not directly relate to spirituality or sexuality, the plenary session conducted by Barnaby B. Barratt, PhD, on "Is Our Access to 'God' Sourced in our Loins? The Spiritual Call of Sexuality and Death" in conjunction with the daily workshops (based on the titles) indicate an intersection between the two. Numerous experiential sessions were designed to explore the body and support one's sensual and sexual experience. Considering Dr. Barratt's spotlight on differences and homogenizing our cultural realities, it was a relief to see workshops offered dealing with LGBT issues, gender identity and sexuality, on somatic resilience in gay men, colorism, and erotic recovery. While these topics may not yet be easily integrated into the psychotherapy setting, it appears that the clinicians who are involved offer a safe and innovative container in which to explore.

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15th European Congress of Body Psychotherapy

The Embodied Self in a dis-Embodied Society

A Review

Nancy Eichhorn

International Body Psychotherapy Journal *The Art and Science of Somatic Praxis*
 Volume 16, Number 1, Spring 2017 pp 77 - 80. ISSN 2169-4745 Printing, ISSN 2168-1279 Online
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It's been said that the power of dance is beyond words. For many, dance constitutes a ritual, a core element of religion, as well as part of celebrations honoring all that encompasses our lives. From our earliest beginnings dance has symbolized the conscientious presence of life—people have danced their way through war and peace, through marriage and separation, through the annual planting and reaping of the harvest.

In ancient Greece dance was considered a sacred activity of great importance, even the stars and planets were said to perform a cosmic dance of their own. To dance, together, in circles, symbolized the cohesion of the community.

This tradition of dance—the embodiment of culture, tradition, unity and community—symbolized the 15th European Congress of Body Psychotherapy in Athens, Greece.

Throughout the week-long event (counting two pre-conference and one post-conference days), dance punctuated important moments of connection offering comradeship, integrity, and at times levity. Celebration and honor, gratitude and acknowledgment, connection to self and with others were all part of the dance. Professional differences were even bridged as a room designed for a capacity of 50 bulged with more than 150 rambunctious participants there to learn traditional Greek dances; the circles interwove so close many a toe was stomped by mistake with apologies and hugs flowing freely. People left with a sense of community.

The Congress not only signaled the sharing of theoretical and scientific considerations and methodological explorations and expansions, it also heralded the General Assembly vote and public acceptance of a new EABP Board of directors with Carmen Joanne Ablack now president, Sladjana Djordjevic General Secretary, Thomas Riepenhausen Treasurer, and David Trotzig joining the Ethics Committee.

Outgoing EABP President, Lidy Evertsen, opened the congress. She welcomed not only some 500 participants (who traveled from as far away as Uganda, Pakistan, Iran, the United States of America and Canada and included 300 non-EABP members), but also Greece's Minister of Health who came because of his interest in body psychotherapy and how it contributed to psychotherapy in Greece, in general. The number of Greek participants was simply overwhelming; this conference earned the record for the largest number of local attendees.

The Congress Committee's Herculean efforts to present this year's event during a time of intense financial crisis and immigrant chaos even included emailing the Greek Air Traffic Controllers Association, as its members had threatened a multi-day strike that in

turn threatened attendance at the conference—no planes would mean no people. Sofia Petridou, Chair of the Congress Organizational Committee and Chair of the Greek Association for Body Psychotherapy (PESOPS) personally wrote the email explaining potential ramifications not only to the conference but to all community members in Athens and beyond. The strike was averted and an air traffic controller representative offered a gracious response to Petridou's email. Petridou also stepped beyond the basics and contacted a wealthy Greek patron-of-the-arts, who in turn donated funds for the opening night cocktail party that highlighted traditional music and cultural dancing along with Greek libations. The sense of offering, of giving of the self to better society was felt in many ways throughout the conference. Even the Congress advertising materials—images used for posters, handbook covers and so forth—involved a search for imagery to best reflect ancient Greece and its culture of the body, how embodiment was expressed through statues during the Hellenistic period. Visiting the National Archaeological Museum for inspiration, Petridou saw Poseidon, noted his posture and his role of governor of the unconscious but then she saw Aphrodite and Hermes. The two statues faced each other, leaned in toward each other, offered both the Hellenistic and Roman eras—different energies were represented while the statues were placed to allow dialogue and connection. The choice was made.

As for dialogue, Greek history is noted for orators who made the most of their creative skills within the concept of dialogue. To further support conference dialogues, translators worked in soundproof booths at the back of the room, translating on the spot. Multiple languages were offered so participants could hear the address or offer their voice in their primary language. A robust round of applause for the translators enthused the conference closure.

It felt as if the Congress committee's positive and supportive energies infused participants with the same sense of presence and opening. Whereas at Congresses in the past, where road blocks were common place, where separation and individuation were at times maddeningly apparent, the overarching feeling during Keynote speeches, pull-out sessions, roundtable discussions and outside seminars felt support--presenters mentioned one another's work--and peaceful, as if olive branches cloistered the rooms indicating acceptance and surrender. One flare-up between two roundtable participants on the use of the word 'intervention' to describe the work body psychotherapists do was tempered as Gill Westland, founding director of Cambridge Body Psychotherapy Centre and author of *Verbal and Non-Verbal Communication in Body Psychotherapy*, stood and offered: "The words we use have enormously different meanings that have an impact. We have to be careful how we use them. We need to unpack the words, see what individuals mean. Otherwise, things get charged without understanding." The energy shifted in the room, the process back to productivity rather than two men going to wits over a word.

Creative Scheduling

The layout for the conference proper was creatively composed. Wake-up sessions—e.g. body awakening, Tai Chi, Energy Dance—were offered on the roof of the Titania hotel, with 360 panoramic views of Athens, including the Acropolis (which, at night, when the Parthenon and the Temple of Athena Nike were lit up, well the view was stunning). In this same vein, mini-sessions for body connection and movement were guided by congress volunteers throughout the main addresses (idea-wise good, in function, a bit chaotic as

people left the room and others coming in resulted in, resulting in discord in an otherwise smoothly flowing program). The morning keynote addresses stood solo while after lunch there were auditorium presentations and workshops. A buffet was included for two days that allowed participants to use the time to network rather than scramble to find sustenance. The Scientific and Research Symposium and the Psychotherapy and Politics Symposium took place on Saturday with workshops offered as well. If the quality of the workshops presented matched those given by Christina Bader-Johansson (Embodiment—BPT for Beginners), Stig A. Hjelland (Mindful Authentic Movement), and Noa Oster and Shinar Pinkas (Soul Retrieval), then it is safe to say the materials informed, enlightened, and awakened an embodied presence in those in attendance.

To try and describe every keynote, every symposium, even some of the workshops is beyond the scope of this conference review. Suffice it to say that in reflection on this year's keynote addresses, those who used lots of big words that: (a) needed to be defined; (b) were used to differentiate one's process rather than to create a foundation for commonality and understanding; and (c) who wrote a paper then stood behind the podium reading at a quick clip with either an occasional reference to a Powerpoint or even read aloud what was on the screen, missed the opportunity to engage and interact with their audience.

Some speakers, however, stood out. Maxine Sheets Johnstone emphasized that we enter this life moving (*we, who are alive, are not 'still' born*) and even in silence there is movement not stillness. Genovino Ferri clearly owned his topic; his passion vibrant as he walked about the front of the auditorium. And Judyth O. Weaver stressed the importance of bringing prenatal and perinatal experiences into “body” psychotherapy—we can't leave out the importance of early (even preconception) imprints when supporting our clients' growth and healing. Christine Caldwell, PhD, founder and former director of the Somatic Counseling Psychology Program and Dean of Graduate Education at Naropa University in Boulder, Colorado, USA, and innovator of somatic work she calls moving cycles, stood with the audience, in front of the tables, the podium, the stage. She paced her voice, her words easy to follow as she offered new ideas and challenged existing paradigms. She even earned an appreciative applause when tears welled in her voice and in her eyes as she said, “Terrible things are happening in this world (*today*) obscuring the fact that racism is a visceral experience we must not look away from.” She spoke of the importance of moving out loud, of the body speaking, narrating its story and not being interfered with by the violence of an interpretation (from the therapist). That is, letting the body sequence its story on its own terms . . . not say this is about, not create a restricted or oppressive verbal narrative on top of it. She noted an important sense of agency and ownership—my body is moving versus I am moving my body, to reconfigure the body narrative in relational aspect in therapy. Further, the energy during the round tables on *The Female Body in Society and Psychotherapy*, the *Concept of Energy in the Process of Embodiment: An Interdisciplinary Approach* (Francois Lewin drew a hearty round of applause) and *Common Ground in Body Psychotherapy* kept participants engaged (and in the room) while other presentations had fewer people; with other workshops juxtaposed during this time, it was not surprising.

During the closing ceremony, Petridou noted that attendance exceeded their anticipations and that “we all know nothing can be perfect in this life” as the rooms were often filled beyond capacity and presenters made due without the necessary technical equipment. Then, she stepped out of her own patterning and said, “For the first time in my life, I will do something different. I always leave myself back. This time I would like to thank ‘little Sofia’

NANCY EICHHORN

for her enthusiasm and love for fellowship as well as others who supported her by all means. I also thank my husband who, for the past two years, without protest, accepted my absence, supported my efforts.”

With plaques, flowers, paintings, kind and gracious words, and much applause, the conference closed. Pantagiotis Stamboils, Chair of the Congress Scientific Committee summed up the finale succinctly, humorously, “This,” he said, “is gratitude therapy.” And then, of course, people started to dance.

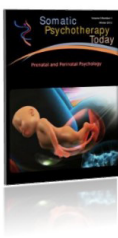
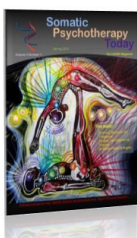
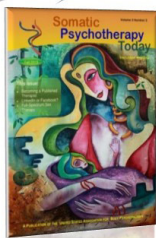
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BIOGRAPHY

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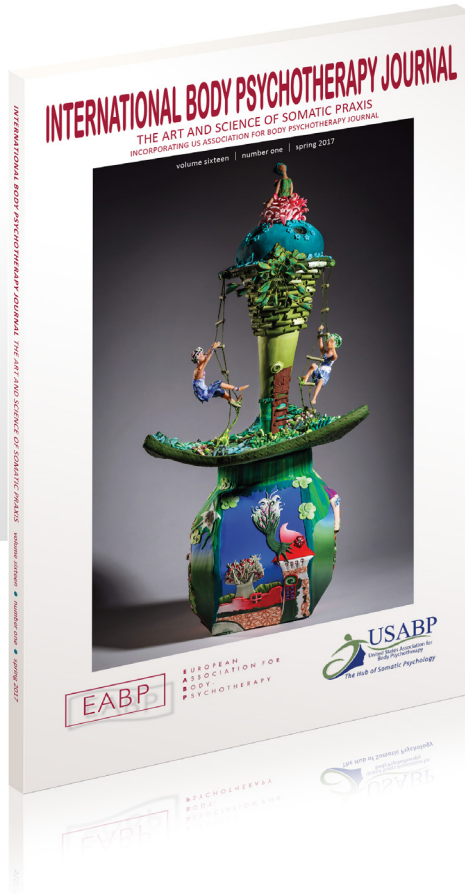
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