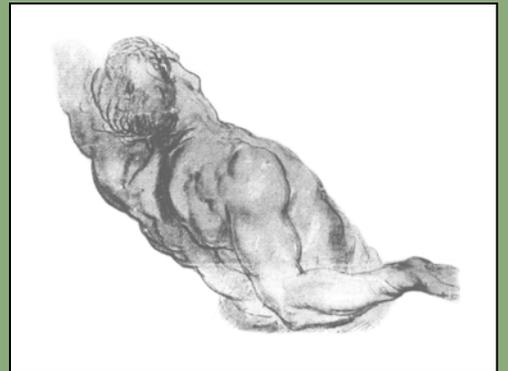


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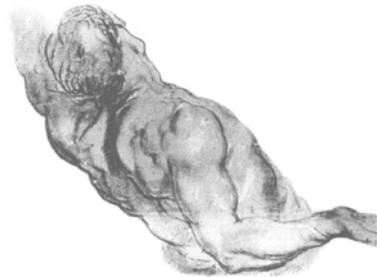


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USABP Mission Statement

The USABP believes that integration of the body and mind is essential to effective psychotherapy, and to that end, its mission is to develop and advance the art, science, and practice of body psychotherapy in a professional, ethical, and caring manner in order to promote the health and welfare of humanity. (revised October 1999).

Listening to the Body Pragmatic Case Studies Of Body-Centered Psychotherapy

Amelia H. Kaplan, Psy. M. and
Laurie F. Schwartz, M.Th., M.S.

Abstract

Body-centered Psychotherapy (BcP) is a developing field of academic investigation. The present research employed the Pragmatic Case Study Method ("PCS Method") for systematically studying how verbal and somatic interventions are combined in a single therapy in two 12-session cases seen by an experienced BcP therapist. Following the PCS Method, the cases begin with a presentation of the therapist's theoretical approach, or "guiding conception," and a description of how it is applied to each client. The data analyzed in each case include videotapes and transcripts of selected therapy sessions; pre- and post-therapy scores on standardized, quantitative measures; a pre- and post-treatment goal-setting interview; and a semi-structured, post-therapy, outcome interview. The results revealed substantial progress and statistically-significant quantitative changes in both clients. Additionally, distinctly different patterns of progress occurred, as the therapist tailored therapy in accordance with the needs of each client.

Body-centered Psychotherapy (BcP), also known as "Body Psychotherapy" and "Somatic Psychology," is a developing branch of psychology based on the vital connection between psychological symptoms and physiological states. Although many non-BcP therapies attend to bodily experience, what distinguishes BcP as a unique subfield within psychology is the centrality of somatic sensory experience throughout diagnosis, formulation, and treatment (e.g., see such pioneer therapists in the field as Ferenczi, 1953; Kurtz & Prester, 1976; Lowen, 1958; Reich, 1945). Additionally, physical touch is more often used by BcP therapists, even though many BcP therapists do not use touch or only introduce it tangentially.

The most comprehensive set of references to BcP exist on a CD-ROM Bibliography developed by the European Association of Body Psychotherapy (Young, 2005). There exists extensive literature on the healing power of touch (Field, 2001; Harlow, 1974; Montagu, 1971) and on touch in psychotherapy (Hunter & Struve, 1998; Smith, 1985; Smith, Clance, & Imes, 1998), yet Somatic Psychology has mostly been developed clinically. May (2002) conducted a comprehensive literature search over the previous 30 years and found 23 empirical BcP studies. A brief review of such studies follows.

The first major prospective clinical trial is currently underway in Germany and Switzerland (Koemeda-Lutz et al., 2003). In this study, eight major BcP outpatient clinics are measuring clients to study the effectiveness of BcP under natural conditions. Preliminary results are promising, finding that after six months of BcP treatment (n=78), small to medium effects were reported across all clinical categories.

Ventling and Gerhard (2000) conducted a retrospective study of 319 former patients to study outcome and stability of the efficacy of Bioenergetic therapy with adults in a private practice setting. Drawing from the patients of sixteen certified Bioenergetic therapists, the authors collected data from former patients who had a mean of 91 sessions (modal 26-50 sessions), and who terminated therapy between 6 months and 6 years previously. The responses demonstrated that for 107 (75%) of the patients, Bioenergetic therapy proved effective to very effective and that the results had lasted from at least 6 months to 6 years.

Several studies have investigated the outcome of BcP using case study designs. Bourque (2002) collected pre and post-test data on four chronic pain clients who engaged in eight weekly "Somatics" sessions and found statistically significant decreases in pain and increases in pain-free activities in three of the four subjects. Employing a qualitative analysis of a single case, Bridges (2002) found that Bioenergetic therapy addressed the client's "somatic defenses against affect" and significantly increased affective expression in a short-term psychodynamic treatment (McCullough et al., 2003a). Finally, also studying a single case, Price (2002) examined the effects of adding an 8-week adjunctive BcP therapy alongside an ongoing verbal psychotherapy for a woman with childhood sexual and physical abuse. The client demonstrated significant improvement on such standardized quantitative measures as the SCL-90-R (also used in the present study) in such areas as depression, anxiety, and obsessive symptoms, as well as decreases in her physical symptoms. In addition, the client qualitatively reported improvement in "feelings of safety, ability to tune in to internal processes, and ability to access emotion."

A recent meta-analysis of massage therapy (MT) research, drawing from a wide range of sources (psychology, nursing, medicine, and kinesiology), found MT significantly effective for both physiological and psychological outcomes (Moyer, Rounds, & Hannum, 2004). Additionally, reductions in trait anxiety and depression were MT's largest effects, similar to those found in psychotherapy meta-analyses. The authors speculate that combining massage and psychotherapy may significantly increase effectiveness more than either alone.

The present research builds on previous systematic, empirical studies to help fill the need for many more such investigations in BcP in order to create a solid scientific foundation for the field. Specifically, this investigation

includes in-depth, systematic case studies involving qualitative process compared with standardized quantitative measures to examine how BcP integrates the body into psychotherapy, as seen through the work of Laurie Schwartz, M.S., L.M.T. (Licensed Massage Therapist), a widely known BcP practitioner with 25 years of practice in the field. The main questions guiding this study include: What does BcP therapy look like? What themes in BcP therapy are unique or distinguishing? And how does BcP therapy integrate talk and touch in a unified therapy? In addition, by looking at what is distinctive about a BcP approach, this study can begin to contribute to the questions of whether it is effective to combine talk and touch in a single therapy, and if so, what are the mechanisms of change in such a therapy.

METHOD

Conceptual Design

The present study uses the Pragmatic Case Study Method (The “PCS” Method) to study BcP systematically in detail and in context (Fishman, 1999; 2005; Peterson, 1991). Through methodical and rigorous case studies, the PCS Method offers a structured way to investigate what about BcP treatment is distinctive and useful. It does this through the process of Disciplined Inquiry, a method of action-research that includes both quantitative and qualitative data in order to study how a psychological service such as a BcP practitioner can meet the needs of clients.

As shown in Figure 1 below, the Disciplined Inquiry Model calls for description of a client’s situation and presenting problems (A), then a setting forth of the practitioner’s “guiding conception” (B). The guiding conception is the overarching theory a practitioner brings to his or her work, as informed by previous research and clinical experience (C). The guiding conception is then traced as it interacts with the specific needs of the client, through the steps of assessment (D); formulation, including treatment plan (E); action, or intervention (F); monitoring evaluation and feedback (G); possible recycling through earlier steps (H-K); and concluding evaluation (L). The feedback processes are essential, action-research components of the Disciplined Inquiry Model. In the present project, the methodology is being pilot-tested with three case studies, however due to space limitations, only two cases are outlined in this paper.

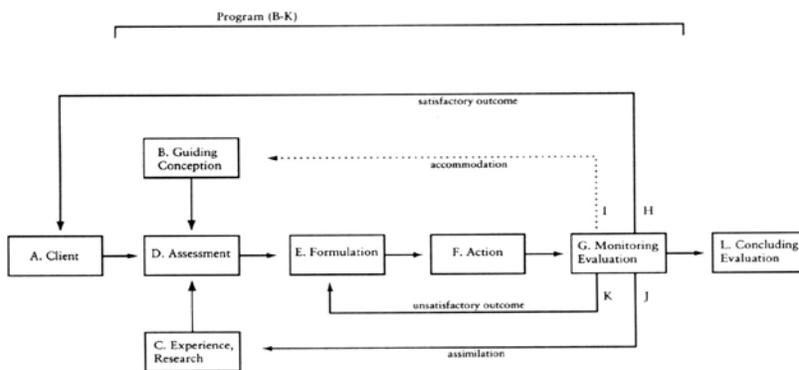


Figure 1. Professional Activity as Disciplined Inquiry
(adapted by Fishman (1999) from Peterson, 1991).

Following the PCS Method and Disciplined Inquiry model, the first step in this investigation was explicitly documenting Laurie Schwartz’ “guiding conception,” which includes her theoretical assumptions concerning problem assessment, goal setting, techniques, treatment plan, and intervention (Peterson, 1991). This documentation was completed by the first author based on a series of interviews with Ms. Schwartz, hereafter referred to as “the therapist.” The second step was examining how the therapist’s guiding conception played out in three of her cases, two of which are included in the present report.

Research Design

The two research subjects are individuals from the therapist’s referral network. To participate in the research, these individuals could not have crisis conditions, e.g., suicidality, severe depression, and intense difficulty with separation. The first 12 sessions of therapy were offered at a reduced fee in exchange for participating in the research protocol. When the client was suitable for the study, the researcher (the first author) met with the subject to review the consent form as well as administer the assessment measures. Subjects were also apprised of the role of videotaping sessions. In writing up the cases, all names and identifying information

have been changed. The study was approved by the Institutional Review Board of Rutgers University in September, 2003.

Before treatment began, the subjects met individually with the researcher. At that time, they each completed several self-report measures, which included: the Treatment Evaluation and Management (TEaM) Scales for assessing symptomatology and life functioning (Grissom, G.R., Lyons, J.S., & Lutz, W., 2002); the Symptoms Checklist 90-Revised (Derogatis, 1993); a Scale of Bodily Connection (Price, 2004); and an interview-based goal measure, Goal Attainment Scaling (Kiresuk, Smith & Cardillo, 1994). Since treatment was meant to occur naturalistically, at the initial interview, subjects were instructed that if the measures evoked any reactions or clinical details, they should explain them directly to the clinician.

Within the study, each subject received 60 minutes of treatment per week for 12 weeks. Although treatment in the cases was open-ended, only the first twelve sessions were included in the research. The BcP sessions consisted of focused, body-oriented psychotherapeutic techniques and psychoeducation, e.g., subjects were asked to attend to their internal physical sensations for cues to their mental states.

At the end of the treatment (or the end of 12 sessions), subjects were administered the same measures to evaluate their current level of functioning and whether they experienced any changes from the treatment. Subjects were also interviewed to determine their subjective experience of the treatment process and symptom change. The objective measures (both pre- and post-treatment) were sealed and kept in a locked cabinet until the completion of the case analysis, after which they were viewed and compared with the other data as a source of reliability information and quality control. In other words, the quantitative measures functioned as an independent source of data with which to compare the qualitative results.

Data consisted of a series of process and outcome measures, as well as transcripts of the videotaped sessions. The videotapes themselves were a crucial source of information (Alpert, 1996; McCullough et al., 2003b) - both as independent sources of data and additionally through the therapist and researcher together reviewing the videotapes of these sessions to articulate how the therapist's guiding conception interacted with the presenting problems and goals of the subject, and how she integrated that information into her theoretical intent which guided the next interventions.

Data Analysis: A Framework for Presenting and Analyzing Each Case

For the qualitative analysis, selected sections of each subject's treatment sessions were reviewed together by the therapist and researcher during which the practitioner discussed her guiding conception and elaborated on the treatment process. The researcher and clinician identified 19 themes that are involved in the theory of a BcP treatment. The researcher selected three core themes related to the interaction of verbal and somatic interventions to guide cross-case analysis. Due to the extensive amount of data, the narrative analysis was limited to sessions 1, 6, and 12, which were analyzed in depth. For the pre- and post-therapy quantitative data, the statistical test that was most appropriate to the case study was the Reliable Change Index (RC) developed by Jacobson and Truax (1991).

Laurie Schwartz's Guiding Conception ("B" and "C" in Figure 1)

A Model of Health

As mentioned above, following the PCS Method, the first step in understanding a case is to set forth the guiding conception of a therapist, including related research and experience. In the therapist's theory of BcP, the ideal of health is for a client to move towards a more related way of being with one's self and body, aware of sensations, feelings, and thoughts, while staying related to other people. This therapeutic model draws from psychodynamic developmental theory, including object relations and self-psychology elements focusing on the mother-infant dyad (Aron & Anderson, 1998; Schore, 1994).

In the therapist's theoretical framework, individuals have a core essence which, given supportive conditions in infancy, guides the person's development into a fully-formed healthy adult. If children are loved and nourished, then they can be creative, feel seen, have social engagement; they learn that their needs can be met, that they can express themselves, and successfully follow their impulses. If the parent is relaxed and grounded and gives the infant a feeling of containment, the infant has a chance to become "oneself" - a person who learns that there is a boundary around itself as separate and not just as an extension of another person. All of these help a child feel happy.

As studies have shown (Porges, 1997; Tronick, 1989), much regulation of affect occurs between caretaker and infant (Schore, 1994). A large part of a child's self, including the ability to self-regulate its own nervous system, develops in this dyadic connection (Schore, 1994; Tronick et al., 1998). It is through this relational process that children develop a sense of self as well as a self in relationship, a concept which forms the backbone of the therapist's method of BcP work.

Since much communication between mother and infant is somatic and non-verbal, it is in this early stage of development that persons learn to self-regulate, i.e., modulate their affective levels within their nervous systems. The goal is to encourage health by helping people self-regulate and enjoy emotional resiliency (Caldwell, 1997). Biological self-regulation means that a person's nervous system can fluidly go through states of activation and discharge (Levine, 1997). Emotional resiliency means the ability to let emotions flow through one's system without having to act on them impulsively or deny them by blocking or repressing. Health also has an interpersonal aspect, as well as a somatic component. Health is being able to "be" in one's body, name feelings verbally, move in a fluid way from one feeling state to another, discriminate and make decisions freely, tap into creative inspiration, and self-regulate one's nervous system. Therefore, health involves learning to remain in one's body consciously while staying in relation to others.

Dysfunction in Development

Due to genetic, biological, societal, and emotional factors, many people grow up not to be embodied or grounded. This means these people do not allow (or do not know how to allow) their selves to be nourished. Often the results of inadequate "holding" by caretakers, lack of mirroring, and not enough experience of feeling separate and contained are found in the body, which must overcompensate in order to hold the "self" together. The "armoring" of the body - the holding patterns that often make up a person's rigid or collapsed body posture - can result from these early psychological deficits (Kurtz, 1990; Reich, 1945). One of the therapist's main tenets of practice is making characterological patterns conscious through mindfulness.

Based on Buddhist meditation practice and a central tenet of Hakomi therapy (Kurtz, 1990), mindfulness is an awareness-based state of consciousness in which a person has heightened attentiveness to his or her inner states, without judgment. Mindfulness usually occurs with clients' eyes closed as they look inward and stay present for whatever thoughts, feelings, memories, images, impulses, and sensations emerge moment-to-moment. The therapist's theory of change focuses on helping a person understand and heal the wounds of an infant/caretaker breach by encouraging clients to witness, experience, and understand their habit patterns and how they are organized, in order to change them. If a person can get into a state of mindfulness, she or he can come to observe beliefs and habit patterns manifest in the body through physical behaviors and gestures -- and in doing so access a core self (Kurtz, 1990).

Yet clients who cannot access mindfulness often have serious trauma histories resulting in severe hypervigilance (e.g., the case of Jan). In the therapist's model, trauma is conceptualized as energetic impulses frozen in the nervous system without discharge (Levine, 1997; van der Kolk, 1994). When events cause enormous "shock trauma" (e.g. rape, violent attacks, military action, disasters, accidents, etc.), they flood and override the coping of the nervous system. Levine (1997) describes how unlike animals who shake off the freeze through twitching, shaking, or moving, which helps them regain their normal function, often humans do not move through the survival response to resolution. People impacted by traumatic experiences, if they cannot metabolize them cognitively, emotionally, and sensorily, remain "frozen in time" (van der Kolk, 1994).

The focus of trauma-oriented work is therefore to bring the nervous system back into biological self-regulation by completing the frozen response. The therapist follows Levine's model of going step-by-step through the "felt sense" of bodily sensation so clients learn to stay in their bodily sensations as well as learn the language of sensation (i.e., tingling, freezing). The therapist believes clients can be helped to resolve trauma by slowing them down so their bodies can complete defensive orienting motor responses (Levine, 1997). Unblocking frozen trauma in the nervous system often involves such physical discharge as heat, sweating, palpitations, shaking, and twitching.

It is not, however, enough to experience one's bodily sensations. A lot of the therapist's work therefore involves helping clients to relax in their bodies, because if a client cannot access relaxation, then they cannot work at the levels of high excitation of trauma without fear and tension overtaking them. Therefore, the first aspect of the therapist's work is to teach her clients to access their inner resources, i.e., experience positive feelings of relaxation and grounding. If they were to tell their stories without such bodily grounding, they would merely be reliving the trauma sensations without any healing effect.

Physical Touch

To understand the role of touch in the therapist's guiding conception, it is important to understand there is a direct connection between mindfulness, awareness of sensation (for healing trauma) and touch. Awareness of

inner bodily sensations does not come naturally to many people who are traumatized or characterologically cut off from their bodies and bodily sensations. Touch is used as an important technique for teaching clients awareness of their own body sensations, i.e. their “felt sense.” Often without any physical touch, people can stay largely cognitively oriented, cut off from much of their experience. Touch can therefore help clients develop a sense of their inner sensory world, and thereby develop kinesthetic and body ego.

At the beginning of therapy, the therapist prepares clients for the touch component in her treatment, and revisits their comfort and safety frequently. As discussed in the therapist’s consent form: “Touch may be used as an ‘experiment in mindfulness’ to support (‘take over’) physical protective posture. Nothing will be done without your approval and your sense of feeling safe and right about it. You are invited and encouraged to discuss openly and freely with me any question or concern you might have about the process we are in together at any time.”

It is unusual for the therapist to touch a client within the first few sessions, as it takes time for appropriate safety to develop in the alliance and to understand how touch technique will interact with a client’s needs. The therapist emphasizes being in the moment with the client and following the needs of her client, trying to let the client’s unconscious lead the way. In the therapist’s own words, “I don’t force myself to diagnose or analyze a client right away - if you are in the present moment and have implicit trust in the body, and you partner them moment to moment, then memories that are stored in the cells of the body will reveal when the person is ready.”

Assessment

The researcher categorized aspects of the therapist’s assessment of a client’s embodiment:

Essence: Where is this person in relationship to self? To caretakers? How far is this person from the ideal notion of health?

Biological: Is this person able to regulate biologically? Does this person know what self-regulation looks like and feels like?

Embodiment: How are they connected to and with their body? Where is energy moving or not moving in their body? Are they able to stay in their body?

Sensation: Are they aware of sensation? –e.g., my jaw is tight, my upper body feels empty, my lower body feels like lead. Are they able to ground in sensation?

Affect: Can they be in a feeling state? Can they articulate a feeling state? Do they have emotional resiliency? Can they be in touch with all their feelings and still function?

Cognitive: Can they identify thoughts and beliefs that are influencing their daily life?

Family systems: What are the developmental experiences and memories that are affecting their sense of self? What affecting them might be generational?

Goals/Intentionality: What would you like to work on today? i.e. where are they in their life journey and what would be helpful in this stage?

Consciousness/Awareness - How much awareness does this person have? Where is their awareness of their feelings, my presence - who am I to them?

Mindfulness: Are they capable of mindfulness? Are they capable of tracking? How do they feel about going into mindfulness, especially closing their eyes?

Formulation and Diagnosis

To create a formulation, the therapist uses four kinds of questions: Does the client know how to be grounded? What is missing for the client at the level of bonding? What is the intention of the client? Can the client access mindfulness? Due to the therapist’s holistic focus, she does not use traditional DSM-IV-TR diagnoses. The diagnoses in the cases were formulated by the researcher.

Treatment Plan

The therapist focuses her BcP treatment plan on four different levels:

The Developmental Level: The therapist identifies and supports clients’ unmet developmental needs, to learn to nourish and develop in ways they were not able to at a young age (i.e., a person who did not have enough contact learns to “hold herself” and someone without enough mirroring learns to affirm himself). She helps clients make the unconscious conscious.

The Trauma/biological Level: She works with clients to come out of trauma reactions and re-regulate their nervous systems.

The Characterological Level: She often works to attend to habit patterns so clients can understand their characterological organization.

The Dream/Spirit Level: She works with dream analysis and imagery to access formerly inaccessible beliefs, feelings, and behaviors. She follows the psychodynamic principle that such access leads to more healthy control and life choices.

RESULTS

Case Analysis Themes

From the initial analysis of the case material, the researcher and therapist inductively derived 19 themes. Three themes were chosen due to their salience in addressing how to combine talk and touch in a single therapy.

Theme 1: Helping Clients Feel “Nourished” by Their Internal Resources

This theme refers to the therapist bringing clients’ awareness to a positive, nourishing aspect of their lives (e.g., loving feelings, a calming image of the ocean). It could be through thought, feelings, imagery, etc. As discussed above in the section on the therapist’s guiding conception, only when people are grounded in a way that they can connect with their internal resources can they tolerate the difficult sensations of trauma and enjoy nourishment without trauma. Too often the work of verbal psychotherapy has been problem or deficit-focused. BcP’s emphasis on working with the bodily experience of positive feeling and the sensations that get in the way of enjoyment offers a major paradigmatic shift in treatment. Empowering clients with tools to access nourishment and find inner resources themselves appears to be one of the most important aspects of BcP.

Theme 2: Using Physical Touch

The hypothesis that touch can provide a healing modality which is different or adjunctive to talk is the theme that originated the study. Some questions: How does a BcP therapist use touch in a therapy? When does she touch the client, at what points in treatment, and what is the client doing that leads to wanting to touch? What are the constraints? How does the therapist introduce it? Does that change as clients get used to touch?

Theme 3: Working with Narrative Versus Body

This theme involves how much to focus on body-oriented techniques versus working within a client’s narrative in the treatment. The therapist’s guiding conception includes the belief that a client must be adequately grounded before telling a trauma narrative, yet at times clients will seem more inclined to “figure out” through talk, which may appear at odds with the therapist’s body-orientation. Often some struggle exists between therapist and client around talking versus focusing on the body.

The Case of Jan

Jan, a 49-year old Caucasian Catholic twice-divorced professional woman, presented with long-term symptoms of tension and anxiety around sexual and physical abuse by her father. She had no explicit memories of sexual abuse, but had vague memories of being struck from behind by her father, as well as strong fear sensations in her body of possibly having been a victim of incest. Jan suffered from chronic anxiety and neck pain. She was a successful professional woman, yet had been in two failed marriages. Several years previously, Jan made a commitment to “get off toxic relationships” and heal herself. At the time of referral, Jan had been in verbal therapy for about five years, and additionally was seeing a bodyworker for about two years for chronic neck pain. With consent of Jan’s two other therapists, the therapist worked alongside them as a co-therapist offering her sensory-oriented, trauma orientation. Jan maintained all three appointments weekly; and all therapists were informed of the activities of the others.

Jan’s tense and rigid posture and flat affect were important themes throughout treatment. Jan chose this treatment at a time when she was trying to turn her life around. She had a long-term interest in artistic and spiritual pursuits; and during the treatment she remained focused on her art and her spiritual growth, including planning a career change to the healing arts. During the early sessions of therapy, the therapist described what became a

recurring theme: “Jan’s decided to stop the re-enactment. She is just learning to trust people. She’s dealing with trust, love, and mutuality. Can she allow more emotional connection?” Jan showed little affect and made few relational comments except when she was discussing her artwork. At those times she would begin to laugh and beam with joy. Of the three clients examined in this study, the therapist assessed that Jan appeared the most impaired, most traumatized in her body as well as interpersonally.

Jan’s case is distinctive for this type of work since she was expert at tracking and articulating her bodily sensations. In fact, she often got so involved in her moment-by-moment sensory experience that there was little place for emotion or relationships. Therefore, unlike the psychoeducation around finding sensation that often involves much of the treatment, in this case much of the therapist’s work was to bring Jan to a feeling of safety within her body so that she could begin to relate externally with others again.

History of Client (“A” in Figure 1)

Jan was the youngest of three siblings of an intact family. Her father was a well-respected medical doctor, who due to his professional career, caused the family to live for several years on the grounds of a mental hospital. Jan has come to understand that she probably suffered in childhood from some kind of anxiety disorder, which remained undiagnosed despite the fact that both parents were in the mental health field. She remembers her father as being cruel and short with her; her few memories of outright physical abuse are being hit from the back. Her mother she considered the enabler; she would watch and not intervene.

She has functioned well professionally, but has had unsuccessful relationships, keeping two husbands solvent, as they remained gainfully unemployed. Several years ago, after her second husband emptied their bank account, she finally resolved to bring her attention and energy to herself. She entered verbal therapy, which led to a conjoint referral for energy/body work to relieve some of her intense neck pain. Over the course of this treatment, she found the therapist, and embarked on a third journey into healing her trauma.

Assessment (“D” in Figure 1)

Qualitative Assessment

The therapist’s assessment was that Jan was not calm and grounded: her body seemed frozen and constricted. Jan appeared to live in her body “with a lot of tension in her joints and tissues” suggestive of long-held trauma. Her speaking style was rapid and flat, without much affect or relational sensibility, often interjecting comments throughout the therapist’s speech. The therapist assessed that Jan must be able to find her internal calm and remain grounded before she could open up her trauma narrative (Theme 1). A major challenge would be to learn how to work with Jan’s rigidity and how physical touch might be useful and appropriate (Theme 2). At the same time, however, Jan was very aware of her bodily sensations. She had an amazing ability to track her sensations. Yet Jan would often stay almost entirely in her bodily experience, unconnected to her narrative or relationships in her life (Theme 3).

Quantitative Assessment and Goals for Treatment

On the SCL-90, Jan’s initial scores according to the computer-generated clinical report were in the “clinical range” of at least ten points above the mean on several subscales, including Anxiety, Paranoid Ideation, and Psychoticism. (See Tables 1 and 2 for Jan’s pre and post treatment scores.) Her high levels on all three symptom indices: the Global Severity Index, Positive Symptom Distress Index, and Positive Symptom Total Index reflected the severity of her initial symptoms. Her TEaM responses reflected Jan’s high levels of vocational, social, and personal functioning, which was consistent with her active professional life. On the Scale of Bodily Connection, Jan’s scores reflected hypervigilance of her internal sensations and a difficulty with experiencing inner pleasure.

Jan identified three goals in the Goal Attainment Scaling procedure. The first involved connecting more with actual, vivid childhood memories of her abuse instead of her previous vague sensations. She also hoped to be able to express her anger in constructive ways, by speaking up in her relationships. Third, she found that one way she monitored her obsessive fear was “making lists” upon waking in the morning. Jan’s goal was to feel less of this anxious fear, which she would know when she made fewer lists.

Formulation (“E” in Figure 1)

The therapist formulated that Jan lived in a state of hypervigilance prepared for intense threat, fearing that if she were to relax and enjoy herself, her father might enter the room and hurt her. This hypervigilance and interpersonal fear kept Jan from feeling safe in relationships. These dynamics were reflected in the Paranoid Ideation and Interpersonal Sensitivity scores of the SCL-90. In terms of a treatment plan, the therapist

hypothesized that in order for the therapy to address the interpersonal part of Jan's experience, first Jan had to come back into biological self-regulation.

DSM-IV-TR Diagnosis

Axis I: Generalized Anxiety Disorder 300.02
 Post-traumatic Stress Disorder, Chronic 309.81
 Axis II: R/O Schizotypal Personality Disorder 301.22
 Axis III: Neck pain
 Axis IV: Memories of childhood physical and sexual abuse
 Axis V: GAF= 55 (Current)

Action ("F" in Figure 1)

Session 1: "Creating a Manger of Safety"

In this session, Jan was very hypervigilant, saying immediately "yes" or "right" after the therapist's sentences. The therapist's dominant strategy for this session was to join with Jan in an attempt to educate and slow her down so she could get into mindfulness. The therapist used her tone of voice to help Jan access her felt sense, and together they discovered how Jan was organized. The therapist used a lot of imagery with Jan. They worked on helping Jan find her inner resources (Theme 1) through an image of Jan inside the Christmas manger she had created with a community of healers, as well as getting in touch with a bodily based "energy fluid" that Jan described. By the end of the session, Jan is able to voice: "My whole being hurts."

Laurie: And you think your neck hurting is connected to that?

Jan: Mm-hmm. **And I keep thinking that my father's going to show up and tell me that, you know...there's something wrong with what happened, and I should be happy and I should be taking...you know...doing something for them, or something like that. [sigh]**

L: So that's the thought you have. Your father will show.

J: That he'll appear... and he'll...

L: And if he would appear, he would say to you?

J: Yeah...or 'What the hell do you think you're doing?!' That's what he usually... 'What the hell do you think you're doing?!' I don't know where he would go after that. I mean...the thing about it is, he'd have to...**He's in his late 70's and he would have to fly here. And then he would have to get past my doorman...I mean, you know [laughs] But it doesn't help me any. I continue to have that emotional sense that he's going to do that. It's an intellectual... Yeah, intellectually I know that... but emotionally, my body...it's really my body...It isn't even my emotions, but it's my body is just, like, getting ready for him to come. And so I can't enjoy myself. I can't relax and just be in the present.**

L: So you're always anticipating being threatened.

J: Mm-hmm.

L: That someone is coming...

J: Mm-hmm. Yes.

Session 6: "Fear of the Naked Lady"

By this session, Jan is fully engaged in the treatment. She has experienced some important shifts in her awareness. In the beginning of this session, Jan comes in with a memory of father coming to hit her, which indicates an important change for Jan. This was one of the first vivid specific memories she has ever had of her father abusing her. Jan is excited by the spontaneous way it emerged, which also indicates a change in the therapy.

L: Okay. So it's a big week?

J: Yeah, yeah. Just a lot. Yeah, and I wanted to tell you about this memory that I had this morning...it was really unusual because the other memories that I had before I would describe as body memories where I physically remember the impact of it, like you know in the past I'll be laying on the floor or sitting in a chair resting comfortably and then I'll feel in my flesh how my flesh felt when he was hitting me. I don't have a recollection of when or where or anything else but I just feel it in my flesh. Okay, and so I write that down.

L: And when did you...?

J: But today, so today this is a different thing. So here I am walking to come here and thinking about what's going on and all of a sudden I get this, I have this really clear recollection of a minute, a second and a half or two seconds of him being here, so I can see his head and I see his hand coming at me and hitting this side of my head really hard and then I keep...what I wrote down is my neck creaks so I didn't break my neck but I can sense and

hear my neck creaking with this. Ok. It's very much from the hits coming this way and going like that. Remember how we were going like that?

L: Yeah.

J: It's like I see . . . What's really startling for me is that this is a visual, there's a sense of it, but I see him. Yeah, kind of what's been really noticed this week is that I feel, the way I said it, it's hard for me to articulate, but to try to say it is that I feel more connected to my fear, to my frenzy. From the past, whatever this is, I recognize there's nothing to be afraid of right this minute. So I feel more connected to this. It's sort of like I feel much better because I'm more connected but I feel I'm really aware of how agitated I am and how afraid I am, so it's kind of like...So I've been kind of in this place where I feel agitated and yet I feel much more peaceful on the other hand because thank god I'm more connected.

Also in this session, Jan has a powerful memory of being a small girl living on the mental hospital grounds and being startled by a mentally-ill naked woman. She remembers not shrieking, instead remaining silently afraid. Here is an important example of a trauma symptom frozen in the nervous system: It is as if all these years Jan was shrieking on the inside, yet never actually expressed or completed the shriek.

J: See now I'm having the, well I can just hear myself shrieking and just screaming.

L: Okay, so we're going to go slow. So as you start to feel the comfort in the palms of your hands and in your ankles you can remember or hear the voice of you shrieking.

J: Mm-hmm.

L: And do you have a sense of what age? Were you a little girl?

J: Mm-hmm. I don't know if I really shrieked or if it's just like I wanted to shriek and it's sort of like, I don't know you know what I mean, I can't tell that..

Jan is starting to understand how remaining frozen in this silent, never-spoken shriek has cut her off from a lot of nourishment (Theme 1), and how she had to be vigilant since no one was protecting her. The therapist works with her to imagine the healthy parent. The therapist also initiates physical contact by suggesting it, but given Jan's high level of arousal merely sits next to her on the couch without any touch contact (Theme 2). In working in mindfulness, the therapist sat next to Jan, who is tense and rigid, without touching her. With her level of somatic trauma and rigidity, that's enough contact for Jan. They do not discuss it and simply talk about Jan's body sensations (Theme 3) as she becomes more grounded.

Session 12: "Moving into a New House"

In this final session for the study, Jan reported feeling in a "new house" of her body. She described feeling a different sense of embodiment, in which she is "lower on the treadmill." Finally, to illustrate how the alliance and Jan's experience in her body has shifted, Jan allowed the therapist to initiate physical touch with Jan's neck and the occipital base of her skull (Theme 2). By the end of the session, Jan felt physically "contained" and was able to access her positive internal resources throughout a difficult focus on fearful memories of her father (Theme 1).

Concluding Evaluation ("L" in Figure 1)

Quantitative Results

Table 1

Jan SCL-90-R Results*

	Jan 1	Jan 2	Pt diff	RC**	Sig at p≤.05
Global Severity Index	67	58	9	-1.59099	
Positive symptom distress index	66	47	19	-3.35876	*
Positive Symptom Total	63	61	2	-0.35355	
Somatization	63	55	8	-1.41421	
Obsessive-Compulsive	57	57	0	0	
Interpersonal Sensitivity	69	60	9	-2.06474	*
Depression	60	58	2	-0.4	
Anxiety	74	63	9	-2.45967	*
Hostility	54	40	14	-2.6943	*
Phobic Anxiety	58	54	4	-0.83406	
Paranoid Ideation	71	57	14	-3.3955	*
Psychoticism	79	60	19	-3.96177	*

*All scores are T-scores with a mean of 50 and a standard deviation of 10. The SCL-90-R was normed on a nonpatient sample, with lower scores indicating healthier functioning

** Reliable Change Index (Jacobson & Truax, 1991).

Table 2
Jan TEaM results*

Subscales	Jan 1	Jan 2	Pt diff	RC	Sig at p≤.05
Subjective Well-Being	59.48	65.44	5.96	0.993333	
Depression	63.57	60.08	-3.49	-0.74407	
Anxiety	47.84	57.49	9.65	1.489027	
Phobia	46.75	50.71	3.96	0.571577	
Obsessive-Compulsive	49.48	53.32	3.84	0.64	
Somatization	59.65	59.65	0	0	
Panic Disorder	56.67	52.49	-4.18	-0.81977	
Post Traumatic Stress Disorder	45.11	49.16	4.05	0.640361	
Symptom Checklist	53.04	55.58	2.54	0.567961	
Personal Functioning	68.03	57.57	-10.46	-1.61401	
Social Functioning	62.24	58.01	-4.23	-0.56526	
Vocational Functioning	67.87	54.55	-13.32	-1.81262	
Functional Disability	68.09	56.05	-12.04	-2.12839	*
Behavioral Health Status Index	61.49	60.16	-1.33	-0.27149	

*All scores are T-scores with a mean of 50 and a standard deviation of 10. The TEaM was normed on an outpatient sample, with higher scores indicating healthier functioning. Because test-retest reliabilities were not available for the TEaM, internal consistency reliability of coefficient alpha was used to calculate RC, which is likely to be higher.

At the end of the 12 sessions, Jan's clinical profile on the SCL-90-R had gone down dramatically. Of the 12 scales, at post-treatment 11 decreased, and all 10 were under clinical levels (below 61). At the beginning of therapy, Jan's symptom picture had been in the clinical range. In the words of the SCL-90 computerized interpretive report, her Somatization had been "unquestionably in the clinical range"; her Anxiety was "consistent with the emergence of a psychiatric disorder of serious magnitude"; her Paranoid Ideation was "almost certainly associated with a formal psychiatric disorder which possesses clear paranoid overtones"; and her Psychoticism (indicating a withdrawn lifestyle) suggested profound alienation or "intense confusion." After treatment, she experienced statistically significant decreases in six subscales: Positive Symptom Distress Index, Interpersonal Sensitivity, Anxiety, Hostility, Paranoid Ideation, and Psychoticism.

Although Jan's results must be considered within the context of Jan's combined therapies, it can be noted that the mitigating variable within the twelve week time period was the introduction of the BcP therapy. Such statistically significant changes, which are consistent with her qualitative results, illustrate how Jan may have changed through BcP. For example, Jan experienced a significant decrease in her Anxiety scale, which included many somatic aspects of anxiety such as trembling and tension, as well as terror, apprehension and dread. This was a main focus for Jan in her work with the BcP therapist, thus providing an important corroboration of their therapeutic work. Jan's reduction in Psychoticism from 79 to 60 - her biggest change in T-scale points - could have been from the therapist's "validating" her body awareness and helping her to put this in perspective and not to be as upset by it. Additionally, Jan's Interpersonal Sensitivity subscale, referring to her self-consciousness, feelings of inadequacy, and marked discomfort during interpersonal interactions, decreased significantly at post-treatment. Given the centrality of relational problems for Jan, her significant drop is an important finding across her work in therapy. At post-therapy, Jan's Anxiety score of 63 is still "slightly elevated," suggesting continued difficulty, again consistent with the qualitative findings, but not to the extent it had been previously.

On the TEaM scales, six subscales increased and seven decreased, which indicates no clear pattern. The decrease in Jan's Functional Disability subscale was the only statistically significant finding. As often the case in psychotherapy studies, it is possible to interpret this finding as indicating that Jan may have been doing better by doing worse. Specifically, she was increasing her awareness of her symptoms, and in the past two weeks spending less time socially and more time experiencing her symptoms (crying, sleeping less). This interpretation is consistent with her qualitative data, which indicated that Jan was going through dramatic shifts in her awareness and internal experience at the end of the twelve sessions. It is for this very reason that the study allowed for a continuation beyond the twelve weeks. Jan intended to continue treatment. Allowing herself to feel "worse" seemed to indicate her commitment to working-through in the therapy.

While the Scale of Bodily Connection does not allow for statistical analysis, a content analysis of Jan's responses indicated an increase in her connectedness to her bodily experience. Additionally, Jan showed much more integration of her physical and emotional world in her responses. For example, on the item "I notice how my body changes when I am angry," she moved from "most" to "all of the time."

Results on the Goal Attainment Scaling indicated that Jan improved in relation to all three of her goals. She was more able to experience and express her anger in a healthy way by speaking up once a week, as compared with her baseline at the beginning of therapy of once every 3 months. She felt more relaxed and in control upon awakening, going from a baseline of obsessively making lists every day to three or more days per week not making such lists. Additionally, concerning memories of early abuse, she had a more complete memory of some of the early abuse than at baseline.

Qualitative Outcome Results: Exit Interview

Jan was ebullient about the therapy and the effects it has had on her experience of herself in her body. Particularly salient in Jan's analysis of her treatment was her emphasis that no single therapy alone would have been enough: "I feel much different than I did in December - a profound difference. I think the change is a result of my commitment to healing in combination with the variety of therapies that I am doing. I firmly believe it is the combination - one or another as a stand-alone would not have given me the results."

What was distinctive about the therapist's work with Jan was its emphasis on positive feeling and calmness. "What Laurie is doing is help me feel calm, deeply feel calm. What I notice is that I have a much greater sense of peace, calmness in myself." In her outside life, Jan noticed that she found herself having to lie down and relax, in a way she finds "very, very healing." At these times, she finds that, having internalized aspects of the therapist's work, her body is leading her.

Reviewing the Narrative Themes

Theme 1: Helping clients feel "nourished" by internal resources. At the beginning of treatment, the therapist witnessed how, immediately upon feeling happy or satisfied, Jan would freeze as if her father were about to come upon her. The therapist formulated that Jan was largely unable to access her internal resources without fear. Her treatment plan largely focused on: a) bringing Jan's awareness to her rigidity and embodied fear and b) helping Jan access an internal sense of calm and nourishment without feeling under threat.

Theme 2: Using physical touch. This case illustrates how, with minimal actual physical contact, a BcP therapist can still work with a body-orientation, using physically oriented language and imagery to help a client become embodied. Jan was often overwhelmed by the experience of physical closeness, so the therapist worked on just sitting next to Jan instead of actively touching her. Much of the contact involved the therapist placing her feet on top of Jan's for several minutes, to help her relax and feel grounded by connecting with her feet on the floor. Imagery also proved to be an important aspect of "feeling touched" without physical contact, which was very important in Jan's treatment. The therapist used imagery of protection to help bridge this gap in contact. Jan immediately responded every time, for example, one time bringing fantasy animals close to her; and in another, surrounding herself with her three therapists and religious monks, who protect her and soothe her.

Also noteworthy was the high frequency of language of discharge that Jan spontaneously used to describe her sensory experience in the sessions. As previously discussed, in Levine's (1997) theory, ending traumatic "freeze" in the nervous system includes sensations such as shaking to discharge tension. Jan instinctively described in very specific language feeling "jerks" and "a warm fluid" moving through her body.

Theme 3: Working with narrative versus body. Jan told very few details of her life story in the treatment, e.g., in only one session does she give factual history. Most important in Jan's case, however, was that she also had a concurrent verbal therapist whom she met with weekly throughout this treatment. Jan emphasized at the end of treatment that she could not have imagined having the progress or doing this work without her combination of therapists. Jan was aware that without the narrative component that she obtained from her verbal therapist, she might not have had the tools to translate what she learned with the therapist (a concern that appeared in Terry's treatment). "If I only did [BcP], it would have taken me to a certain point, and then I'd want something else. I am sure it's the combination that was best for me." Therefore, although she did not use much narrative in the BcP treatment, perhaps this was because telling her story did play an important part in her simultaneous verbal treatment.

Summary and Integration of Jan's Outcome Results

As the quantitative and qualitative data corroborate, after the 12 sessions Jan appeared calmer and more accepting of her inner experience in comparison to before the study, important shifts which were corroborated by the quantitative data as well as her own description: "My day to day living is calmer. I'm more at peace. I'm not distracted so much by being upset or worried or in pain. So I'm more engaged in the present." She feels more able to assert herself with others and speak up more, yet still wishes she could "let loose." She is making fewer obsessive lists. And most importantly, she feels more alive and present, with less generalized "vague pain" and fear. "I feel calmer when I wake up. I feel calmer all the time." This calmness reflects the therapist's guiding

conception, which largely focused on helping Jan access inner resources in order to confront her traumatic memories and sensations. Jan remarked on the success of this work, as she experienced many inner bodily changes as well as cognitive, as she reported her “head (ie., thinking) is slowing down.” Jan cited this change in her relationship to her own sensory experiences as the unique contribution of BcP.

The changes Jan gleaned from the sessions were translated as well into actions in her outside life. Since she underwent BcP therapy, she decided to look for a new job, which she found and successfully changed jobs. She was accepted at graduate school in religion and art. In the last four months, she functioned at a high level: she saw three therapists concurrently, took two classes, went regularly to the gym, church, and applied to graduate school. At a three month follow up, Jan continues to function in a happier and more related way, as she is turning her career towards a helping and people-oriented profession.

The Case of Terry

Terry, a 60 year-old Caucasian professional divorced woman, was referred to the therapist by a colleague who had been a client of the therapist's. Terry had been married twice, had one now-grown son from her first marriage, which she described as horribly violent and abusive, and was currently in a less-than-satisfying relationship. She felt blocked, unsure of next steps in her life. She presented for therapy to address some of the pain and sadness that she had been carrying for years. She was also a chain smoker, a habit she detested yet found herself unable to control. She had briefly tried therapy before, but had not engaged in treatment. Unlike Jan, Terry was a newcomer to psychotherapy. Her treatment involved a lot more fear; she was afraid of the painful feelings that would emerge in treatment, and felt ashamed of taking this time for herself.

History of Client (“A” in Figure 1)

Terry was the eldest child of married parents. She was born while her father was on duty during WWII, and after the war, he was a traveling salesman and often away. She described her mother as a very anxious woman who dealt with her nervous energy by moving constantly. From her mother, Terry learned that it was not acceptable to relax. Terry also remembered that her mother often compared her unfavorably to others, sending a message that she was “never good enough.” Terry compensated by always being a caretaker. She has vivid memories of caring for her younger sister and two brothers (six and ten years younger) - feeding them, putting them to bed, reading them stories. She remembers enjoying taking care of them, but “I never really got to be little.”

This theme of learning to take care of others remains the most salient aspect of her personality. It allowed her to function well when working with the feelings of others, but left her without the inner ability to allow herself joy and nourishment. Terry also recently fell in love with her high school sweetheart, Jack, who, unfortunately for Terry, seems unwilling to have a full relationship with her. Most of their connection occurs through an intense email correspondence. The two see each other rarely, and have never consummated their relationship. Terry yearns for more connection with him, yet knows she will probably never get it. When asked at intake about her goals for treatment, she never mentioned this relationship. Only after several sessions did Terry admit to the therapist that her “missing attacks,” in which she would feel intense pain at not having her desire for closeness with Jack fulfilled, were really the reason for her coming to therapy now.

Assessment (“D” in Figure 1)

Qualitative Assessment

The therapist described Terry with “softness, yearning, longing, and melancholy” in her appearance. She got a feeling of Terry seeming “worn out.” Terry admitted to having a lot of sadness in her. There was a sense that she did not feel empowered to nurture herself. Terry showed great difficulty receiving help and nourishment without immediately moving into the role of caretaker. The therapist assessed that Terry was not able to sense her inner resources and feel relaxed and nourished. This would become an important theme in the treatment (Theme 1).

Quantitative Assessment and Goals for Treatment

Consistent with Terry's presentation at intake, she appeared depressed, lonely, and anxious on the quantitative measures. (See Tables 3 and 4 for Terry's pre and post treatment scores.) On the SCL-90-R, several of her subscales were reported on her computer-generated report as in the “clinical range.” Particularly Terry's Depression level at 68 was “manifestly elevated, and evidence suggesting a true depressive disorder may be present.” She agreed “Quite a bit” with items such as “Feeling lonely” and “feeling blue.” Her Anxiety score of 63 suggests a level “significantly elevated and clinical in nature.” Terry's record also indicates some social alienation “which should be explored further.” Her TEaM scales indicated a high level of personal and vocational functioning,

which was consistent with her successful professional position. Her social functioning was lower, which reflected her difficulties with relationships. On the Scale of Bodily Connection, Terry's scores reflected a relatively low degree of bodily awareness and comfort with her inner sensations, e.g., "When I am tense, I take notice of where the tension is located in my body," she endorsed "a little bit," and "I feel separated from my body," she indicated "some of the time."

Terry identified three goals for therapy in the Goal Attainment Scaling procedure. She wanted to quit smoking, something she had long wished to do but had never done successfully. She was realistic in that twelve weeks may not be sufficient to have quit; she wanted at minimum a plan in place for quitting. Second, instead of always professionally writing for others she recognized that she wanted to do more writing for herself; her second goal involved spending more time journaling on her own. Finally, she admitted that she felt somewhat lost in her life, and needed a new life goal to be excited about. She hoped that through the treatment she may identify some new goals for the future. As she admitted later, this goal really described trying to find a way out of the "missing attacks" she felt with Jack, but at the time of this intake, these are the goals she listed.

Formulation ("E" in Figure 1)

The therapist formulated Terry's dynamics as suffering from an early developmental trauma in which she was not adequately contacted, held, and joined with when she was very young. The therapist described how Terry's demure, deferent and exceptionally other-oriented style (in which she often becomes so worried about the other that she forgets herself entirely) suggests a breach at the level of existence: can I belong? The therapist formulated that Terry coped with this anxiety by creating the belief: "My survival depended on loving other people. Giving love was my life." Therefore, the therapist hypothesized that Terry has mostly worked hard to love others, and is not very capable of loving and nurturing herself without guilt and self-attack.

Since Terry appeared nourishment-starved, the therapist wanted to create some new nourishing experiences which might be very beneficial for her. Therefore, she planned to help bring Terry back into her body, in order to access her inner resources (Theme 1). The therapist formulated that for this type of deprivation-based trauma, Terry would probably benefit considerably from physical touch in the therapy (Theme 2). The therapist also hypothesized that Terry often used her telling of her story as a defense: "to go into the story without spending much time in her body." Therefore, as described above, the therapist's interventions were intended to keep Terry focused on her inner awareness and experience and less in narrative disclosure (Theme 3).

DSM-IV-TR Diagnosis

Axis I: Dysthymia, Early Onset 300.4

Axis II: None.

Axis III: Eczema; blindness in one eye; shoulder pain; chain smoker.

Axis IV: Unrequited relationship; history of physical abuse.

Axis V: GAF= 65 (Current)

Action ("F" in Figure 1)

Session 1: "Linking Her Body to Feeling"

In this session, Terry talked a lot about who she is and what brought her to treatment (Theme 3). She appeared to have a great deal to share about her long life lived without much support. Terry described herself as having "a genuine capacity for joy, but a lot of sadness," and put her hands up to her chest a lot during this session, perhaps physically indicating some of her sadness. The therapist worked a lot to slow Terry down and make some of the patterns more mindful. Terry took this education a step further, and associated to her own characterological pattern which relates to her physical gesture.

Laurie: When we do body-centered work, we often slow time down. So, you will hear me at times just letting you slow down time, to stay with nourishment. And then we want to keep some sort of being sensitive to what happens when you can just rest in the peacefulness.

Terry: Yeah, and I was noticing that I felt really completely relaxed, except for my hands. And it was as if the tension...and I mean, sometimes my hands hurt, but, um, I don't usually, it's as if they were the only parts of me that were not relaxed.

L: And everything was relaxed, but underneath your wrist?

T: Yeah.

L: The tension that was normally in your shoulders seemed to be in your hands?

T: Yes.

L: So you felt that impulse...So, could you do that movement slowly? I just invite you to relax into the experience.

T: I feel peaceful....and it's interesting to hear you talk about slowing things down because...I come from a long tradition of...I didn't found the tradition but I inherited the tradition of coping via acceleration.

As Terry entered mindfulness, she remembered an important mind/body experience from her very early life. As she described her painful early childhood eczema, they worked on connecting this memory with her current character patterns.

T: You know, it's very interesting to me about that... **I don't know why I never really thought about this before, because once I started thinking about it...but it was partly about coming to see you and something else triggered it,** I don't know what it was, but. When I, um, **there was a question there about the earliest childhood memory...**and, uh, I've been thinking about how few childhood memories I can, you know, dredge up and it suddenly hit meI was at work and I was doing an article on eczema and they made a new discovery and they were talking about how debilitating eczema was and that they found that it was this autoimmune disease and stuff. **And I was born with really terrible eczema,** I mean, I really terrible...uh....and my earliest memories are of having tar, you know, on my arms and legs and ace-bandages and having my hands tied, so I couldn't scratch myself...

L: Oh boy.

Session 6: "Finding Her Feisty"

This middle session turned out to be a very important illustration of body-centered "working through." Terry reported that the previous session, in which she had contacted intense sadness within herself, had been very powerful for her: "Grief in every cell of my body." The therapist worked with Terry to experience more nourishment (Theme 1), including using physical touch by having Terry lie down on a pad on the floor and receive touch (Theme 2). At the end, they did an experiment of saying thank you to Terry's mother which elicited a great deal of unexpected anger in Terry. Note how Terry's strong sighs may indicate important bodily discharge.

T: That was something that last session...that was really something. **I was really sad afterwards.**

L: Mmm.

T: **[Sigh]... I think I wrote down at one point I just had this sensation that there was grief in every cell of my body.** But it was **just such an incredible thing being able to go there** and not just say out loud, you know, because there isn't much I have allowed myself to think that I haven't said out loud to somebody. **But there is some stuff that I hadn't gotten around to allowing myself, and it was the feeling of being unwanted,** you know? And uh [big sigh] I think that I was so tired, you know, **Monday night I was like cooked spaghetti, but the amazing thing was that I really felt as if I touched bottom, and I think I wasn't really sure there was a bottom, which is one of the reason I wasn't very eager to go down there...**[Laughs]. **If I go down there I might not get back up.**

L: So there's space, that there is a...

T: So, I really want to thank you. I mean, it was just a, that was just a huge, it's so huge that I haven't really processed it yet. You know, I just sort of ahhh... [big sigh].

Session 12: "Coming Home to Myself"

Terry was very activated in this session. Prior to this session, her colleagues had offered her a spa vacation as a gift. Illustrating a change in her ability to take in nourishment (Theme 1), Terry thoroughly enjoyed the spa and was able to verbalize her pleasure. She also reported feeling more connected to herself in her body, which (similar to Jan) she described as "coming home to myself."

T: My weekend was great. I went to the spa, you know.

L: That's right!

T: Oh my goodness, [Laughs]. That was some experience, I have to tell you. Oh! It was just wonderful. It really was. It was just great, it really, just to stop and swim and lie around and get a massage and eat like a pig [Laughs]. It was great. **And I thought of you a lot because I really was, you know, I turned my head off pretty much, I mean, for me, anyway.** [Laughs].

Here is a beautiful shift in Terry's object relations. Although it is still hard for her to feel entitled to spontaneous joy, she has internalized the therapist as a helper in reframing her ability to nourish herself. Terry then tells a story of associating from her sensations in her body at the spa, to having spontaneous memories of all the houses she's lived in and how she could only imagine them externally. Now however she felt herself sensing the inside of these houses for the first time, which she describes as "coming home to myself."

T: **There was a meditation room, I was just lying there, very sort of dark and quiet. And uh, for some reason, I started thinking of all the places I had ever lived.** And, it turns out there are 20 of them. Which is a pretty good number, I mean even for how old I am, I guess. And then I tried to go inside the different places and I could see everything very vividly from the fourth place on. **But I have absolutely no recollection of inside the house.**

L: So, what does that mean to you when you think about it?

T: I was wondering. You know, because I have some very vivid memories of my siblings and friends and school. I can see school clear as a bell. **So, something, the only thing I could think of, was that I didn't really live there...you know, in my...**

L: You didn't feel alive or present.

T: Yeah.

L: You didn't feel like you really existed.

T: It's amazing. I was glad it came to me while I was in a quiet place while lying down, because it didn't glom me, but...

L: Does that feel related to the sense of emotional turmoil that's emerging for you?

T: I think. I don't know if I get the connection exactly, **but I have a feeling, I guess of um, coming home to myself, you know.**

The image of Terry "coming home to myself" is a statement often articulated in BcP therapy. No longer experiencing herself as disgusting and stared at for her eczema or only through her ability to do for others, Terry invokes feeling more "at home" in her body. Finally, Terry reported with pride how she had allowed herself to feel her anger at a friend and set a healthy boundary for herself. The therapist supported this important shift by using physical touch to push their hands together in order to feel the boundary and connectedness while saying "enough!" This exercise in embodying the boundary also helped Terry experience in a felt sense that anger could be a connector, which was a major breakthrough for Terry.

L: Uh huh. I want to feel you push through, push into the earth. That's it, relax your back, so you're not hurting yourself. What's happening in your arms, your spine?

T: I'm just really, I'm pushing

L: How does it feel to make contact and say, "That's enough!?"

T: That felt good.

L: Keep pushing out.

T: Okay, now, you know one thing I just noticed. Like, it feels like I don't need to push that far. It feels...as if...I don't need you to go to the other side of the world.

L: Just a little bit. Just dance with it.

T: Yeah. And I keep thinking that, you know, if I'm a charitable, forgiving person...What was amazing about that, it didn't feel selfish to defend myself with you and it didn't feel bad with [my friend] either.

L: And sometimes, you know, sometimes in relationships, people push because they really want connection. And when you push back they feel connection. Which is the unmet need is connection.

T: [Big Sigh]. Wow.

Concluding Evaluation ("L" in Figure 1)

Discussion of Quantitative Results

Table 3

Terry's SCL-90-R Results

	Terry 1	Terry 2	Pt diff	RC	Sig at p≤.05
Global Severity Index	61	56	-5	-0.88388	
Positive symptom distress index	53	50	-3	-0.53033	
Positive Symptom Total	63	58	-5	-0.88388	
Somatization	53	53	0	0	
Obsessive-Compulsive	57	49	-8	-1.46059	
Interpersonal Sensitivity	62	60	-2	-0.45883	
Depression	68	62	-6	-1.2	
Anxiety	63	59	-4	-0.89443	
Hostility	40	40	0	0	
Phobic Anxiety	58	54	-4	-0.83406	
Paranoid Ideation	49	41	-8	-1.94029	

Psychoticism	60	53	-7	-1.4596	
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Table 4
Terry's TEaM results

Subscales	Terry 1	Terry 2	Pt diff	RC	Sig at p \leq .05
Subjective Well-Being	47.33	54.42	7.09	1.67113	
Depression	56.60	63.57	6.97	2.10153	*
Anxiety	57.49	60.71	3.22	0.70266	
Phobia	62.62	62.62	0	0	
Obsessive-Compulsive	61.00	64.84	3.84	0.9051	
Somatization	59.65	59.65	0	0	
Panic Disorder	56.67	60.84	4.17	1.15655	
Post Traumatic Stress Disorder	57.26	57.26	0	0	
Symptom Checklist	60.86	63.96	3.10	0.98031	
Personal Functioning	68.03	68.03	0	0	
Social Functioning	60.13	66.46	6.33	1.19626	
Vocational Functioning	67.87	67.87	0	0	
Functional Disability	67.53	69.21	2.32	0.42	
Behavioral Health Status Index	59.66	64.10	4.44	1.28172	

Terry's clinical profile on the SCL-90-R changed from clinical to within normal limits after the 12 sessions. Pre-study, she appeared clinically depressed, as well as lonely and anxious. After treatment, Terry's scores were mostly "within normal range." Although none of her SCL-90-R scores were statistically significant using the RC calculation (which may be due to her lower initial symptom levels), a trend can be noted in which 10 of 12 subscales decreased, with some of more than one standard deviation difference. These findings suggest a trend towards decrease of symptomology, which is consistent with Terry's qualitative findings.

Terry still suffers from depressive symptoms and some social alienation, which is understandable given only twelve sessions of treatment. However, her final profile on the SCL-90-R indicated someone in the normal range, distinct from the clinical levels of her initial profile. Her Depression subscale of 62 is still elevated, which suggests continuing difficulty with painful feeling - as even her relationship with Jack is largely unaltered - but not at the extent it had been previously. Her Anxiety remains at 59 in a "moderate level," yet this may be Terry's normal range of functioning, which appears consistent with her own statements. On the TEaM scale, 9 scales increased, which suggests an overall trend toward improvement. There was also a significant decrease in Depression, which appeared her main source of symptomology. She had admitted early in the treatment that she had "a lot of sadness" within her, and thus such a shift corroborates the work that she did in therapy to address this depression.

On the Scale of Bodily Connection, her items shifted towards more awareness of herself. For example, "When I am tense, I take notice of where the tension is located in my body," she earlier endorsed as "a little bit" and now "most of the time. With "I feel separated from my body," she previously indicated "some of the time," and now "a little bit."

Terry enjoyed success in her treatment goals as indicated by the Goal Attainment Scaling. She was able to develop a concrete plan to stop smoking. She also began to write more for herself, another important goal in helping her find her own voice. As for her final objective of "finding a new life goal," Terry admitted it was really a substitute for dealing with her "missing attacks" with Jack. Sharing her real goal with the therapist, as well as expressing her difficulty discussing it, were important indicators of the successful aspects of the treatment.

Qualitative Outcome Results: Exit Interview

Terry praised the therapy: "It's been a very meaningful experience for me." Initially, she explained, she had enormous resistance to treatment. A year prior to this study, she had therapy, yet found it unsuccessful as the person was "quite aggressive" and "it just made me shrink." Terry described being deeply moved by the early memories she accessed in the treatment, which were "very unexpected." The change in Terry's acceptance of herself is striking. She spoke with great clarity about her character organization, ("The caretaking is the only thing I know how to do.") and with compassion about the lack of nurturance in her life:

I think what emerged from these twelve sessions is how much I was taught and taught myself to surmount those things. I had a fair amount [of hardship] and I got pretty adept at it. There is something about going into something instead of going over something that was very revealing. For example, I have a lot of pain in my shoulder. And Laurie said something about 'breathing into it.' That was very helpful.

The treatment appears to have helped Terry develop more compassion for herself: "My relationship to my flaws has changed. I don't feel guilt for the flaws. Guilt has been a full-time job for me. I don't feel shame. I feel some level of compassion for myself. And that's a very different relationship."

One place to see the change in Terry is in her relationship to smoking. In the treatment she learned how much she depended on smoking to soothe herself. Making the connection between the addiction and her own need for nurturance allowed her to find other ways to nurture herself. When offered the spa invitation before the last session, she was able to accept without guilt, and she brought a patch for quitting smoking to the exit interview.

Another important change for Terry was in her relationship to anger. Allowing herself to express anger with her co-worker and then experiencing it physically as a connector by pushing hands with the therapist were both major breakthroughs: "I always thought of anger as something so diabolical and wounding. My associations are of hiding under something or behind something. This idea of anger as connection just blew me out of the water. It really, really did."

When asked about what was not helpful about treatment, Terry expressed that sometimes it had a "New Agey" feeling. She explained that she finds some aspects of U.S. culture too self-centered, which the treatment invoked: "I'm lying on this mattress in this womb-like place...what am I doing?! That was hard for me." Yet despite her strong resistance, she found that she experienced some of her most important changes from the body-focused work.

Reviewing the Narrative Themes

Theme 1: Helping clients feel "nourished" by their internal resources. The therapist assessed that Terry appeared "depleted," with not enough activation in her nervous system. The therapist helped Terry learn how she is organized around taking in nourishment through caring for others, and through that awareness, learn to take in nourishment by accepting love and letting others care for her. Finding ways for Terry to find her internal nourishment to replace smoking or caretaking became a central theme for how Terry changed in this treatment. When Terry was offered a spa weekend right before the end of treatment, she enjoyed herself without guilt.

Theme 2: Using physical touch. Touching in this treatment offered an important example of how The therapist's guiding conception interacted with Terry's needs. The therapist wanted to use touch as an intervention to help Terry access nourishment without fear. However, physical touch for Terry brought up powerful feelings of longing, as well as fear of selfishness; all difficult emotions that needed a lot of resources to work through. Working slowly and with great sensitivity to timing and safety in treatment was crucial in maintaining their treatment alliance.

Finally, as Terry uncovered feelings of anger and sadness, she was more able to experience herself as entitled to positive feeling. Therefore, her relationship to her body changed, which led to change in her experience of touch. It can be hypothesized that she may not be willing to accept a relationship without contact for much longer. However, although this has shifted, the therapist noted that Terry still needs a lot of reassurance. It is unclear if she has sufficiently internalized the change to be able to assert herself in her relationship with Jack.

Theme 3: Working with narrative versus body. How the therapist intervened with Terry's narrative remains an important illustration of how The therapist's theoretical framework interacts with the needs of the client. Terry had never been in therapy before, was 60 years old, survived a violently abusive marriage, and was currently in an unfulfilling "long distance relationship." She needed to talk. To the therapist, a lot of Terry's storytelling was a defense against connection. How to get Terry out of "story mode" was a challenge for the treatment. The therapist holding Terry to her body versus allowing her space to talk was a central friction in the treatment. Although Terry's learning to support herself through finding and holding nourishment in her body was crucial, telling her narrative may have also helped Terry develop resources. "Sometimes I wanted to skip the whole body thing and just talk," Terry admitted. How much to interrupt talking to focus on the body illustrated the difficulties of combining verbal narrative and body-oriented techniques in a single treatment and requires much further research.

Another area that Terry spoke frankly about was the difficulty of switching from the verbal to the more physically-oriented modes. Terry admitted that sometimes the transition between talking and working in the body was hard to manage. There were times when she was frustrated with the therapist cutting her off when she was talking. "Sometimes I'd be talking and I would be in 'breakthrough territory.' What do you mean stop?!" She came to accept it, but it never got easier for her to integrate the work. "I had a sense of discomfort and frustration at first. But then I came to see it that I'm not liking it, but it will be good for me [small laugh]." Knowing when a therapist is

working with resistance versus pushing a client's boundaries too far is very important in BcP work and demands further research with appropriate feedback from clients. Ultimately, it mattered less what the technique was than the strength of the alliance: "Frankly, there's a quality that Laurie has...she created a space where I felt safe. I think the nature of the therapy mattered less to me than the quality of her presence."

Summary and Integration of Terry's Outcome Results

Terry worked on a major identity shift in this treatment. She has become much more able to access her inner resources by herself (Theme 1). Her acceptance of the spa is an important example of her being able to accept such body-oriented nourishment. Through their work Terry became more flexible, able to see herself as one who gives and also feels entitled to receive. Both the quantitative and qualitative data suggest that as a result of this BcP work, Terry has become less depressed. This shift could be seen in the therapy room: Unlike early sessions in which Terry had little bodily awareness, over time Terry began to adjust her own pillows, which suggests she felt more entitled to access comfort. And with that comfort seemed to come a greater love and compassion for herself. Overall, Terry came to know herself and accept herself. The power that was unleashed for Terry in the treatment was in finding out she was knowable. "I always thought if I had the courage to go down there, I thought I'd find a monster chained in the basement. When I went down there, I found there wasn't anything that evil. That was a really nice discovery."

The treatment also helped Terry work on her anger. The therapist formulated that a lot of Terry's sadness, grief, and melancholy came from her freeze around anger. As Terry became angry, she also felt a new sensation of power; she discovered a new way of being in connection with people such that she was finally able to feel safe enough in her own skin to set a boundary with others. Through the treatment she experienced she could be angry and assertive and still survive.

As both the quantitative and qualitative data indicate, Terry made some important strides through the therapy, yet her work was not yet done. Terry intended to continue working with the therapist. Whether she will continue these sessions for herself now that the study is over is still an open question. Has she shifted enough to be able to give freely to herself? It remains to be seen.

DISCUSSION

Combining qualitative and quantitative data was valuable in developing a method for studying Body-centered Psychotherapy. The cases demonstrated that consistent with Peterson's Disciplined Inquiry model, the therapist adjusted her techniques based on the needs of each client in ways that appeared beneficial to them. It is important to remember the large number of limitations in the present research: only three clients were studied (two of which are described in this article), there were no control subjects, only one therapist was involved, one of the clients was simultaneously in two other therapies, and so forth. Thus, the findings must be interpreted cautiously and may be most useful as guides for subsequent research. With these caveats in mind, the results suggest that BcP's emphasis on clients' sensations alongside emotion, cognition, and behavior appears to be a powerful contribution to change processes, particularly with trauma (van der Kolk, 1994).

Another major contribution of BcP is the focus on helping clients experience internal resources through calm, relaxing images, sensations, and feelings. The two clients in this study spoke about experiencing newfound "calm" in their bodies as a major impact of the therapist's treatment. Mindfulness, progressive muscle relaxation, and other techniques are entering the psychological mainstream (Dimidjian & Linehan, 2003; Teasdale, Segal, & Williams, 2003). What remains particularly noteworthy in BcP treatment is the seamless integration of this relaxation-focused work within the therapy - not as an added technique, but woven through the core narrative work, moving back and forth without pause.

Additionally, the "New Age" aspects of BcP work must be confronted for this work to become palatable to the majority. Since BcP uses interpersonally complex, verbal interventions as well as physical touch, this work requires more training of therapists, not less. The issues of training and quality control in BcP are crucial. Currently, there are inadequate BcP training resources in many areas of the country, as well as too many BcP-oriented professionals working without advanced degrees and little accountability. There is a great need for more rigorous, accredited training programs, as well as education for the public.

Finally, the question of BcP as a stand-alone therapy remains open. The data from Jan's case suggest that an adjunctive talk-based therapy in combination with BcP might be particularly helpful. Future studies might include replication of the PCS Method examining numerous BcP therapists in practice. Additionally, more quantitative sampling across the sessions would allow for single case design research and greater statistical analysis. Further research designs are needed that employ videotaping, as well as combine qualitative and quantitative measures. Rigorous methods for analyzing videotapes will also help BcP develop methods for determining treatment efficacy. Larger controlled studies are necessary to help demonstrate efficacy for insurance reimbursement. The United States Association of Body Psychotherapy is in the process of developing a

“videotape database” of various BcP styles (Psychotherapy, 2004). Such a rich database would support analysis of multiple techniques and encourage understanding common factors across BcP cases and therapy types. Practitioners and clients need to be educated further about the potential benefits and risks of “listening to the body.”

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Biography

Amelia Kaplan, Psy.M. graduated from Harvard University with a B.A. in History and Literature. She is currently completing her doctoral requirements in Clinical Psychology at Rutgers University, as an intern at VA Northern California HealthCare System in Martinez, CA. Ms. Kaplan pursues interests in mind-body psychology, STDP, group therapy, and human sexuality. She has also trained in massage and Zen Bodytherapy. Her original dissertation research studied three cases of Body-centered Psychotherapy with practitioner Laurie Schwartz.

Laurie Schwartz is a Counseling Psychologist and Licensed Massage Therapist in private practice since 1982 integrating somatic and psychotherapy modalities including Rubenfeld Synergy, Hakomi, Jin Shin Jyutsu, Somatic Experiencing, Modern Group Analysis, and Hellinger Constellations. Ms. Schwartz is also a photographer and African Drummer who has created sacred ceremonies for the restoration of healing and consciousness in community.

This project was conducted as dissertation research for Ms. Kaplan's Doctor of Psychology (Psy.D.) doctoral dissertation at the Graduate School of Applied and Professional Psychology, Rutgers University. For correspondence regarding this article, please contact Amelia Kaplan at akaplan@post.harvard.edu. Laurie Schwartz can be contacted at nyhakomi@aol.com

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