INTERNATIONAL BODY PSYCHOTHERAPY JOURNAL

Published by the European & United States Associations for Body Psychotherapy & Somatic Psychology

The Art and Science of Somatic Praxis

XIV EABP Congress – Berlin 2018
and USABP National Conference
Santa Barbara, California 2018

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The Art and Science of Somatic Praxis
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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.

Correspondence Address
Editor-in-Chief: submissions@ibpj.org

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The Art and Science of Somatic Praxis

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Volume 18, Number 2, Fall/Winter 2019-2020

A Message from the Editorial Team

Madlen Algafari
Editor-In-Chief

Aline LaPierre
Deputy Editor

Antigone Oreopoulou
Managing Editor

Dear Colleagues,

This issue covers many of the seminal presentations of the 16th EABP Congress titled *Body Psychotherapy and Challenges of Today – Alienation – Vitality – Flow,* held in September 2018 in Berlin, and of the USABP National Conference titled *The Science of Connection; Honoring Our Somatic Intelligence,* held in November 2018 in Santa Barbara, California.

We thank the many presenters who answered our call and contributed articles based on their presentations. The response was so enthusiastic that it soon became clear that it was an impossible task to cover in one single issue two scientific forums of such stature involving participants from all over the world. We could not fit all the articles we accepted into a single issue and so we have opted to divide the presentations between this issue and the Spring/Summer 2020 issue.

As your editorial team, we have worked with great enthusiasm to organize the wealth of new ideas and leading edge developments that were brought forth in both assemblies. You will find the articles categorized as follows:

- *Our Roots*
- *The Culture in the Body and the Body in the Culture*
- *Body Psychotherapy and Somatic Psychology Practice*
- *Working with Trauma*
- *Research*
- *Interdisciplinary Approach*
- *Professional Ethics*
- *Scientific News*
- *Body Psychotherapy Around the World*
- *Book Review*

In addition, Judyth Weaver, recipient of the USABP 2018 Lifetime Achievement Award, generously offered three *Sensory Awareness Meditations* to remind us to keep body and mind in connection as mind becomes absorbed in taking in the Journal's intellectual sustenance.

In the last few months, we have experienced an increase in article submissions from colleagues from the Eastern-most to Western-most parts of the world. This encouraging development tells us that body psychotherapy and somatic psychology are progressively attracting new supporters. We see it as reflecting the growing awareness that achieving health and happiness depends on treating human beings with psychosomatic unity.

This poses a significant ***challenge*** for all of us body psychotherapists. Although for us, it might seem as absurd as proving that *water is wet*, can we increase global awareness of the ***connection*** between body, mind, and soul? Our world needs it!

We hope that this international issue, which brings together authors from both sides of the Atlantic, will further our common professional goal—***the challenge of today***—increasing awareness, decreasing alienation, increasing vitality, and honoring our somatic intelligence to bring healing to the body and soul of our planet.

Your Editorial Team,

A Message from the USABP Honorary Director of Research

Stephen Porges

At the 2018 USABP conference, I was honored to receive the Pioneer Award. However, since I am neither a somatic therapist nor a member of USABP, I didn't immediately understand the contribution I had made to body psychotherapy, or to the organization, that would merit being honored. In accepting the award, I had to reflect on the history of somatic therapies and how my work conceptualizing the Polyvagal Theory influenced and interacted with the diverse community of somatic-oriented therapists. I started to review my experiences and interactions with the world of somatic therapists.

The more I reflected upon and reviewed these interactions, I realized that there were strong synergistic relationships between my work developing Polyvagal Theory and the field of somatic-oriented psychotherapies. This history started in the mid-1970s when I met Peter Levine, who was exploring neurophysiological explanations for the consequences of trauma. Peter was curious about atypical autonomic response patterns that emerged during trauma-related memories. From these initial interactions, we developed a strong friendship. Through conferences and workshops at Esalen in the late 1970s and early 1980s, Peter introduced me to the world of body-oriented therapies. Although the body is now an acceptable portal for treatment in many trauma-informed therapies, its acceptance is relatively recent. Only during the past decade have body-oriented psychotherapies become accepted in the world of academically oriented or affiliated therapists and clinical researchers.

My first exposure to the diverse realm of body-oriented psychotherapies predated the formation of USABP, when I was invited to the first US Conference of Body-Oriented Psychotherapy in 1996. As an academic scientist, the meeting was remarkable in scope, enthusiasm, and metaphor. The meeting provided an opportunity to witness variations

in somatic treatment models and schools of therapy, and to meet many passionate therapists who would be leading and defining the emerging discipline of somatic-oriented clinical practices.

I was struck by four aspects of the meeting: first, the passionate commitment of the participants to somatic therapies; second, the welcoming curiosity of the participants about my research as providing a language to understand their clinical practices; third, the lack of an integrated underlying theoretical theme that could identify common mechanisms across treatment models, and be translated into the metaphors and vocabulary of medicine, psychology, or neurophysiology; and fourth, the relative importance of treatment brand (e.g., school of therapy) that seemed to provide the strongest organizing principle for the emerging discipline. It was this latter point that concerned me, since if too much effort were dedicated to differentiating treatment models (i.e., treatment brand), then there would be limited interest in identifying common mechanisms that would support positive outcomes.

A few years later, in 2002, I was invited by Mark Ludwig to be a keynote speaker at the third National USABP Conference. The meeting highlighted the transitions that were occurring in somatic-oriented psychotherapy, including the widening acceptance of somatic therapies in trauma, and the evolving strong interest in underlying mechanisms through which research could explain how and why body psychotherapies worked — especially with cases that did not respond to other forms of psychotherapy or pharmaceuticals. My talk formally introduced Polyvagal Theory to the world of somatic psychotherapy. The talk started a dialog with somatic-oriented therapists about how the theory could be used to understand and treat trauma. In subsequent years, I gave a keynote at EABP in 2012, and will be giving a keynote talk at the 2020 EABP in Bologna.

As my dialog with somatic therapists expanded, I realized that many somatic-oriented therapists were on a quest for a viable theoretical perspective that would integrate the more traditional top-down models (*i.e.,* traditional psychotherapy) with their intuitions and observations of the power of bottom-up treatment models (*i.e.,* somatic manipulations). I also realized that Polyvagal Theory might support this quest by providing a bidirectional understanding of how psychological processes could influence physiological states, and how physiological states could influence psychological processes.

Metaphorically, as the body has become an acceptable portal to work with the consequences of trauma, Polyvagal Theory has become the neural thread providing the bidirectional connection between brain and body. Through the welcoming and timely acceptance of the role of the body in trauma treatment, Polyvagal Theory is emerging as an integrative construct within the world of trauma-informed therapies.

As Polyvagal Theory has become embedded in somatic and other trauma-informed therapies, I have experienced the dual roles of being both teacher and student. Since I was not a therapist, I was curious about the impact of somatically-oriented therapies on autonomic state. and how shifts in autonomic state would provide a neurophysiological platform for improvements in mental and physical health. Trained as a psychophysiologist, my research initially focused on how mental processes, including cognitions and emotions, influenced physiological state. My research

strategy was based on a top-down perspective in which neural pathways originating in higher brain structures could reliably influence autonomic function. This top-down approach supported a metaphor that the heart is a window to the brain. However, as I entered the world of somatic therapies, this top-down perspective was informed by a bottom-up perspective. In a way, my interactions with the world of somatic therapy provided an opportunity to integrate top-down and bottom-up metaphors. Thus, as Polyvagal Theory evolved, it became welcome in somatic therapy.

Polyvagal Theory was welcomed because it provided a tangible functional model that contained intuitive metaphors to support the expanding world of body therapies — including therapies directed at optimizing psychological processes as well as those targeting shifts in physical structure and neurophysiological function. Polyvagal Theory provided a neuroanatomical/neurophysiological basis to potentially explain how somatic therapies work. Polyvagal Theory is not only explanatory, it also provides a language that is consistent with contemporary neuroscience and compatible with Western medical practices. Moreover, many of the constructs embedded in the theory are also consistent with Eastern philosophical practices, such as yoga.

This issue of the *International Body Psychotherapy Journal* contains papers based on presentations at both the EABP and USABP 2018 meetings. The papers reflect the maturation of somatic therapies as a clinically relevant perspective, especially in the treatment of trauma. This maturation brings with it a greater scientific sophistication in method, and a deeper understanding of neurophysiology. My observations and interactions with the somatic therapeutic community have spanned more than 40 years. During this period, I have been appreciative of how the somatic community has welcomed me and helped me understand, often through demonstrations, the powerful impact that shifts in structure and functional physiology state have on psychological processes. The product of these interactions contributed to the evolution of the Polyvagal Theory.

Personally, it has been a wonderful experience to witness how somatic therapists have used Polyvagal Theory as they embed features of the theory into their treatments and explanations for healing. Polyvagal Theory provides a roadmap of portals for treatments. Thus, from a Polyvagal perspective we are learning that subtle forms of stimulation, such as listening to sounds, vocalizing, and breathing may have a powerful impact on neural regulation of both visceral organs and somatic structures. We are also learning that top-down visualization strategies may complement bottom-up manipulations as more coherent personal narratives are structured in response to bodily feelings. I look forward to the new knowledge that we gain as science and clinical practices work synergistically to develop treatments that optimize health, growth, and restoration, as well as our capacity to co-regulate with each other.

Three Sensory Awareness Meditations

Judyth O. Weaver

SENSORY AWARENESS is the name Charlotte Selver gave her work as she taught in the United States. Her teacher, Elsa Gindler, hadn't named it at all.

It is the practice of becoming more aware, of paying attention, of being "more fully here" for whatever is happening. It supports us in being more responsive and authentic…in rediscovering our whole, true selves.

Sensory Awareness has influenced and been incorporated into many varied forms of somatic psychotherapies, body/mind practices, and meditations.

The sensory awareness meditations can be found on pages 12, 133, and 228.

International Body Psychotherapy Journal *The Art and Science of Somatic Praxis*
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Judyth O. Weaver, PhD *in Reichian Psychology, taught at the California Institute of Integral Studies, San Francisco, CA, for 25 years. She is founding faculty at Naropa Institute, now Naropa University, Boulder, CO, where in the 1970s she created its T'ai Chi Ch'uan program. Co-founder of Santa Barbara Graduate Institute, she is the creator and founding chair of its PhD Program in Somatic Psychology. She is certified in Reichian Therapy, Somatic Experiencing®, massage, Biodynamic Craniosacral Therapy, Pre- and Perinatal Therapy, and as a senior teacher of T'ai Chi Ch'uan, Rosen Method, and Sensory Awareness, which she began studying in 1968. In 2016 and 2018, Judyth offered pre-congress workshops at the EABP Conferences, and she is honored to have been the Lifetime Achievement Awardee at the 2018 USABP Conference.*

Judyth O. Weaver

SOMATIC MEDITATION 1

The following are questions for inquiry; there are no wrong answers.

As you hold this object and look at the material, of what are you aware?
What do you notice in yourself?

Are you aware of the weight of what you're holding?
of its texture?
is the surface cold or warm?

What is the sensation, if any, of your own weight?
of your own temperature?

Whether you are sitting or standing or lying,
do you feel the support of whatever is under you?
Are you allowing yourself to be supported?
Or are you holding yourself up?
Could you allow yourself to be more supported?

How do you experience your muscles?
Are they contracted? Soft?

How do you experience your breathing right now?
Right now?
And again, right now?
Where do you sense your breath?

Early Coping Strategies
Addictive Behaviors That May Sabotage Connection

Alice Kahn Ladas

Received: 20.08.2019; Revised: 10.09.2019; Accepted: 23.09.2019

Alice K. Ladas *attended her first Conference at Orgonon in 1948 and was personally examined by Reich in 1951 in order to join the staff of his Infant Research Center. She is possibly the only living person in the USA today who knew Reich in person. Here, in her own words, are some of her memories of the early days of our field, and how she influenced its development.*

Keywords: coping strategies, intimate connection, body psychotherapy, addiction

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People often ask how come I am in relatively good shape at my august age, and I have given the usual answers: luck, genes, diet, exercise. Now I add body psychotherapy. Most questioners have no clue about what that means, which gives me the opportunity to tell them. Encountering the work of Reich and many of those who followed him was, for me, life-changing and I am forever grateful.

Photo of me and Fred Lowen at Reich's grave during a conference we attended at Orgonon in 2016

I am probably the oldest member of the USABP, the eldest living person who has been involved with body psychotherapy for the longest time, and the only current member of USABP who met in person the physician who brought this form of body psychotherapy to the United States.

A Review of the Past 65 Years

Before I talk about early coping strategies and how they can sabotage connection, I would like to review, briefly, what I have observed happening in the United States Reichian branch of body psychotherapy over the past 65 years. Contemporary brain research confirms the importance of the mind-body relationship, and has brought psychotherapy around to what Reich had discovered almost a century ago. Before his work challenged Viennese cultural norms and they expelled him, Reich was Freud's star pupil. The reasons why Reich was attacked in Europe and in the U.S. remain unclear. Was it the communists, the psychoanalysts, McCarthy, European emigré psychiatrists, Russia, or all of them combined? Conflicting versions of that story are reflected in two books: Myron Sharaf's *Fury On Earth* and James Martin's *Wilhelm Reich and the Cold War.*

I attended my first conference at Orgonon in 1948, and was personally examined by Reich in 1951 in order to join the staff of his Infant Research Center. That same year, I brought orgone therapist Dr. Allan Cott to meet Eleanor Roosevelt because Reich believed, at the time, that orgone energy might counteract the effects of nuclear radiation. Mrs. Roosevelt ran the information by Robert Oppenheimer, who said it was probably a "hoax." (See copies of the correspondence on p.19) That same year, Reich learned he was wrong: Oranur proved destructive.

I was around for the book burning
and destruction of Reich's scientific equipment
but did not turn in my books or orgone accumulator,
and still have these precious ancient possessions.

Reich has the distinction of being the only person to have his books burned by both the Nazis and the United States government, as well as being on Russia's top hit list. I was around for the book burning and destruction of Reich's scientific equipment but did not turn in my books or orgone accumulator, and still have these precious ancient possessions. But I left the field of psychotherapy for several years; the event was so appalling.

To further connect our beginnings with our present moment, here is a quote from *Reich's Brief to the US Court of Appeals* in 1951.

"Not protection of old financial or political privileges,
but safeguarding the Planet Earth,
and transforming its technological structure is the task of today.
Let us hope that the great industrial powers
of our planet have retained their pioneering spirit."

Studies with Alexander Lowen

In 1955, I returned to psychotherapy to join the study group organized by Alexander Lowen and John Pierrakos, and began introducing Lowen at his public lectures. Following Freud's dictum that only medical doctors could practice psychoanalysis, orgonomy was initially restricted to physicians. Therefore, Lowen completed his medical degree before creating his own version of body psychotherapy. Stanley Keleman was part of Lowen's original group. So were many others with whose names you are familiar.

My suggestion that they form a not-for-profit organization was greeted favorably. After introducing Al to his first publisher and writing his first brochure, I joined the original board of five, and remained there for many years. I also served on the Board of USABP from 2000 to 2007. So I have been involved in body psychotherapy for a VERY LONG time!

Doing It To the Patient

Reich relied on his patient's words at the start of therapy, but very little after that. He did therapy to the patient and was highly evaluative. If you want to know exactly how one person's therapy went, A.E. Hamilton kept a diary of his sessions—although Reich told his patients not to. I rescued his diary from a snowdrift, and you can read it in three *Journals of Orgonomy,* 31(1), (2)1997, and 32 (1).

I had therapy sessions with both Lowen and Pierrakos and can testify they followed Reich's pattern of evaluating and doing it to the patient, until a highly qualified psychiatrist patient screwed up his courage to ask *"Would you like to know what is happening to me?"* After much internal struggle, bioenergetic analysis gradually moved towards patient and therapist doing the work together, as a collaborative adventure based on connection. But it involved a huge struggle and a lot of hurt feelings.

Casting Thinking Aside

For many years, there was such a strong emphasis on feelings that thinking was virtually cast aside—understandably, since feelings had been neglected for eons. My friend, colleague, and founder of Radix™, Charles Kelley, discovered to his dismay that his seminars on feeling were well attended, but those on purpose were not. My article, *Using Goals in Bioenergetic Analysis,* was rejected by the *Bioenergetic Journal* and published instead by the American Association of Psychotherapists. I believe, and suspect you do too, that both feelings AND thoughts matter.

The Importance of Research

A related pattern of resistance to change concerns research. In 1961, Yale Professor of psychiatry, Dr. John Bellis was forced to resign as Director of Training for the International Institute for Bioenergetic Analysis, partly because he wanted to include a research project as one of the requirements for becoming a Certified Bioenergetic Analyst. My husband Harold and I conducted a research project, *Women and Bioenergetic Analysis*, which was disowned by IIBA. It was finally published by the Connecticut Society for Bioenergetic Analysis in 1981. Dr. Bellis was the leader of the group. At my insistence, it was included as an appendix in our *New York Times* best seller *The G Spot and other Discoveries About Human Sexuality.* The study, presented as *From Freud Through Hite, All Partly Wrong and Partly Right,* at a meeting of the Society for the Scientific Study of Sexuality, was what led to meeting our coauthors, the researchers Whipple and Perry. As a result, readers from 18 countries and almost as many languages have the opportunity to learn something about body psychotherapy outside of normal channels. (Postscript: IIBA has recently begun to give research awards.)

In 2000, after 40 years of failing to persuade IIBA to establish awards for research, I joined the Board of USABP. They established two research awards one for practitioners and one for students and, in 2008, named those awards after me. Unless we publish research in peer-reviewed journals other than our own, body psychotherapy is unlikely to gain the recognition it deserves. Murray Bowen said in a 1980 speech titled *Psychotherapy - Past, Present and Future,* "A theory is just a theory until it is validated by research." In September 2018, the new director of the American Psychological Association (APA) sent me an email confirming Bowen's statement. He indicated that he was not familiar with body psychotherapy.

Recent brain research not only confirms that working with the body is vital, but that we need to engage all parts of our brain in order to recover and grow. Since my involvement with Reich and Bioenergetics, many other helpful methods of body psychotherapy have evolved. Now that we include the brain as an organ to address consciously along with other parts of our bodies, we have the opportunity to include both the thinking and feeling parts of that organ, along with the primitive section that tells us to continue doing what we once did to accommodate and stay safe in our family and culture of origin.

Had any of my therapists, verbal or body-centered,
said to me at the start of therapy,
"What did you do to adapt to your family and culture of origin?"
we might have discovered precisely what to work on,
and saved lots of money and time.

Early Adaptive Coping Strategies

It took me more than 60 years to come up with the idea I want to share now. Many of you work with similar concepts; it is the ***manner*** and ***timing*** of working with it that differs. I have found it exponentially increases the effectiveness of what I was already doing. Had any of my therapists, verbal or body-centered, said to me at the start of therapy, *"What did you do to adapt to your family and culture of origin?"* we might have discovered precisely what to work on, and saved lots of money and time. One of my present goals is to teach this work to other clinicians before I get too old. If you think what I write today has merit, invite me to do a workshop.

Following the medical model, we diagnose. Theoretically, this leads to the best methods of treatment and gets paid by insurance. My diagnosis made me feel less than worthy. Wouldn't you rather be told there is something right about you than something wrong? By focusing early on a client's coping strategy in their family and the culture into which she/he was born, and viewing it as *lifesaving*, you make clients right. That helps promote the positive client/therapist relationship so crucial to all successful therapy.

When clients become aware of what they did to cope with their family and culture of origin, it is often the same as what they are still doing that prevents them from experiencing the kind of life they long for. Were they running away? Hiding? Fighting? Afraid to reach out? Freezing? Stealing? If it helped them survive, they were doing something right.

Early coping strategies show up in bodies just as clearly as they do in words. These early questions are not a replacement for bodywork. They facilitate it. *"If we decide to work together and are successful, what will that look like?"* is on my written form for new clients. Some can answer that question and others can't. Since intention plays an important role in the success of therapy, I have been seeking a written answer to that question for years.

Today, I ask a second more difficult question early on: *"In your family and culture of origin, what did you do to get along?"* Since early coping strategies are often partly, if not wholly, unconscious, this can take time. Once we identify it, we know what to work on. What they did in childhood was useful, but as adults, it gets in the way of what they long for NOW. I view their adaptation as "right" instead of "wrong." Did they hide, steal, fight, run away, keep their thoughts and feelings to themselves, try to be perfect?

Here are some questions I find important for therapists to consider asking early on:

- *If we decide to work together and are successful, what would that look like? How might your life be different?*

- *Tell me how you coped with or kept yourself safe during your early years in your family and culture of origin?*

- *Where and how, in your behavior and your body, does this way of keeping safe manifest today?*

- *Would you like to modify or change your early way of staying safe because it no longer helps you be or manifest what you want?*

- *If you modified your early response, would that make you feel anxious? How would you handle the anxiety?*

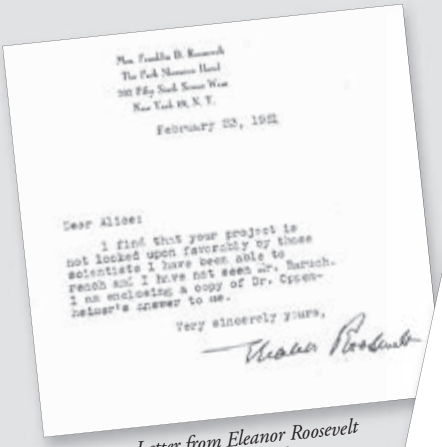
After identifying a client's early coping strategy (and I say client instead of patient deliberately), I warn that changing a way of responding that was once lifesaving, but no longer works, is as difficult as changing any other kind of addiction. The amygdala warns us not to change any behavior that once kept us safe. It does not understand we are no longer trapped in a situation we did not choose. Pay attention to what triggers that initial coping strategy. Take small steps to modify your response to the trigger. Instead of reacting, take a breath and act in order to get what you WANT NOW.

Be patient, and expect you will have to deal with anxiety, possibly severe anxiety, as you make the changes needed to create the life you seek today. We discuss and practice many ways of handling anxiety.…keeping knees soft, releasing the diaphragm and breathing, noticing your present surroundings, exercising, meditating, or going over the Bioenergetic stool if that was part of your training. An 11 year old told me he had a lot of anxiety. *"What do you do about it"* I asked. *"I blow on my finger."* Great idea.You breathe without thinking about it. We practice the many ways that can help manage the inevitable anxiety resulting from the work of getting rid of any addiction. The focus is not what horrible things were done to you, but what you did to survive and are still doing.

Alice K. Ladas, Ed.D. CBT, *is a psychologist and co-author of* Women and Bioenergetic Analysis, Using Goals in Bioenergetic Analysis, *and the NY Times bestseller,* The G Spot and Other Discoveries About Human Sexuality. *She is possibly the only living person in the USA today who met Reich in person. She wonders if this is true for Europe as well.*

Email: aladas@aol.com

Letters from the Archives of Alice Ladas



Mrs. Franklin D. Roosevelt
The Park Sheraton Hotel
202 Fifty Sixth Street West
New York 19, N. Y.

February 22, 1951

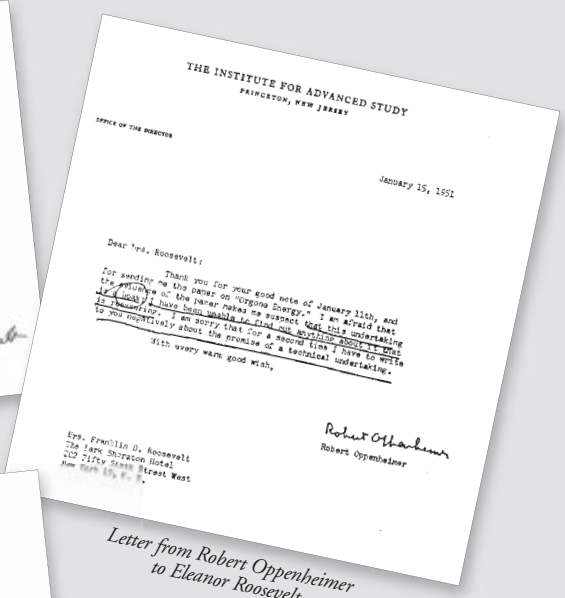
Dear Alice:

I find that your project is not looked upon favorably by those scientists I have been able to reach and I have not seen Mr. Baruch. I am enclosing a copy of Dr. Oppenheimer's answer to me.

Very sincerely yours,

Eleanor Roosevelt

Letter from Eleanor Roosevelt to Alice Ladas



THE INSTITUTE FOR ADVANCED STUDY
PRINCETON, NEW JERSEY

OFFICE OF THE DIRECTOR

January 15, 1951

Dear Mrs. Roosevelt:

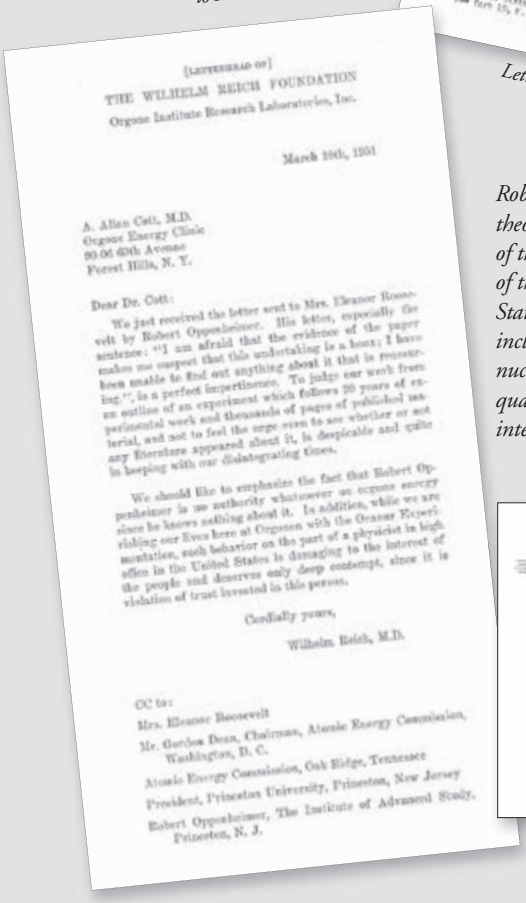
Thank you for your good note of January 11th, and for sending me the paper on Orgone Energy. I am afraid that the evidence in the paper makes me suspect that this undertaking is dubious, and I have been unable to find out anything about it that is reassuring. I am sorry that for a second time I have to write to you negatively about the promise of a theoretical undertaking.

With every warm good wish,

Robert Oppenheimer

Mrs. Franklin D. Roosevelt
The Park Sheraton Hotel
202 Fifty Sixth Street West
New York 19, N. Y.

Letter from Robert Oppenheimer to Eleanor Roosevelt



[LETTERHEAD OF]
THE WILHELM REICH FOUNDATION
Orgone Institute Research Laboratories, Inc.

March 19th, 1951

A. Allan Colt, M.D.
Orgone Energy Clinic
90-06 62th Avenue
Forest Hills, N. Y.

Dear Dr. Colt:

We just received the letter sent to Mrs. Eleanor Roosevelt by Robert Oppenheimer. His letter, especially the sentence: "I am afraid that the evidence of the paper makes one suspect that this undertaking is a hoax; I have been unable to find out anything about it that is reassuring.", is a perfect impertinence. To judge our work from an outline of an experiment which follows 20 years of experimental work and thousands of pages of published material, and not to feel the urge even to see whether or not any literature appeared about it, is despicable and quite in keeping with our disintegrating times.

We should like to emphasize the fact that Robert Oppenheimer is no authority whatsoever on orgone energy since he knows nothing about it. In addition, while we are risking our lives here at Orgonon with the Oranur Experimentation, such behavior on the part of a physicist in high office in the United States is damaging to the interest of the people and deserves only deep contempt, since it is a violation of trust invested in this person.

Cordially yours,

Wilhelm Reich, M.D.

CC to:
Mrs. Eleanor Roosevelt
Mr. Gordon Dean, Chairman, Atomic Energy Commission, Washington, D. C.
Atomic Energy Commission, Oak Ridge, Tennessee
President, Princeton University, Princeton, New Jersey
Robert Oppenheimer, The Institute of Advanced Study, Princeton, N. J.

Robert Oppenheimer (1904-1967) was an American theoretical physicist credited with being the father of the atom bomb. After the war, he was chairman of the General Advisory Committee of the United States Atomic Energy Commission. His achievements include work on the theory of electrons and positrons, nuclear fusion, and important contributions to quantum mechanics, quantum field theory, and the interactions of cosmic rays.

Original and copy of Reich's letter to Allan Colt in response to Oppenheimer's letter

Finding Our Intercultural Ground

An Essential Element in 21st Century Body and Somatic Psychotherapies

Carmen Joanne Ablack

Received: 28.07.2019; Revised: 23.09.2019; Accepted: 04.10.2019

ABSTRACT

This article pulls together and expands upon a range of key concepts and ideas that were first explored in two separate talks given by the writer highlighting the importance of intercultural ground in body and somatic psychotherapy. After speaking at the European Association for Body Psychotherapy (EABP) Congress in Berlin 2018 and then presenting an opening keynote speech at the United States Association for Body Psychotherapy (USABP) conference in California later that year, the writer explores macroscales of culture and multiculturalism, social and socioeconomic considerations, political cultures and microscales of signs, symbols, rhythms, creativity, societal symptoms, and embodiment, leading to the idea of intercultural ground. Throughout the writer attends to pitfalls and possibilities for both body and somatic psychotherapy, with a specific focus on organizational, practitioner, training, and supervisory levels in the context of the wider world.

Keywords: dialogue, embodiment, intercultural, ground, relational

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Introduction and Definitions

As revealed through our conversations and communications, EABP and USABP are two different and engaged organizations with a multitude of practitioners from many different traditions. At our best, we are constructing, deconstructing, and reconstructing ourselves while attempting to be understood and understand each other. This is true at all levels and in all forms of discourse: verbal, non-verbal, visual, aural, oral, and kinesthetic.

In considering factual differences (such as you are white and I am black), differentiation (discerning how we each experience the differences) and diversity (the shared experience of noting our differences), some recourse to philosophical thinking and understanding must be made. Any exploration of wider cultural dynamics and contemporary existence leads necessarily to considering embodied relational and intercultural dynamics, not simply as cognitive and behavioral constructs, but also specifically as philosophically influenced ways of being for the organizations we work in, for us as therapists and practitioners, and also for our clients.

Here, intercultural dynamics refers to the nature and capacity of engagement that emerges as co-experienced phenomena; in other words, what happens and what emerges when different people, groups, communities, and societies interact in depth.

My original talk at the EABP 2018 Berlin Congress titled *Towards Intercultural Working: Pitfalls and Possibilities for Body Psychotherapy* set out my ongoing exploration and discovery of what I call embodied intercultural ground. It includes a deepened understanding of the centrality of differentiated and inclusive dialogical dynamics that are necessary for the vitality of wider social bonding, embodied relational meeting across heritages, communities, and also across our own varied disciplines of somatic psychotherapy and body psychotherapy.

These emergent intercultural dynamics also bring us to potential tensions, conflicts, and misattunements, all of which require paying careful attention to *processes of identifying* and *felt sensing of identification,* and what these could mean in dialogic relation with others. This is an ongoing process of learning and insights for me, particularly in my more than 30 years of experience of teaching, training, and facilitating in the fields of diversity, and what I now refer to as the intercultural and intercultural ground. My intention here is to continue to stimulate dialogue within and beyond our body and somatic psychotherapy communities.

Over my decades of being a psychotherapist, and before that as a training and development specialist, I learned to embrace being challenged at the level of the personal, cultural, and behavioral norms that represent my habitual position in the world. I believe one of the key tasks of a psychotherapist is to be willing to have one's personal norms, habits, and ideas scrutinized, challenged, and changed—both inside and outside the therapy room, intentionally or otherwise.

Alongside this willingness to be challenged out of my habitual positions, I also have learned to hold in awareness what van Manen (2016:62), drawing on Husserl and Brentano, describe as being "simultaneously 'in' and 'of' the world". This is at the heart of much phenomenological enquiry methodology in psychotherapy. It is also part of growing discussions and developments about what is happening in the moments before we can identify our own actions of reflective and reflexive practice. Speaking to the work of Levinas (non-intentional phenomena), Marion (significant communications flooded with meaning), and Romano (where lived meaning is a gradual process of awareness and learning), van Manen highlights the ideas of meaning emerging not from self but from "experiencing the otherness of the other" (2016: 64).

Therefore, allowing possibilities of newly emergent understanding by engaging with processes of identification involving various dynamics of differentiated power and authority has become a major key in my understanding of good psychotherapeutic practice. It has become central to my work to go beyond simple awareness and engage as fully as I can with deepened awareness of power, authority and privilege as it arises. To be immersed while also holding reflective awareness of my immersion. It is a mentalizing embodiment that I am referring to; one that continually looks for the pitfalls of my own cultural and training cultural biases, in the moment and beyond.

From the Personal to Professional Practices and Ideas

From a very young age (around 5 years old), I was encouraged to think beyond some sense of centrality of my own personal existence. As a child, I was asked to speak about things from different perspectives. This was how my Dad, in particular, taught me to think. My mother encouraged me to appreciate the media of the arts as an expression of deeper meanings, not just through watching, but by doing. So, I danced, I wrote poetry, and later, I performed my poetry and acted. I got engaged with improvised acting and then with Shakespeare. I went on learning, training how to facilitate actors, performers, and others *in understanding creativity as emotionally sourced from self in interaction with others.* I went on to work with a theatre company on issues of embodiment, creative expression, and emotional meaning through the body, and I now continue to work as a psychotherapist with performers—especially performers in some form of existential and /or traumatic crisis.

Explorations in the performing arts and other creative endeavours have offered me a different and possibly deeper way to gain recognition of reciprocal relating and social bonding with humans and other living beings.

> At age 9, having just moved to the U.S. after the recent assassination of Dr King, I remember asking my dad about hatred: the why, the when, and the how of it. Asking why my sister, who is darker-skinned than me, was not allowed along with other black children onto the DC school bus by the driver, but I was? I did not stay on the bus, by the way.
>
> Later I studied slavery and learned about Rosa Parks, who is most known for refusing to give up her seat on a Montgomery, Alabama bus to white passengers when the bus driver ordered her to. She was arrested and convicted of violating Montgomery's Jim Crow segregation laws. I particularly like one quote generally ascribed to Rosa Parks: *"Each person must live their life as a model for others."*

I realized symbolically and economically that buses were used both for oppression and, later, for the fight for liberation. So at 9, I was already in the territory of *differentiation through discrimination,* and trying to handle others' projections of who I should and could be. And noting my relational response to the projection was as much at play as the beliefs and behavior of the driver himself.

What I know from my experience, and more importantly from working with groups, couples in intimate relationships, and individual psychotherapy clients is that such attitudes continue to carry the potential for destruction from without to within, long after the experience itself is over. This and other early incidents brought me, and I believe my sister as well, into more awareness of the wounds of "shadism" in Black and Asian communities, which was unknown to either of us before being in a post-Dr. King Washington, DC. Later I came to understand all of this as learning: to reflect, to see, and to start to understand similar wounding, in many other ways, for different peoples, families, communities, societies, regions, and countries. I learned that none of us are immune to the effects of differentiation through discrimination.

In my Berlin talk, I posed some rhetorical, and, I believe, important questions:

- Do we as members of EABP, for example, carry something of this when we talk about the low-income countries in particular ways or with particular attitudes?

- What does it mean if and when we apply our thinking in such a way that it affects how we may *conceive* of different individuals, communities, and groups collectively, in and out of our own awareness?

- How do we make sense of diversity, differences, and the context of sociopolitical and socioeconomic inequality, and not fall into "projective" traps in our own communities of teaching, learning, supervising, and practice?

Psychotherapist Lynn Jacobs proposes reconfiguring *projection as a shared experience* in which the "horizontalism of phenomenology" (where all phenomena are assumed to have equal validity) and recognition of multiple valid realities must play a part. What is vital is that we do not pathologize "… the patients' experiential truths…as [some kind of] support for therapists' defensiveness in the face of threats to our [own] emotional equilibrium" (2012: 60).

As a guest of the USABP at their 2018 Conference *"The Science of Connection: Honoring Our Somatic Intelligence,"* I had the privilege of meeting many participants and other speakers before my keynote to the conference. It became a phenomenological process for me as I experienced different voices, perspectives, and perceptions of our two organizations—all with a warm and friendly welcome, from every single person I spoke with. Over lunch, the day before my talk, I felt a collective acknowledgement and shared warmth as we spoke of many of the losses from our communities— Valstar, Gendlin, Keleman, and Woodman to name a few, with awareness of how many of them had focused on the coming generations of psychotherapists.

In my speech the next day, I talked about my vision of aiming for co-created unity and collaborative understanding within our organizations and across them also—of developing a shared vision of unity in diversity and an ongoing conversation that respects the cultural and other diversities represented by and within the two organizations and their membership. What had next become central for me was fostering a form of intersectional understanding. In facing outwards into the world as body psychotherapists, as somatically-informed psychotherapists, the USABP, and EABP (and our members) will, I believe, need to develop an increasing ability to engage in a polyphonic collaborative approach to our joint working, where polyphonic means simultaneous lines of independent melody harmonizing with each other. The *International Body Psychotherapy Journal (IBPJ)* is one of the ways in which the two organizations are trying to do this. These are the early days of that collaboration, and the editorial team and two boards continue to find the lines of melody that manage to harmonize in their dialogues.

From my perspective, the EABP has a central aim of supporting, through dialogue and exchange, a cross-fertilisation of the multiple (polyphonic) methods, approaches, interests and theories of the body and somatic psychotherapies. This is taking shape as

creative collaborative work and multiple perspectives continue to have a voice as both organizations try to find a way to deconstruct old dogmas and look toward collective processes that reflect the values of horizontal co-created working, while respecting each other's histories and perspectives. I believe the acknowledgement already made that body psychotherapy and somatic psychotherapy have many names and guises is vital to finding a successful way forward, where we are associating, relating, sharing, and supportively challenging each other so that our collaborative visions and strategies are able to nourish the life of our associations. Contrary to what prevails in the world as I write, I believe that the USABP and EABP can enrich each other through developing open dialogue and looking at ways for more collaborative engagement. My hope is that many members from both organizations will attend the EABP Conference in Bologna in 2020.

In April 2018, I presented *An Exploration of the Art of Outrage* for the Black, African and Asian Therapy Network (BAATN) Annual Conference in the UK, a not-for-profit organisation that exists specifically to encourage people of black, African, Asian and Caribbean heritage to engage proactively and consciously in their psychological lives so they can emerge from the impact of personal, internalized, and institutional racism. The art of outrage talk for me was an important milestone in describing my embodied and relational work through exploring creative process—not just as catharsis / outward expression, but also as integration through the witnessing presence of others.

Dialogue As Process in Relation to Creative Process

I believe that there is a place for dialogue about culture, heritage, and other minority and seemingly minority identities as process, relating to the body-mind within organizations, in psychotherapy trainings, and in our body and somatic psychotherapy practices in particular. I see this in dialogue as process and the processing of our dialogues, reflecting on the nature and meaning of our reflecting and speaking, holding, containing, and expressing from that place—which, paradoxically, has to be *newly found in each encounter* and yet at the same time be *continually developed.* Such challenges require body and somatic psychotherapy practitioners to develop the capacity to offer a balance between holding, containing, and emotionally expressive work in the context of what I call "differentiated equality." This is an ability to sustain diversity in unity and unity in diversity without suppressing or ignoring—and *actively and proactively engaging with—the reality of power and authority dynamics, both internalized and external,* that are at play in our encounters.

This, I believe, is the adult work of body and somatic psychotherapy, and is what I believe body and somatic psychotherapists need in order to manage today's complex and somewhat unstable world. The art of self-reflective practice, and the capacity to reflect on my reflecting, are key to understanding "embodied intercultural ground," as both are a source of deepened relationship and an ongoing outcome of relational working:

> By hovering over the territory of our work—working with both the wisdom of the body collective and the relationality of the therapeutic and supervisory encounter—we include learning from the creative theater of breath, sound, awareness, and movement in the context of *historical as well as current social and psychological moments.*

I want to look at what a performer has to say / offer us in considering the questions of differentiation, diversity, and intercultural ground through the wider lens of a choreographer, dancer, and performer. I want to focus on my first love, that of dance, and on one of my heroes. Akram Khan's work helps bring me to contemplating processes of identity and movements of people. Through moving in time and space as individuals, family groups, communities, or parts and wholes of populations from places, times, or spaces understood as *origin* to *not origin,* some kind of impact occurs that has profound meaning. The otherness of the other becomes a multilevel experience. Tim*ing*, plac*ing* and spac*ing*, in the new destination, is changed irrevocably. Dancer, choreographer, and a world-acclaimed Associate Artist of Sadler's Wells Theatre in London, Khan describes his work as a dancer and choreographer as someone who is capturing images of the body and putting them together by creating patterns.

In *21 Questions with Akram Khan* (YouTube 2019), I found the following responses he gave intriguing. I deliberately accessed something new, which I hadn't seen before, as I wanted to have an experience of Khan in the moment, so this part of my article would be phenomenological and fresh, today. Khan says, "My body has been my voice," and in response to the question "What is dance?" he replies, "Movement, generous, generative, and generational." He expresses the view that modern society can force the dance "out of us; "that "…all children are dancers," and that we need to be "eternally curious, like children," and he finishes with the thoughts "When we move, we live; movement is life," and that his favorite daily ritual is simply "practice."

As I listen to Khan speak, I hear his cumulative experience of working daily on creating afresh. It is this aspect of performers and artists that inspires me: their *renewal of commitment,* their *engagement in a practice* that is designed to both sustain their capacity to express and communicate, while at the same time is *challenged to be fresh with a sense of immediacy* that comes from staying in each moment as a "new" moment—the eternal curiosity that Khan highlights.

When I spoke in Berlin, I showed photos of him at work on a piece called Xenos. He was attached to ropes, poignantly dancing on a sloping sandy floor. Through this choreography, representing the struggles of one of the approximately four million men from the British colonies who fought in World War I, he shows the sense of the displacement of time, place, and space I discussed above.

Linking the Themes

When I was told "Look at me when I'm talking to you" at school in Washington, DC, and given the counter message at home "Lower your eyes when I'm talking to you," these *mixed injunctions* were multiple cultural habits I needed to learn in order to function in both environments. This is common for many of us: experiencing the dissonance between family injunctions compared to what is expected, required, or simply safer for us outside our homes, our family of origin, or our culture of heritage. Through our personal experiences, we are in the territory of microcosms. We are with macrocosms when we experience displacement and uprooting of people or entire groups of people, sometimes into very hostile and unwelcoming environments.

My hope is that 21st century psychotherapy, and particularly our body and somatic psychotherapies, will find new ways of offering dialogic and co-created spaces for

the intersectional moments of meeting and understanding self and other, that these intersectional understandings become the norm of our work, and that from our practice-based research and

research-based practice, we build this as a core part of our contribution to the wider world. Remembering Jacobs' words, in the microcosm of the therapy room, the therapist must find the capacity to facilitate understanding that a multi-dimensional process is happening, and that meaning-making leading to action and change is possible.

Final Thoughts On Inspiration

Current writing on physics is one source of inspiration. Carlo Rovelli (2014, 2015 translation), in his delightful work *Seven Brief Lessons on Physics,* states: "Science begins with a vision. Scientific thought is fed by the capacity to 'see' things differently than they have previously been seen." I conclude by suggesting that the exploration of intercultural ground and the dynamics of intercultural relating in body psychotherapy are a *vision in process* and progress. In this progress, body psychotherapists would actively engage in developing our capacity to see, be with, experience, embody, and examine "differently than they have previously been," and/or with more clarity about co-created emergent phenomena that leads to deepened awareness and possibilities for action for both therapist and client, student and trainer, and organizations and members, all in the context of the contributions we make to wider society. To borrow from my earlier description from BAATN, it is important that therapists seek to facilitate clients and themselves in *"engaging proactively and consciously in their psychological lives."*

Carmen Joanne Ablack, ***qualifications:*** *Master of Science (University of Westminster), Certificate in Interpersonal Mediation (Open College Network), Diploma in the Principles of the Theory and Practice of Supervision (Metanoia Institute), PG Diploma Integrative, Body Psychotherapy (Chiron Centre), PG Diploma Personnel Management (Polytechnic of Central London), BA Hons Psychology and Sociology (University of Leeds).*

Accreditations and Affiliations: *UK Council for Psychotherapy – Accredited Registrant: Integrative, Gestalt and Body Psychotherapist; Honorary Fellow; Training and Clinical Supervisor, European Association for Body Psychotherapy – Accredited Member and President of EABP, EABP UK and CABP – Full Member, Gestalt Centre London – Full Member, Black, African and Asian Therapy Network – Full and Leadership Group Member, UK Association of Gestalt Psychotherapy – Full member, UK association for Psychotherapy integration – Full Member, British Psychological Society – Graduate Member*

Email: secretariat@eabp.org

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English Smiles, Italian Shoulders, and a German Therapist

Julianne Appel-Opper

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ABSTRACT

With this article I want to highlight how bodies communicate with each other. The rhythms and melodies of how bodies move are so fascinating; so much is said before we even speak. What is communicated by a still shoulder, a glance away, or a slight finger movement? How does a living body sound like an orchestra, playing different melodies from its implicit relational knowledge? How are these tones, pitches, and melodies colored by their cultural background?[1] Would I as a German be able to understand an Italian shoulder or an English finger?

Throughout my clinical practice as an integrative Gestalt and relational psychodynamic psychotherapist, I have explored and studied these fascinating inter-bodily processes: what we say without speaking, and what we see without looking. I wanted to open up and listen to these communications without words[2], but most of all I wanted to find a way to reply in the same language. I wanted to liquefy and move frozen movements held in the body in a safe way, touching from a safe distance without touching each other.

Keywords: implicit body-to-body communications, cultural rhythms and melodies, embodied interventions and experiments

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[1] At the 2018 EABP Conference, the theme of intercultural work received the importance it deserved. Carmen Ablack focused on embodied intercultural ground, motivating us to look deeper into this field. Together with the panelists, Madlen Algafari, Cristina Angelini, Rubens Kignel, Ulrich Sollmann, my colleagues and I discussed the fascinating link between body and culture including macroscale (ethnical culture, society, socio-economic classes, political cultures) and microscale (bodily looks, signs, symbols, rhythms and symptoms). Here, I want to concentrate on how body-to-body-communication is colored in by cultural melodies and rhythms.

[2] In accordance with most colleagues from a body psychotherapeutic background, I see somatic resonance and vegetative identification (Reich, 1983 and 1986, see e.g. in Boadella, 2006) as important tools.

"I had a happy childhood"

A young female client came to see me about her "anxiety and panic." In this first session, Carole[3][4] sits upright in her chair. As she looks expectantly at me, she asks whether I could give her a recipe to deal with her anxiety and panic. I reply that it would be really nice if I could. I smile kindly, and add that we could try to explore this further with a focus on what might be helpful for her. Later, I ask whether she had experienced this or similar states of anxiety and panic before, during her childhood. Carole negates my question, adding that she had a "happy childhood." As she speaks, I see how her index finger moves to her lips and how her spine moves up slightly. I notice how her gaze widens, and how her eyes look straight ahead, silently, away from me. Her breathing is shallow, and her voice sounds less clear, as if it is clogged.

Carole's index finger, her lips, spine, gaze, breathing, lungs, and voice communicate embodied stories from different phases of her life. With the widening gaze, I almost see a bit of the baby's gaze, eyes that do not expect to be met, and that might not have been met enough by early caregivers. The finger, however, which closes the lips and impedes further speaking, comes from an older girl, like a schoolgirl who learned that it is better to be silent. Carole's lungs and spine communicate what happened to them, and what they are expecting physically now in encountering other lungs and spine.

My physical resonance is that I cannot breathe properly. I decide to share my bodily being with Carole and I say, *"When you said this, my breathing got a bit shallow."* She immediately looks at me, quite curiously, saying that she feels that too. *"At times I hardly breathe at all."* To her comment, I say that this sounds interesting. I ask her whether I could breathe mindfully a bit more, and then we could both explore what might happen. After I did that for a short while, Carole shares with me that this felt very pleasant, and that her chest also started to move a bit more. At the end of the session, I asked her whether she was curious to find out more about how her chest had learned these breathing patterns. This was the start of our work, which then went on for two years.

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[3] I like to call her Carole. Carole also represents various clients I have worked with over the years.

[4] A more detailed description of the following scenes has been published in German (Appel-Opper, 2019a) and in Norwegian (Appel-Opper, 2018c).

Hanging arms communicating *"There is nobody there anyway"*

I recall the following scene, which happened months later. Carole talks about her day-to-day student life and how difficult it is for her to reach out to others. She says, *"I feel so lost."* I notice her arms resting motionless on her legs. At the same time, I notice an impulse to move my arms, as if I had to make sure that I could still move them. I decide to begin an intervention, so I tell Carole that I felt I would like to move my arms when I heard what she said. I add that my arms would like to present some movements to her arms. With my use of the word *presenting,* I try to build on previous therapy scenes in which Carole and I slowly, mindfully, had begun to co-create explicit body-to-body-communications in which Carole had been able to watch my movements and inhale them into her living body. From my clinical experience, I have learned that expressing my intention has the effect of reducing fear. These are the words I say to Carole: *"I would like to move my arms forward slightly in a few minutes.* Would that be okay for you?" Carole answers, "Yes, that's okay." I remain kinesthetically related, attuned to how my words reach Carole physically.

If, for example, Carole had moved away from me slightly, or if she had held her breath, I would have asked, *"What is happening?"* In that case, I would have encouraged her to say more, and thus to open up this inter-bodily resonance. In the scene, Carole's breathing pattern does not change, and she doesn't lean back. I read this as an indication that my intention is okay for her. By now, Carole already knows what to expect: she does not have to do anything except sit there. From a safe distance, we both remain in our chairs. Carole can look at my movements (I encourage her to look from the viewpoint of her arms), thus determining the dose of the inter-bodily touch without being touched.[5] We had contracted before that she could say *"Stop"* at any time. Also, if she wanted to suggest changes, she could stop my movements. I breathe consciously in and out a few times. I sense that I am already sitting like Carole. I take a moment to sit comfortably enough to have a good starting point for the intervention. Only when I have a feeling that both bodies are ready for the intervention (sometimes I give a sign and nod) do I start with the movements. Meanwhile, I'm sitting like Carole, with my elbows on my thighs, my shoulders hanging down.[6] I remind Carole about what we had agreed before, that I put my movements in the space in-between us, so that she can choose how much to take in.

The intervention then consists of me slowly moving my fingertips gently forward for about 40 cm. With this movement, my elbows leave my thighs. After about three minutes, I stop my movements, and go back to the starting position, where my elbows

[5] In general, I do not sit opposite my clients; I sit at an angle of about 45 degrees. In this position, the client and I have the freedom to look away from each other. When my embodied interventions contain forward movements, as in this scene with Carole, I have learned that this is also less intimidating. From this position, my movements are not going straight towards her.

[6] During this process, before I start to move, Carole and I work out how to do this. Sometimes, I would ask about the distance between the chairs, whether they could stay like that or needed changing, and also about how to hold my arms, and how far forward to move. Carole and I cooperate as two bodies in this process.

rest on my thighs again. After a while, Carole starts to speak, and reports that her arms feel a tingling, and that this feels strange but good. I smile and nod slightly. After another moment, Carole says that she wants to try the arm movements herself. She says that she is curious about what it feels like when she does it herself. She adds that she had already felt the movement a bit.

When Carole makes the movements, her rhythm is slower than mine. She cautiously peeks forward with her fingertips. As she finishes with her movements, she says that her mother had never hugged her, and that *"My arms do not know how to do this."* I react: *"Can they still learn this, or?"* Carole smiles and says, *"Yes, they are going to do that."* In the remaining minutes of this session, Carole speaks about how this is all foreign territory for her. By being able to formulate everything more clearly in words, something is already changing.

What makes these movements so important and so healing?

Isn't it enough to be talking about childhood scenes? What would have happened if I had asked Carole in the first session, *"How are you breathing at this moment?"* I imagine that she would have had to first think about how she breathes. This question might have put her in the spotlight of receiving a lot of attention, which on one hand she longs for, but which she also fears. At this stage, I had not been aware of the magnitude of her loneliness throughout her childhood, namely to the extent of emotional neglect. In addition to her absent father, her mother had never fully engaged with her. Her widening gaze into nothingness represents the baby who had been left alone, and also the absent mother who was not able to fully engage with this baby.

Before my comment about my breathing and thus sharing my physical resonance with her, I had gathered quite a lot of information about Carole from the way she moved. When I looked at her living body as an orchestra (see Appel-Opper, 2017), I already heard some tones, pitches, timbre, and rhythms even before we spoke. The way Carole had entered my consulting room and sat down in the chair echoed some of the atmosphere of the world in which she had been born. If my chair could speak about Carole, I imagine I would hear, "Carole does not fully sit on me. She sits on the edge so that I do not feel her against my backrest. Does she suddenly want to leave again? Is she unsure whether she is allowed to be here, whether she will find her place? I can feel the tension in her thighs, not landing on me. This body does not breathe properly."

I envisage another challenge around the question in this process: "Would Carole have also been alone again?" By contrast, I tell her how my body breathes as I sit with her. It is as if her lungs had told my lungs some stories of her childhood experience that it would be better not to touch or talk about. In this way, my lungs tell her that they receive her stories.

In the scene later, a question like, *"Can you feel your arms?* Or, *"I can see how your arms hanging down"* would probably have reached Carole through the left brain rather than the right brain (see Schore, 2010). Moreover, with these questions, I would not have been able to reach out physically to the young, lonely girl in the adult.

In a new relational rhythm of mutual relatedness, both our arms, Carole's and mine, liquefy the early, frozen impulses of moving forward and looking for other arms. Both adults and both girls are present. Carole's adult modulates how much of the arm movements reach her and thus allows the little girl to receive impulses.

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With the image of a living body as an orchestra, the musicians also have different ages and gender. In the scene, Carole's arms have a certain age. In my experience, every movement of the body corresponds with a certain scene, and thus a certain age. This scene, and the scenes in which the arms learned to give up moving forward also includes another body, like another player. With regard to Carole, at first, mainly her mother came up, and how her mother had not been able to reach out to her, greeting her with arms wide open, comforting her, hugging her. So, in a way, the hanging arms are the young Carole's giving up on her mother, holding and shrinking back from deep impulses to reach out. However, in the hanging arms there is also a bit of Carole's mother, like echoes of an inter-bodily message of "I am not reaching out to you." This is the offender's behavior and the victim's behavior both entering Carole's body, and living and moving inside her. With my presenting movements, I try to stay within these scenes and their echoes, and thus within Carole's specific age background, thus adjusted to her age. In other words, I am mindful to whom I am reaching out, whether it is a 1-year old or a 6-year-old child. It is an interesting question, how ongoing inter-bodily experiences continue to shape implicit relational knowledge along the life span. From this, I take that I sit with a very young child within the adult, and sometimes with a 6-year old who needs to run, to run away from the unbearable tensions at home. With my embodied interventions, I present how I resonate physically, and then send impulses to unfreeze a held movement, or find ways to kick it off with the inner 6-year old without the adult being shamed or overwhelmed. The body as orchestra also enables me to focus on gender aspects. Beside her mother's arm movements, Carole also holds her father's strict looks and his waving with his hands messaging to her: "Don't talk to me when I'm reading the newspaper." With these scenes, Carole and I also explored her bodily repertoire of how she could embody and express gender. Later in our work, we focused more explicitly on the role her father's nonverbal and verbal relating had played in her life at various stages. Her pain about the deficits of being seen and acknowledged was at times unbearable.

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It is an interesting question, how ongoing inter-bodily experiences
continue to shape implicit relational knowledge along the life span.

Especially in my work with clients with similar traumas of emotional neglect, I have had good experience with embodied interventions and experiments. Unlike people who are traumatized by violence and attacks (besides the victim reactions), an offender enters the body who is rejecting, absent, uninterested, noncaring, and rigid. Then, it is as if a vacuum arises in which the client, here Carole, is alone with herself, which affects her ability to physically reach out to others, and also the development of a reflective inner space. The numb, mute, held expressive movements in Carole's body correspond to inter-bodily messages of, "You are nobody". As a "nobody," it is most challenging both to reach and to be reached, as it is incredibly painful to come into contact with the neglect of her earlier life. Carole had not received enough real physical interaction with her mother or another early caregiver to channel an ability for self-attention and self-care.

My clinical experience has shown me that my mindfully presented micro-movements have reached my clients in ways other than words. It seems that movements were received and taken in much more deeply than with words. Impulses were transported physically, and the procedural memory was reached, which is extremely important for the process of change. Many clients reported that it was precisely these explicit body-to-body-communications in therapy that had been important, and that they still felt the movements even after the therapy.

The culture in the body and the body in the culture

So far, I have not mentioned cultural aspects of my work with Carole. Does it matter where the clinical scenes between Carole and I play out, which language is spoken, which skin color we have, or how we culturally differ? My clinical experiences have taught me that culture matters.[7] Therapist and client can misread and misunderstand each other. Own culture colors in who we are and how we resonate with each other.

With regard to Carole, my smile is probably also related to the fact that I was working at that time as a German with Carole, a white, middle-class English woman in England, and have almost learned the "English contact smile." When I started living in the UK, these smiles used to irritate me. I could not read the intention behind them.

[7] For more clinical scenes see Appel-Opper, 2011b; 2016a; 2016d.

At times, I must have looked pretty serious: a tall woman with a clear German accent who tried hard to make sense of her surroundings. In learning the contact smile myself, my inner space opened up. My smiles can also be seen as my inner German girls inside me resonating with Carole's English girls, as both experienced slightly similar mother stories, yet in different countries and languages, and even different lullabies. In this way, both girls heard and echoed each other as, "Be friendly," "Say nothing," and "Hold your breath."

There is another interesting aspect that I've discussed before (Appel-Opper, 2006), and which I'd like to revisit briefly. Let us imagine that our cellars hoard all the experiences of the generations before we were born. I wish they were cellars that had stayed in Germany, and had not traveled with me. But I took my collective past, culture, and history along. How do Carole's parents and grandparents meet and interact with my parents and grandparents at a bodily level? Who are we both bringing into the room at the same time we work together?

Italian shoulders speaking

For some time, I offered psychotherapy to elderly clients through the National Health Service. Because of my clients' age, I did some home visits. I remember the following scenes with an elderly woman (I like to call her Anna) who had been referred with "severe depression."

As I enter her home, it is as if I enter a different world; the atmosphere feels different. Anna speaks to me in the local accent. However, through the accent, I hear other tones. As soon as I open my mouth, she hears that I am not British. She asks, "Where are you from?" To which I reply, "I am German." When we sit down, she tells me that her English husband had died some years ago. In a sad voice, she adds, "I am alone now." As she says this, I feel a heaviness in my shoulders. From the corner of my eye, I see that her shoulders look and seem heavy, and are somehow held, not moving at all. Also, the word "English" sticks out to me. I ask, "Your English husband?" — to which she explains that she is Italian. In the next sessions, we explore the fact that she had never been back to Italy. She says this in a matter of fact way. It sounds as if she had closed the door to her first Italian world. I say in a soft voice, *"Your shoulders look a bit lost to me."* This intervention unfolds a bodily, and with this, a cultural dimension, in which Anna immediately recalls how her mother had always spoken with her arms and hands. *"She always moved and gestured."* Anna adds, *"My parents are dead now, but both had been against my marriage to an Englishman."* Anna cries and says, *"This was such a long time ago, why am I crying now?"* Later on, I ask Anna whether I could move my shoulders up and down very slightly. I say, *"Can I present these tiny movements to your shoulders so that we both see how this might be for them?"* I recognize that her breathing becomes slightly deeper, and that she appears calm. Anna looks "touched," as if the movements had reached her younger Anna back in Italy while the Anna in the UK is fully present. After a few minutes, I finish with the movements, and we both sit in silence for some time. I ask how her shoulders feel. She replies, *"I can feel my shoulders a bit more and I also feel some warmth."*

However, with the unfreezing of the impulses held in her shoulders, Anna was able to express the frustration and disappointment she held toward both her parents. She spoke about how unwanted she had felt throughout her childhood, as both parents worked day and night to feed the big family in a rural, remote village in Italy.

What would have happened if I had seen Carole or Anna when I was still working in Germany?

During my work as a German psychotherapist in psychosomatic clinics in Germany, I had no perspective on culture. I had rarely asked a client where her/his accent came from. Looking back now, I fantasize that asking had felt too intrusive and also a bit too challenging. With my inquiry, I might have entered a world of experience that might have been quite far away from my own. I feel now that I had not been prepared for these experiences. I had worked from a scenario that my clients were the foreigners in the room, and that my culture was the only reality I could think and breathe in. Culture is so deeply ingrained in us, coloring who we are and how we look at the world, and how we move in this world of experience, in our own reality. My own culture was quite unknown to me. It is only when I lived and worked in other countries, and especially in the UK for nine years, that I learned about my own Germaness, my "cultural unthought known" (Tömmel, 2010, p. 97). I really do not know whether, and how, I would have been able to overcome my own "cultural narcissism" (p. 109) if I had stayed in Germany.

In the UK, as an immigrant myself, I had experienced how I felt less certain about my own self-movements as these were received differently (see Appel-Opper, 2007). I became a bit of a stranger to myself. In my work then, I was the foreigner in my consulting room. I learned that there were more realities than just mine. At that time, my German hand had learned to reach out and greet somebody only at the first meeting, and not at the start of every therapy session. In these meetings as two foreigners, I believe that my hands and Anna's shoulders really understood each other. From my own experience, I learned that as an immigrant I did not want to be too different. Quite similarly, Anna's shoulders also adapted to the new culture, with her past movements from her first Italian world sealed inside. Later on in therapy, we explored how her husband's death had felt like another abandonment, which brought up her earlier experiences around being abandoned. In this respect, I encouraged Anna to speak in Italian when she addressed her mother in the empty chair, telling her what she could not have said before. At the end of our work, Anna told me that she had decided to visit Italy again. I still see her face when she said that, all smiling and with her shoulders moving a lot. The depression of being a fish in foreign waters had lifted.

White sweating arms speaking

I recall a scene from work with a female trainee I like to call Emma. Emma said that it was important that I was not English, adding that she felt freer to share her experience with

"the English" with me. We focused on how her parents had immigrated from a Caribbean country, and how painful and challenging this had been for them. Emma shared with me a very painful memory of being discriminated against because of her dark skin. I could see that her body was there in this old scene, being shouted at, and pushed against the wall surrounded by these "horrible white children" with no hope of getting help. She said that she felt so humiliated, and that this happened again and again, before and after school. There was no escape. I was deeply touched. I also felt ashamed as I sat there as a white person witnessing what these white children had done to her. I started sweating. I recall that because of my sweating, I rolled my sleeves up. This made her look at me, at my eyes first, and then down at my white arms. She immediately said, "You are white," to which I replied, *"Yes".* She then added, *"And you are German,"* to which I also responded, *"Yes".* I recall how we both sat there. Nobody said anything. In the silence, I touched my arms slightly, which Emma looked at and sat with. As I got hesitant, Emma said that she liked my movements, saying, *"Carry on,"* and so I continued for some minutes. At the end of her training therapy, Emma said that this had been a very important part of the therapy. She added that every white person she had ever told about the discrimination had always said *"Sorry,"* and how she had felt shut down by this. She added that my movements had a different impact on her. *"Your arms understood something about me so deeply."*

A German therapist in Germany: who is different?

Since my move to Berlin, I have worked with clients whose first language is British English, American, or some other language. In the latter case, the therapy then takes place in a "third language," as it is neither the client's mother tongue nor mine, nor the language spoken in the country in which we both live.

At that time, I had offered a seminar on cultural awareness in Norway. In an exercise, I asked the participants to imagine that the Extraterritorial ET[8] would ring their doorbell, asking them to tell him everything he should know about Norwegian culture. ET would add that his human body would be transported the next morning, and that he wanted to move freely in this culture. At the end of some lively discussions and giggling, a colleague said quite seriously that it seemed impossible to learn all that, and "how foreigners must struggle".

Sometimes in these first years of coming back to my own culture, I felt as if I was no longer either British or German. Was I ET now? When I had worked in the UK, my own immigration background was noticeable, and audible, with my German accent. Similar to other immigrant therapists (e.g., Kogan, 2007; Lobban, 2013; Sapriel & Palumbo, 2001), my cultural otherness could not stay out of my consulting room. But how would difference now come into my consulting room?

[8] As a visitor from another planet from the movie "ET"

Standing up with four legs is better than two

The client who I like to call Maria speaks several languages. As she had lived for some years in the UK, her English is as fluent as her German. As the sessions went on, Maria and I discovered that she had fled her dominating mother together with her mother tongue. The therapy took place in English. This was important to Maria. *"This language calmed and cooled me when I lived in the UK."* We focused on how the English words acted for her as if she were finding the missing English father who had died when she was quite young. In a later session, she conveyed that she had to leave the UK as she could not bear to live there anymore. Splitting into the ideal English world and the first world of her childhood became permeable. The distance from the flooding mother also distanced her from her own wounded child. In conflicts with her German partner, Maria got overwhelmed with rage and anger. It became clear that she felt easily betrayed and anxious that her partner would leave her.

I recall the following scene in which Maria spoke about a recent conflict, which had happened over the previous weekend. I noticed how her soft English words covered her feelings, as if icing everything over with sugar. As I sat with her, I noticed that my body felt tense, especially my legs and my arms. I could see that Maria too had changed her sitting position, and had sat more upright. Something was happening at a bodily level. I recall that I asked what her body would say. Immediately she stood up and formed her hands into fists, and stood in front of me. I believe that this took us both aback. As we stayed with her bodily position, I asked her to breathe, and just to notice what was going on. I was touched how she stood there; she seemed so young and alone. I then asked her, "Who is in front of you?" Maria promptly said that her father, who had left her behind with her mother, was there. I said that I was with her, that she was not alone. As I said that, I was also not sitting anymore. I stood next to her at a distance. It felt as if two bodies were needed to contain the pain and the rage of this little girl. In this sequence, I just stood there calm and present to support my client if needed. She later shouted at her father, first in German and then also in her first language. It felt as if her body was bursting with the feelings held inside. When we spoke about it later, she said how she always had to look after her mother: *"Everything was about my mother!"* The feelings of the little girl remained unspoken. Maria added that she liked that I had stood with her, that my standing up felt important to her, as if I really intended to be there with her. In subsequent sessions, we both focused on what kind of movements Maria's body needed in order to unfreeze more feelings held in her body. After some time, Maria moved away from Berlin, again to another language and another country.

I have seen many immigrant clients who seem to live in a cupboard, connected with the world online, but without many real relationships with people where they live. Are they staying forever ET, traveling the world, staying some years there, and then moving on and carrying their ambivalent, unresolved attachment patterns from their childhood, and with this the cellars of experience of their grandparents and parents? With every different language spoken, the experience of their childhood becomes harder to reach, like "graves of language" (see Tömmel, 2010, p. 98). My heart goes out to them.

**With every different language spoken,
the experience of their childhood becomes harder to reach,
like "graves of language"**

I hope I have illustrated that in intercultural psychotherapy there are also two living bodies communicating and telling their stories of similarity and difference, and of their experience from different realities. From my experience, we cannot learn to work in a culturally sensitive way solely from books. In that way we learn it with our heads, but not with our hearts. If we know a lot about other cultures, we can even discriminate better as we then know more about what is the custom in this culture. I was able to learn from living, breathing it in, and experiencing different cultures. I had to go through a process of feeling lost, and finding my own feet again in a new culture in order to open up to listening to my clients' stories of being othered.

Besides my private practice, I offer seminars in English for international colleagues in Berlin. The main focus is on bodily processes in psychotherapy. However, as participants come from different countries, the cultural tones and melodies have become a very important part of the bodily processes unfolding, from which we have all learned a lot.

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Julianne Appel-Opper, *Dip. Psychology, German CP reg. Psychological Psychotherapist, UKCP reg. Integrative Gestalt Psychotherapist, Supervisor, University of Birmingham, UK international Trainer and Visiting Tutor. Julianne is now in private practice in Berlin, but continues to work internationally as a visiting tutor at psychotherapy training institutes, presents at conferences, and offers trainings in Berlin in English/German. She has developed an approach to relational bodywork within an Integrative Gestalt frame, influenced by relational psychoanalytic thinking. She is the author of 27 related publications. For 9 years, she lived and worked as a psychotherapist and trainer in the UK, both privately and in the NHS.*

Email: julianne.ao@web.de

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"If you turn me into a fag, I'll kill you!"

Body Psychotherapy and Its Potential Role to Help "Real Men" Become Real Men

Marc Rackelmann

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ABSTRACT

This article explores what needs to be considered for body psychotherapy with male clients. It touches on the debate around masculinity, and presents an overview of the research into why contemporary psychotherapy isn't suitable for many men, and what characteristics male-appropriate psychotherapy needs to have. These findings are then applied to male appropriate body-psychotherapy, and illustrated with brief case descriptions. The article also offers some reflection on issues that can arise when working with heterosexual or gay clients as a heterosexual or gay body psychotherapist. The author maintains that body-psychotherapy, with its emphasis on the unity of body and soul, its "hands on" approach, and its ability to reconcile cognition and emotion, seems to be particularly suited for working with men—if certain adjustments are made for male clientele.

Keywords: masculinity, gender, male-appropriate psychotherapy, psychotherapy research, body-psychotherapy with men

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In the 1999 American comedy *Analyze This,* New York mob boss Paul Vitti (Robert DeNiro) begins to develop frightening symptoms in the aftermath of a shootout that massively affect his ability to do his job. After Vitti is examined at a hospital, the doctor breaks the good news to him—that his attacks weren't heart-related, but were panic attacks. In response, Vitti has his men beat up the poor doctor. Then, he secretly finds himself a psychoanalyst. After the first session, Vitti clarifies to the analyst that one outcome from therapy has to be ruled out in advance: "If you turn me into a fag, I'm gonna kill you!"

In a funny way, the movie illustrates the minefield in which psychotherapy with men often takes place. Heterosexual men, stuck in the traditional image of masculinity (and they aren't the only ones), often find it embarrassing to seek help. If they do, they try to stay in control of the therapeutic process, and avoid emotional closeness that is perceived as effeminate. At least at the beginning of therapy, many men approach the therapist with an expectation that can be paraphrased through the German proverb: "Wash my fur, but don't get my hair wet!" The English equivalent would be: "Make me an omelet, but don't break any eggs!"

"Men are often perceived as 'difficult' patients, even if they have already gone into psychotherapy. Because of their emotional defenses, their fear of dependent relationships and their inability to accept weakness, they confront the psychotherapist with special challenges." (Möller-Leimkühler 2013: 6, translated from German)

In this article, I will shed light on what needs to be considered for doing body psychotherapy with men. After a brief look at the public debate on masculinity and the challenges of working with straight/gay men as a straight/gay therapist, we examine the results of psychotherapy research, and its significance for the field of body psychotherapy, illustrated with short examples from my practice.

One conclusion in advance: in my opinion, body psychotherapy, with its immediacy and focus on emotional experience, is particularly suitable for working with men—if we consider certain conditions.

When Masculinity Turns Toxic

Once upon a time, women were considered the deviation from the male norm—the "dark continents" whose souls seemed unfathomable, who envied men for their penises, producing strange disorders such as "hysteria" (Freud 2010).

Nowadays, men are being targeted as the problematic gender. Whether it be violence or crime, sexual assault, school failure, unemployment, loneliness, suicide rates, or cigarette, alcohol, or drug abuse, in all mental health parameters, men are falling far behind (RKI 2014, APA 2018, Hesse 2019, Hollstein 2017).

In the debate, there is an increasing belief that a key factor of this development is a limited (and limiting) understanding of masculinity, which is often referred to as "toxic masculinity"[1] (Addis et al 2005). Characteristic of toxic masculinity is an overemphasis on traits such as independence, assertiveness, objectivity, aggressiveness, risk-taking, dominance, hardness, etc., while condemning qualities considered feminine, such as caring, kindness, delicacy, receptivity, or emotionality (Möller-Leimkühler 2013, APA 2018).

But it is not just the adherents of traditional toxic masculinity who sometimes feel its burden. On the other side of the spectrum, particularly in large urban areas of industrialized nations, we find men willing to change, committed to partnership and equality. These men are struggling with the existing, contradictory role expectations for the modern man: they should and want to be empathetic and cooperative, but also gripping and self-confident, good fathers and successful at work, sensitive, but no sissies—"purring cat and penetrating tiger," as the German sexologist Volkmar Sigusch put it (Haberl 2015, see also Rackelmann 2017: 18ff). No wonder these ideals cause many men to feel insecure about themselves. The media-mediated images of masculinity contribute to this chaos. On the one hand, we see the male world-saving heroes in movies and TV shows (nowadays tinged with some irony), and on the other hand, we have the unsettled, eternally adolescent nerds of "The Big Bang Theory."

[1] In this article terms like "toxic masculinity,""stereotypical male," or "real man" are used synonymously.

As an antithesis to "toxic masculinity," American psychologists Mark Kiselica (2011, 2016) and Matt Englar-Carlson (2010) suggested the term "positive masculinity." They define positive masculinity as "beliefs and behaviors of boys and men that produce positive consequences for self and others [...] learned and internalized through a socialization process while fostering a sense of duty to others." (Kiselica et al, 2016:126). But, as shown, realistic role models of positive masculinity are still rare.

Men and Psychotherapy

Psychotherapy research has critically determined that psychotherapy in its present form is tailored for the needs and strengths of women, while it often doesn't fit the needs of men. Psychologists Robinder Bedi and Mica Richards from Western Washington University have examined what makes men shy away from psychotherapy. They summarize their findings, which are consistent with other studies (Brooks/ Good 2001, Sonnenmoser 2011), as follows:

> "Although a range of both masculinities and therapeutic approaches exist, conventional elements of psychotherapy and traditional elements of masculinity seem mismatched, leaving many men unlikely to seek mental health care or to receive gender-informed services because of gender role stress or conflict […]. For example, many characteristics considered desirable in a psychotherapy client are traditionally feminine— clear expression and verbalization of emotions, the ability to discuss personal pain, the willingness to be vulnerable, and turning to others for help resolving problems […], yet the traditional masculine gender role teaches men to avoid acting or expressing themselves in ways typically considered feminine […]. Thus, men may view counselling or psychotherapy as feminizing and believe that seeing a mental health professional would threaten their masculinity […]. Conventional masculine gender norms also emphasize separation and independence at the cost of attachment and connection, yet counselling and psychotherapy call for a bond between the professional and the client […]." (Richards/ Bedi 2015: see also Sonnenmoser 2011)

So, it seems that the behavior of our mafia boss mentioned above is not that far from reality. Although men are still psychotherapeutically severely undersupplied (Möller-Leimkühler 2013, Mörath 2013), the willingness of men to go to psychotherapy is generally increasing (Habich 2016). At the same time, there are fewer and fewer male psychotherapists. In Germany, about 70% of all psychotherapists (and clients) are currently women (Degner 2013). According to the German Federal Psychotherapeutic Chamber, 91 percent of therapists under the age of 35 are female (Habich 2016). This trend is likely to be similar in most developed countries. Even though most men would prefer to work with male therapists (Sonnenmoser 2001), studies show, however, that the gender of the therapist plays only a marginal role in therapy's success (Bedi/Richards 2011, 2015). For this reason, male therapists are often in strong demand by men (Habich 2016). In my own practice, about 75% of my individual clients are men, of which about 80% are heterosexual and 20% homosexual.

The reasons why men come to see me are (in no specific order): relationship issues, advice on professional issues, depression, anxiety, addiction, loneliness, sexual problems, PTSD, life and transition crises (like becoming a father), and health issues.

Gay or Straight?

When we use the general term "men," we should not forget that we're dealing with heterosexual as well as homosexual men.[2] Depending on the gender and sexual orientation of the therapist/client dyad, individual dynamics, transference issues, and blind spots may arise. In the context of this article, however, we can only briefly touch on this topic.

In addition to the dynamic of a female or male therapist working with a male client, concordant therapist/client pairings (hetero therapist/hetero client, gay therapist/gay client) as well as discordant pairings (hetero/gay, gay/hetero) in terms of sexual orientation are possible.

When I work as a heterosexual therapist with gay clients, I'm fully aware of their often very different life experiences. This includes the experience of discrimination or violence, a sense of being different, different life and relationship concepts, a different approach to sexuality, etc. (see Wolf 2016 and APA 2011). At the same time, the male gender role—such as being strong, capable and independent, the separation of emotion and cognition, sex and heart—is no less pronounced in gay men than in heterosexual men. For gay men, the pressure to be physically fit and sexually attractive often comes in addition. The availability of non-binding sexual contacts in metropolitan gay subcultures brings its own challenges, both to love relationships as well as to the integration of sexuality and intimacy.

The issues related to a client's homosexuality are furthermore heavily dependent on the social environment he is living in. A gay fifty-year-old in a long-term relationship living in a liberal Western city deals with different issues than a man in his twenties in a rural religious area.

Being non-discriminatory as a therapist does not mean being uncritical. Having questioned my own value judgments and norms as a heterosexual therapist (or my norms as a gay therapist respectively), I can and must look critically at my gay clients' life practices and evaluate together with them if they are acting in their own best interest.

Elements of Body Psychotherapy for Men

Although body psychotherapeutic work with men brings its own methodical challenges, essential results of the research on the development of a male-appropriate psychotherapy equally apply to body psychotherapy.

We have learned that the following tendencies can be observed in men[3]:

[2] I have no experience with transgender clients and therefore cannot comment on this topic.
[3] Compiled after Brooks / Good 2001 , Bedi / Richards 2011 + 2015, Vennen 2013a + 2013b, Kehr 2016

An overemphasis on rationality, a functional understanding of the body, emphasis on autonomy, action and solution orientation, a tendency towards externalization (looking more outward than inward), and high inner tension (Kehr 2016: 81f, Vennen 2013a).

If we look at men's resources, research lists humor, self-assertion, rationality, and action and result orientation (Vennen 2013a, Kiselica/ Englar-Carlson 2010).

As elements that have proven useful for the psychotherapeutic work with men, the literature mentions focus on resource, clarity and structure in context and communication, professional and personal transparency, psychoeducation and practical help, focus on experience, and humor (Vennen 2013 a+b, Englar-Carlson 2010).

Let's take a closer look at some of these points, and how we can apply them to a body-oriented approach.

Resource Orientation, Psychoeducation and Transparency

How can the widespread male propensity for objectivity and rationalization be used as a resource? The German psychotherapist Johannes Vennen uses the technical affinity of many men by providing online diagnostics, and having them use smartphones to record sessions and tablets for visualization (Mörath 2013, Vennen 2013a + b). I sometimes let men try out a biofeedback device to objectify and visualize the degree of their current stress level.[4] Since many men are not used to paying attention to and interpreting their own somatic signals, this external validation can be useful for getting a feel for the expressions of their own body. Many men are surprised to find out how stressed they actually are. When men realize that their scepticism and their need to grasp something intellectually are welcomed and accepted, they are more willing to embrace new experiences.

Thus, it is helpful to make our therapeutic procedure transparent and, where necessary, give some theoretical background as briefly as possible. Models of emotional regulation, such as the Polyvagal Theory (Porges 2017) or results from developmental psychology, can be outlined in a few sentences (and reread, if necessary). This helps to categorize experienced emotional and sensory states. For most men, at least initially, science-oriented models and concepts are more appropriate than "esoteric-"sounding terminology.

I often offer body exercises for reducing tension, grounding, and centering (such as stress positions from Bioenergetics or TRE by David Berceli (2007)), or pelvic floor exercises from Sexocorporel (Bischof 2017 a+b, Rackelmann 2017: 137-151), which can be practiced at home. Sometimes I use psycho-educational teaching material, such as short texts or online videos. I've asked a client with a pronounced schizoid structure to watch a YouTube video of the Still Face experiment.

[4] I use an emWave2. But there are also sensors that can be controlled and read with a smartphone. These devices measure heart rate variability (HRV) as a stress marker (McCraty et al 2001).

He had previously noticed that he was often inappropriately sober and rational in personal relationships. We talked about his depressive mother, and the video made it more tangible to him how his low-resonance parents may have affected his own early development and to what extent his present-day experience could be a result of this lack of resonance.

Experience Orientation and Mindfulness

Many men lack an active connection to the expression of their own somatic self, to their body intelligence, or their endo self, as Will Davis (2014) puts it. For my male clients, therapy largely entails learning to listen to this deep self, and to integrate its utterances as part of the self. When the curiosity for new experiences is awakened, the modalities of body psychotherapy offer a variety of possibilities to rebalance one-sided rationality through connection with one's own somatic self.

I usually start my sessions with a short body scan, in which both my client and I get in touch with our current states: what's going on inside of me right now? What feedback do I get from my body? How am I breathing? Where do I feel tension? How would I name my current state? Am I able to focus on awareness of my body, or do I immediately start thinking? How do I react to the other person sitting across from me?

I make it clear that this is not a relaxation exercise, but merely an inventory. The client's self-assessment also gives us diagnostic information about how differentiated his connection to his somatic world is.

Borders, Transgression, and Trauma

In conventional psychotherapy, we sit across from each other and talk. Working with the body directly can sometimes feel like a transgression in and of itself, particularly for men. Standing face to face with the therapist or lying down puts clients in a vulnerable and potentially unsettling situation.

To mitigate the impact of this transgression, we need the explicit (and always revocable) consent of our clients, and we need to focus on their boundaries. Even if we do have their conscious consent, it may be that the man's body contradicts the verbal consent given. He may do so, for example, by showing high sympathetic activation or unconsciously holding his breath and withdrawing internally. If we act cautiously, pay attention to these non-verbal signals, and name them, we can use them very productively in the therapeutic process. We can tell if a man knows what's happening inside. Does he understand what makes his body react in such a threatened way? When male clients volunteer for the first time to lie down on the mattress, I often let them decide how close they want me to be. This diminishes the feeling of being at the mercy of others, and gives us the opportunity to see how human (in my case, male) proximity affects them. We also recognize whether the verbal and nonverbal signals appear congruent to us. When a man, often for the first time, focuses on his own boundaries and the subtle aspects of human closeness, he is often surprised at the strength of his own body's response. If a man dissociates, he may not perceive his reaction as a sense of threat. This also provides a good starting point for further exploration: "Don't you find this interesting too? Your body seems

to say, 'It's too much, I can't stand it,' yet you're telling me you're fine. Does this sound familiar to you, that you endure things that are unbearable, and you put up a brave front?"

The stereotypical male image of having to cope with difficult issues alone means that traumatic events cannot be adequately processed. We therefore find untreated trauma in many male clients, which they are unaware of. I would go so far as to say that becoming a "real man" involves a ton of traumatic experiences.[5] The manifestations of it are many of those already described: high levels of internal and muscular tension, a tendency to rationalize or dissociate, limited contact with and understanding of the expressions of the body, depression, addictions, etc. Hence, with many men, gentle foreplay (the irony!) is required, which opens them to the fact that they are showing signs of unprocessed trauma. Therefore, body-psychotherapeutic work with men must include trauma-therapeutic competencies (see Ogden et al 2006, Schnarch 2017).

A sequence that reminded me yet again of the importance of focusing on the boundaries of my clients: Richard, a gay client in his mid-sixties who had been in therapy with well-known body-psychotherapists in the 1970s, told me he had had very mixed experiences there. According to him, it was very much about the expression of aggression with a tennis racket; one therapist had told him that he wasn't gay and should fuck a woman instead.

After he hesitantly lies down on the mat in the first session, I ask him: "Would the touch of my hand be comfortable anywhere on your body?" "No", he says after a short pause.

I ask him to find a sentence for his "No." He says directly: "Don't touch me!" As soon as he says that, he becomes sad. So far, I've been sitting close to the mat, and I suspect that my mere proximity is perceived as threatening to him. I ask him: "At what distance do you want me to be?" We try different distances. Finally, we find the right distance, about 1.5 meters away from his head. His sad eyes are seeking contact with mine, and his story begins to burst forth. For the first time, he tells me about the violence in his childhood, and sexual abuse by his father.

Again and again, I find that an explicit focus on boundaries and mindfulness when approaching a client builds trust. This can lead us directly to the central traumatic issues, especially if violence and sexual or emotional abuse play a role, and we are less likely to retraumatize our clients.

Speaking of male closeness: since for many men, physical proximity amongst men has either a gay or an aggressive connotation, closeness and touch by a male therapist is an issue for some heterosexual clients. When I'm putting my hand on a client's chest for the first time, I ask him how he is doing. If I deem it appropriate for the client, I ask if his "homo alarm" is ringing. The somewhat provocative and humorous response may be helpful to open this potentially embarrassing topic to an open exchange.

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[5] The wonderful 2015 documentary "The Mask You Live In", about being and becoming a man in the U.S., presents vivid and touching examples of the trauma involved in that process.

Sexuality

When they started to mate, it was a great discovery for many men that their sense of isolation, at least for a moment, could be overcome in a sexual encounter. That factor is often overlooked when we're looking for the reasons why, for the majority of men, sexuality is of such particular importance.[6] Hence, the disappointment, anger, and shame, when it comes to sexual difficulties, regarding the penis or the partner refusing to function "as they should." Unrealistic and technical notions of sexuality–nourished by, among other things, pornography–combined with the widespread shame of talking about sexual issues, often lead to lonely suffering for men. Sexuality and relationship issues are a focus of my work, which is why men tend to trust me in this intimate and vulnerable area. On the somatic level, I work with modalities from Sexocorporel, a very elaborate model of body-oriented sex therapy (Bischof 2017 a+b, Rackelmann 2017: 137-151). It can be easily demonstrated to men how a tense body not only affects their sexual experience and emotional contact with a sexual partner, but how it may also cause sexual dysfunction, such as premature ejaculation or erectile dysfunction. The desire for a "better functioning" sexuality thus provides us with an excellent opportunity to help men perceive the relationship between their own history, trauma, body tension, emotions, and sexual experience. Men experience that the "better lover" all men want to be is the man who is connected with his emotions and his heart, and able to relate.

Creating a Working Alliance — From Seeing and Being Seen

Creating a sustainable working alliance is often the hardest part of successful psychotherapy with men. At the beginning of therapy, men are sometimes openly or covertly sceptical, reserved, aggressive, prolix, and rationalizing. An invaluable tool for my work, especially during the initial phase, is the use of mind mapping.[7] This means that at the moment when two people meet, they always automatically check each other out, and form an image of the mind of their counterpart. This also applies to therapists and clients. Very rational and unassuming male clients can lead psychotherapists to the misconception that they would not closely monitor and assess them because they appear to lack empathy. Female psychotherapists tend to be even more susceptible to this misjudgement, as men generally know how to fly under women's radars, including the man the therapist is in relationship with (Schnarch 2011b).

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[6] I often notice that men who are particularly sensitive to sexual rejection have experienced early deprivation. It appears that there is a link that warrants further research. See the case story in Rackelmann 2017: 255ff.

[7] See Schnarch 2011 a+b, 2017. The research on "Theory of Mind" (ToM, Fonagy et al 2004) demonstrates the ability of almost all adult humans to form an image of the mental inner world of their counterpart. The American couples and sex therapist David Schnarch uses the term "mind mapping" (synonymous with the ToM, Schnarch 2011 a+b, 2017). However, Schnarch points out that emotional empathy is only the emotional aspect of mind mapping. This is the part that is understood by "mentalization" (Fonagy et al 2004). In fact, mind mapping involves a mental aspect that develops even more in difficult conditions. Schnarch emphasizes that MM is primarily a survival mechanism already present in (unemotional) reptiles. MM can be applied prosocially (getting somebody a surprise gift) as well as antisocially—lying, cheating, and cruelty.

But in fact, as therapists, we are being monitored closely, even and especially by men, who watch us with a poker face, creating the impression that they can't even tie their own shoelaces, emotionally speaking. This lack of resonance, and the feeling of being secretly observed, can trigger some stress in the therapist. When we perceive and respond to what is happening right now, it can be the beginning of a wonderful friendship—well, at least, of a viable therapeutic relationship.

An Example From A Preliminary Session

Rick, a man in his mid-thirties, gives only very short, general, and sarcastic answers to my question about his reasons for seeing me, while he's watching me with alert and belligerent eyes. He's testing me. Immediately I see a man in front of me who must have grown up in a hostile environment, in which any form of closeness was dangerous, and in which he had to develop the ability to become aloof, using attack as his best option for defense. I say kindly, "How about you tell me what brings you here, rather than forcing me to worm the information out of you?" His posture changes instantly. He becomes softer and more accessible. I seem to have passed the test. In fact, from then on, we have a very good working alliance despite the fact that he actually came from a sadistic, violent, and reality-distorting family. At the core, my remark merely signalled to him: "I see what you're doing, and I'm in relationship with you."

Of course, usually one successful remark doesn't do the trick, and, there are often repeated tests for the therapist. Once we have passed these tests, deep and sustainable therapeutic relationships can arise surprisingly quickly.

Some men have very clear and fixed ideas about who they are and what the world is like. If we challenge these ideas too soon, we risk losing their confidence. If we do not challenge them at all, the therapy will remain superficial, and we won't be able to help them. Take, for example, the man who came to see me because he felt offended by almost everyone, and despaired at the madness of the world. He described himself as a "stranger in a strange land." On the one hand, it took my willingness to take his ideas seriously (there are good reasons why we can despair of the world), and on the other hand, I had to gently open him to the possibility that he wasn't only lost to the world, but was also lost to the depths of his soul, as well as to trauma that he hadn't previously been aware of and, therefore, hadn't processed. This unconscious, unprocessed trauma came to the surface.

Therapeutic Relationship

Research confirms that the therapeutic relationship is central to all successful psychotherapy (Grawe 2000). This is particularly true for body psychotherapy with men (Bedi/Richards 2011). Regardless of whether you are following an approach that involves hitting a foam mat with a tennis racket or mindfulness, the relational aspect in therapy is the most significant one. This applies both to the relationship between client and therapist, and to the relationship of the client to himself. In my experience, a certain personal approachability and—in appropriate doses (Tanner 2017 a+b)—the personal transparency of the therapist is helpful to build this relationship. Since male contact can

quickly become dominated by competition, we can counteract this by making ourselves tangible as human beings, ready to reveal that we know the abysses of human existence (and, for male therapists, the impositions and limitations of a traditional male role) from first-hand experience.

Sooner or later, men may realize with horror that they have feelings, tendencies, and interests inside that cannot be reconciled with the stereotypical image of a "real man." We can alleviate this horror by revealing that there are comparable tendencies within their therapist as well. Here's an example from therapy with Michael, a police officer in his mid-forties, who grew up in a rural area. When he initially came to see me, Michael usually spoke with a rushed and inappropriately loud voice. He wasn't aware of the extent of his inner pressure. At the same time, he was repeatedly surprised by his tears, to which he couldn't assign an emotion or a memory. In the course of therapy, he learned to better listen to what his soul wanted to express, and to integrate certain childhood experiences. His tears connected with past experiences and emotional states. In accordance with a classic male stereotype, he had built a house with his own hands as a young man, and he derived great pleasure from tinkering with vintage cars.

But then, he also found sensual, sensitive and lyrical aspects inside, which didn't line up with his own ideas of what it means to be a man. One day, he bashfully confessed to me that living with his wife, he was the one who took care of the flower arrangements, or decorating the breakfast table. And he loved the roses in his garden, which blossomed under his caring hands. I suggested that he look at me and say out loud: "I'm Michael and I love roses!" This resonated strongly with him, and tears came to his eyes. Crying, he added, "... and I love to go through the forest after a rainstorm!" I was very touched by his courage to show himself this way, and I just wanted to tell him about my own weakness for robins and nightingales, when I promptly heard a robin singing outside my window. I pointed this out to Michael, and I told him about my secret love. Two real men listened intently to the melancholy and delicate beauty of its song.

By the way, for many men, music is an important access to their emotionality. Often, in the life of a lone wolf, music is his only consolation (until he tries assigning this task to women). Sometimes, I let men play music that is emotionally important to them. Completely independent of my own musical taste, listening to a piece of music together can be very intimate and emotionally opening.

It may be a ground breaking discovery for men that other men are also sensitive, know crises, have to deal with failures, sexual difficulties, feel scared, or have a soft spot for flowers, ballet, or songbirds—even their therapist. Often, men think they are the only male specimen with a "flaw." Our willingness to let our clients see us as sensitive, imperfect, and sometimes struggling human beings can help them develop a healthier and more realistic idea of what a real man is like.

Summary

We live in a period of upheaval in which the gender roles and patriarchal structures of our societies are undergoing fundamental change. The rule of the traditional, patriarchal male is slowly crumbling. The current strengthening of authoritarian-

patriarchal tendencies all over the globe can be understood as a reaction to this development (Peglau 2018, Hollstein 2017, Moore 2019). The problem is not masculinity itself, but the dominant toxic version of it, with deep roots in thousands of years of patriarchal rule and social structure (DeMeo 1998). But men are beginning to realize that they themselves are needlessly suffering when they try to adapt to a stereotypical image of a "real man." And many are willing to find their own ways into the new and uncharted territory of becoming a real man.

Especially since the Me Too movement, the toxic aspects of masculinity have come under public scrutiny. Public health policy has also discovered the male gender role as a subject (APA 2018, RKI 2014, Strong, 2013). The common goal is the development of a positive masculinity. In this masculinity, the powerful and assertive as well as the delicate and receptive aspects are in a healthy balance. Body and mind, emotionality and rationality work together. This new form of masculinity is open and flexible. It has positive effects on one's own health and wellbeing, as well as on human relationships, on social interaction, and, last but not least, on the ecology of our planet (Milton 2019, Swim et al 2019). In fact, without a different form of masculinity, there will be no solution to the various crises we face (Scheub 2010, Rosin 2012). For many men, becoming a true hero begins when they find the courage to acknowledge who they really are.

A therapist is often the first person a man openly speaks to. Hence, psychotherapy in general and body psychotherapy in particular can play an important role in the development of positive masculinity.

Body psychotherapy attuned to the needs of men needs to consider the relevant research. This implies using male resources like pragmatism, rationality, and humor and taking seriously men's issues, pace, and boundaries. Body psychotherapy, with its emphasis on the unity of body and soul, its "hands-on" approach, and its ability to reconcile cognition and emotion, seems to be particularly well-suited to guide men on their journey toward becoming healthier and happier beings, which is to become real men.

Marc Rackelmann, *is a body-psychotherapist, couples therapist, and sex therapist in private practice in Berlin, Germany. He is a trainer for BPT and couples therapy and author of Make Love – das Männerbuch, a German book on male sexuality, and several articles. Working with men is a focus of his work. In addition to his BPT training, he has done and continues to do further training, including sex therapy, couples therapy, and Crucible Neurobiological Therapy with David Schnarch, Sexocorporel sex therapy with Peter Gehrig, and pre- and perinatal work with Matthew Appleton. He is married and lives with his wife and two sons near Berlin.*

Website: www.koerperpsychotherapie-berlin.de

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Female Sexual Objectification and the Castrated Feminine Re-Membering Embodied Intelligence

Maryanne Comaroto and Rebecca Pottenger

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ABSTRACT

Arising out of a deep concern with the prevalence of psychological and physical violence against women, this article brings together theories underscoring a somatic and Jungian approach to understanding female sexual objectification as a cultural complex. It posits the mind–body split within patriarchal cultural and female sexual objectification has caused us to lose contact with our embodied experience and intelligence, and has infused our relationships with self, others, and the environment with traumatogenic effects. Our research illuminates female sexual objectification as a normalized cultural complex, and self-objectification as a strategy for social belonging and security. Research points to body-centered, group inquiry as an effective process for bringing awareness to the effects of female sexual objectification and its normalization and internalization. The spontaneity of an expressive movement and reflective small group process facilitated contact with the somatic unconscious and women's embodied knowing. This included awareness of women's experience and their internalization of female objectification. Further, women accessed and embodied energies of the feminine that promote agency and self-efficacy.

Keywords: sexual objectification, archetypal feminine, embodied knowing, cultural unconscious, patriarchal culture, somatic unconscious, post-Jungian cultural complex theory, embodied experience.

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As U.S. culture, institutions, and politics struggle with the continuing proliferation of crimes against females—as clearly evidenced in the #metoo movement and President Trump's response to being accused of rape ("She's not my type," Baker & Vigdor, 2019, para. 1)—it seems to us crucial to address the patriarchal forces that have disempowered the feminine and dispossessed women of their bodies and embodied knowing through sexual objectification. As women who have been affected by female sexual objectification, we undertook research into this phenomenon. In Maryanne Comaroto's (2017) doctoral dissertation research, we found that although women experience and carry sexual objectification as personal trauma, it is also a cultural wound. Thus, our research views female sexual objectification as both a sociocultural and a psychological phenomenon, and women's internalization of sexual objectification as a psychosocial survival strategy. It synthesizes objectification theory with theory from analytical, archetypal, and somatic

psychologies. It explores the thematic and cultural material constellating in the dynamics of female sexual objectification, and its traumatogenic effects toward discovering how it can be ameliorated, bringing the rejected body, embodied knowing, and sacred feminine sexuality out of the shadow and back into consciousness.

Clearly, patriarchal culture has also crippled men and those who identify as neither male nor female. Although this is also a crucial issue, it is beyond the scope of this paper. However, as demonstrated at the last women's march, when virtually everyone raised their hand to acknowledge being or knowing a woman who has been sexually abused, sexual objectification has a particular and pernicious effect on women, which arises out of and maintains the hierarchical structures and power dynamics that have privileged white males and valued the masculine at the expense of women, marginalized peoples, and the natural world.

Sexual objectification occurs when a person is treated as a tool for another's purposes; is denied self-determination; is seen as interchangeable with other objects or treated as if she has no right to personal boundaries, or is treated as not having her own experiences and feelings. In sum, objectification happens when a person is perceived as her body, and her body as an exploitable object devoid of mind or spirit (Calogero, Tantleff-Dunn, & Thompson, 2011). Moreover, the sexual objectification of the female body happens in the simplistic division of human nature into a male–masculine versus female–feminine paradigm. This is a damaging psychological and sociocultural inheritance that has both limited and devalued what it means to be feminine. We suspect that much of the archetypal feminine, and much of our experience of what it is to be female, has sunken into the somatic unconscious, split off from awareness in the divide between the head and the rest of the body. Our intent is to open the portal of the imagination, inviting new and liberated feminine energies and images that emerge from embodied experience and knowing. We define embodied knowing as the perception that arises from how something is experienced in and through one's body. This involves attention to the movement of energy in one's body, sensations, gestures, postures, emotions, images, and intuitions.

From a Jungian viewpoint, the image of life as structured around a masculine and a feminine principle is archetypal. It is seen across cultures and history in the yin/yang of the Tao, and in the king and queen in ancient alchemy. As an archetypal idea, it is a collectively shared inheritance that supersedes the individual and is rooted in the most unconscious layer of the psyche (Jacobi, 1957/1959; Jung, 1954/1969). Jung noted that archetypal potentials are fundamental to human experience and psychological expressions of instinctual life. From this perspective, the perception of human nature as masculine or feminine can be seen as a reflection of the reproductive instincts of biological life. The bare bones of archetypal ideas reside in the collective unconscious as potential ways of structuring experience. As they emerge in cultural material, they are shaped into ideas and images that form an objectified structure that includes values and assumptions about the nature of reality (Singer & Kimbles, 2004). The contents of the cultural unconscious form complexes, or clusters of historically embedded emotions, beliefs, values, and behaviors. These inhabit the cultural unconscious, which lies between the collective and personal unconscious, and is a primary source of group identities, including gender. The interface between group and personal identities makes bringing female sexual objectification to consciousness difficult, as doing so can threaten social status and belonging (Singer, as cited in Singer & Kimbles, 2004, p. 22).

The rise of patriarchal culture—with its masculine and male-oriented power structure and values—disenfranchised and diminished the wholeness and power of the archetypal feminine, creating within the cultural unconscious emotionally-charged, belief-laden complexes around what it means to be male or female. The demise of the feminine in patriarchal culture can be witnessed in the transit from ancient mythologies replete with diverse images of feminine power to Christianity, rendering the archetypal feminine, if at all present, in the form of the Virgin Mother; her many other faces mostly lost to the unconscious, her fierceness and relationship with natural forces and death demonized.

In the devaluation of the feminine and women, objectification of female sexuality, and supremacy of the masculine and males, inferiority and shame held in the cultural unconscious were projected onto females. The female body was judged by its appeal to men, and divided into sexual parts–breasts, ass, legs. The biases and assumptions within the cultural unconscious inform the personal unconscious, giving structure and meaning to gender identity, sexuality, self-image, and group belonging.

The images of the archetypal feminine that largely surround and inform girls in their psychosocial development and self-image have been diminished to the good mother, the terrible mother, the virgin, and the whore.

Because female sexual objectification is culturally pervasive and normalized, as women we have tended to internalize it as self-objectification. We internalize a male gaze into our relationship with our body, sexuality, and beauty, seeing ourselves from a male point of view and disenfranchising ourselves of our own subjectivity ("Objectification Theory," 2007, p. 633). The images of the archetypal feminine that largely surround and inform girls in their psychosocial development and self-image have been diminished to the good mother, the terrible mother, the virgin, and the whore.

Take a moment to feel into what arises in your body as you contemplate being called or seeing yourself as one of these. What sensations are aroused? What emotions come? What qualities are held? In real life, women are often distraught, having internalized these images as standards against which we judge ourselves and are judged by others.

Images of the feminine seen from ancient mythology—such as the fierce, sword-carrying Hindu goddess Kali, the overarching Egyptian sky goddess Nut, the enraged Greek Medusa with the eyes to turn men to stone, and the Russian witch Baba Yaga who suffers no fools—express a much fuller and diverse idea of her. In contemporary Western culture, media images divorce the feminine from such powerful spiritual dynamics, and, reflecting a male-centric paradigm, continue to divest women, the feminine, and the female body of their subjectivity, making them objects in service to male desires and power. Indeed, female sexual objectification remains so prevalent and violent that the sexual climate in colleges has been described as a culture of rape (Jordan, 2017, National Sexual Violence Resource Center, 2016, "Statistics," para. 5). Rape, and the possibility of being raped, enforces male psychosocial and physical dominance. As Jungian analyst Lyn Cowan (2013) observed, "One of the root fears of women is of men, and this fear is neither totally irrational nor unrealistic" (p. 3). The cultural complex

related to gender dynamics dangerously and unconsciously perpetuates perceptions of normalcy harmful to women. This is seen, for example, in the phrases "boys will be boys" and "It's just locker room talk," as used to excuse President Trump's sexist remarks (Trump, 2016, paras. 16 & 18).

Female sexual objectification is difficult to combat, both because of this normalization and because it is perpetuated by the mind-body split. In Western culture, since Descartes declared, "I think, therefore I am," the body has been rejected as inferior to the mind, and less connected to one's sense of self. The mind-body split conditions us to pay attention to mind as the source of knowing, ignoring the intelligence of the body and its direct, holistic, sensory perception of the world and our experiences in it. The dualistic division of mind and matter causes us to view the body through the objectifying lens of literalism (Moore, 1989), whereas post-Jungian James Hillman (1989), referencing Hegel, argued that the separation of mind from the embodied experience of soul is "itself pathological, an exercise in self-deception" (p. 123).

When the body is split off from the mind,
a woman may cease to know the memories her body holds—
including the trauma and pain of being sexually objectified.

When the body is split off from the mind, a woman may cease to know the memories her body holds—including the trauma and pain of being sexually objectified. She may lose contact with her body's instinctual wisdom and energies, and her desires, pleasures, and dreams. In these losses, she loses touch with the harm done to her and that she does to herself. Experiences, desires, and perspectives that we are unable to process consciously, either because they are too painful and overwhelming, or because the cultural paradigm devalues or invalidates them, remain embedded in the somatic unconscious. This material then tends to plague us as muscle tension, constrictions to posture and movement, disease processes, eating disorders, depression, anxiety disorders, and sexual dysfunction.

Women's internalized sexual objectification often becomes entwined with social survival. We craft our bodies and selves to compete in a world of patriarchal standards. It may be true that crafting a socially-pleasing appearance reflects acts of self-empowerment and free choice, because it creates advancement for a woman or reflects her own desire to look a particular way. However, the dilemma that this assertion hides is that such acts of self- and body-crafting also serve the current social, political, and economic hegemony.

Usually, in our culture and in therapy, women's issues with depression, anxiety, body image, sexuality, and psychosomatic symptoms are seen as the problem—and sometimes the fault—of the individual girl or woman. Post-Jungian cultural complex theory broadens the understanding of self and the personal unconscious to include a framework that recognizes that these symptoms are more than personal. They are the internalization of a cultural paradigm that has objectified and oppressed women and the feminine. Such a post-Jungian approach shifts the psychoanalytic perspective that casts the burden of psychosocial and somatic symptoms onto the individual alone, to one of, as Jungians Thomas Singer and Samuel Kimbles (2004) said, "seeing the continuum . . . of complexes that range from the personal to the cultural to the archetypal" (p. 22).

As a cultural complex, female sexual objectification has dispossessed women of our sexuality, of our embodied knowing, and of the fullness of the archetypal feminine. Beyond this is the cultural and personal loss incurred by the rejection or repression of images and energies arising autonomously and spontaneously from the unconscious because they do not fit in, are invalidated by, or are dangerous to express within the cultural paradigm. Our actions arise out of and presuppose our perceptions, many of which arise from unconscious assumptions about what is desirable, acceptable, or possible. This means that a crucial component to changing female sexual objectification involves women reconnecting with their embodied experience to repair the culturally driven mind–body split, and reclaim their sexuality and embodied knowing.

Cooperative Inquiry

Through the method of cooperative inquiry, Comaroto's (2017) dissertation researches the two of us, together with five other women, to explore the dynamics and traumatogenic effects of female sexual objectification and its internalization by women. Given the objectification of the body and its split from the mind, finding cultural change must include reclamation by women of their sexuality, bodies, and embodied experience and knowing. For us, this raised the question, what images and energies have female sexual objectification and its internalization caused us to shut ourselves off from? It seems clear that the Jungian concept of an archetypal feminine and masculine colludes with the patriarchal binary stereotyping of individuals into male/masculine or female/feminine categories, which does a disservice to human potential, which includes that which is both and neither. Moreover, the oppression and objectification of the feminine and the female body has extended to an objectification of nature itself. As such, we wondered if archetypal images, forms, and energies (potentials fundamental to life, aliveness, and the experience of otherness) might arise from the somatic unconscious. Ironically, might the archetypal feminine, understood as yin—receptive and empathic—break the bounds of male/female and masculine/feminine, showing up as that which is neither and other? If we allow the archetypal feminine to emerge from the unconscious in and through our bodily experience, what might we discover?

As a research process, cooperative inquiry engages participants as co-researchers studying a system of which they are a part to gather information needed to change that system, "or at least explore the need for change" (Bentz & Shapiro, 1998, p. 129). This carries the implicit assumption "that a system is more likely to change if it gathers its own information about its problems, direction, future" (p. 129). Engaging the co-researcher/participants in cycles of expressive movement, journaling, group dialogue, and art production, the research took "a qualitative, feminist phenomenological, somatically informed approach" (Comaroto, 2017, p. 108). Such an approach is important in studying female sexual objectification as it is aligned with "the need for research to honor women's experience and explore it from the inside, often by the adoption of participative methods" (Barbour, 2004, p. 122).

To facilitate investigation of the somatic unconscious and embodied experience and awareness, we used an inquiry process called Open Floor (Open Floor International, n.d.) as our form of expressive movement. An Open Floor movement cycle includes opening one's attention to whatever is emerging and true in the moment, entering

into a specific sensation, emotion, or image and exploring it with curiosity, deepening and broadening one's attention to embrace what shows up, including that which is compelling, disturbing, or recurring. The cycle ends with releasing the experience and allowing the body to settle. Open Floor was followed by journaling and group dialogue, ending with an art production. As reported by Comaroto (2017), the women's journal entries reflected the factors that facilitated the depth of their inquiry: "the safety being established, the importance of the connection they were beginning to feel with the other women, the personal effects of female sexual objectification they were contacting, and their desire to explore feminine energies within themselves" (p. 166).

Research participants' reflections exemplified the transformative nature of the body-oriented, cooperative inquiry process as it related to the mind–body split. One participant realized that she "popped out of her body" when experiences triggered past traumas, but that now, when she became frightened, she would call herself back to her body. Other women commented: "It has been a long journey to come back to the body, my body"; I have been "geared toward the second body"—the objectified body rather than the self—and am now "working on the first body"—one's own embodied self (Comaroto, 2017, p. 154). Comments also reflected the power of the body-oriented, cooperative inquiry process to illuminate and support the participants in differentiating from sexual objectification and its internalization as a survival mechanism:

- I want to be open, but I feel too vulnerable . . . too much scar tissue. (Comaroto, 2017, p. 164)
- I am safe with women without the male gaze; my sensuality when with men is in service to them. When I am with women, I feel mirrored; my sensuality is for me. I notice in my body that I can get bigger or smaller depending on who I am around. If it's men, I puff out my chest, I pretend I am one of them, and I will prove myself until I am tired in my bones. Because this is a man's world. With women it's different. There's armor, but not as thick. It's a pushing away—I can't let you in—I am supposed to want men, need men, and if I have you [women], I won't need them anymore. I am in service to you man, Lord of this world. My parents did not teach me to serve men or objectify women, but society did. . . . My dance teachers would tell me to work harder and I would beat her [my body] into submission with the façade that it was pleasurable, that I liked it, that it was for me. But was it really? Or was it all for the men who would watch me? There's a deep way that women move me, only hidden under dark, thick armor . . . shutting down sexuality and beauty. (pp. 164-165)
- I think I used sex to get love. During the movement I stayed in my head. When we partnered, I started to get more into my body, felt young, connected with the young part of me. Felt sensual, more mature. How do I feel about my internalized objectification: I love you, I want you, my boobs were too big, so I hid them forever [referring to her breast reduction], legs too skinny—ostrich legs. I connect better in pairs. What happened in between the teen and the adult? (p. 161)
- Wanting to disappear, walking in life contracted. My voice trapped inside. I dance angry trying to tear away stitches. I can't! I want to cry. I dance with other women. They are beautiful, I feel beautiful, sensual, erotic, particularly feminine. It's not about sex. There's safety to open to the feminine. (p. 162)

- I want to find a balance. I was hiding. I was someone who wanted to show that I was a good girl, athlete. I am on a good path to celebrate my own beauty. Nourish it. My oath previous to this one was to show off because of someone else, to feel accepted. Today I want to nourish this goddess. My wish is to stay in my fluidity, femininity, sensuality, also to have fire, focus and warrior—an embodied lioness. (p. 162)
- Something happened with my cousin that was inappropriate when I was like eight. It felt like I had to change, not be girlish and excited in life. [I thought I had] "worked through all that; it's still there." [I hope I can be] "my true self"—[at least] "I'm here for this moment." (p. 168)
- I realize I walk through life contracted and then I felt this thing around my voice and the words "female vocal mutilation" came to me. As I'm dancing, I feel a fabric tightly drawn, stitched closed, sewn to my bones, only a small slit left through which my voice can escape, it hurts inside to fight against it, it pulls, contracts won't let me out. I am my voice trapped inside me. I am accommodating, peace-making, trying to tear away the stitches, rip the fabric but I can't. I want to go away, I want help, I want to be left alone. (p. 169)
- When am I going to be able to be with [myself]? (p. 169)
- I would love to have a daughter someday. I would take care not to objectify my daughter, to celebrate her beauty, her femininity. . . . I want to get there and not be shy. I want to be my beauty, and not feel objectified and not shut down. (p. 170)

One participant shared about a warrior image coming to her. She spoke to finding a balance between the masculine idea of this and her own ideas about power, strength, and focus:

- I've been for many years something between [a boy and girl]. I spent a lot of years contracting my body and still feel it. I was raised in a culture where there were wars all the time, and I was with two brothers where we played wars games, boy games, man games. I needed to survive. This is how I needed to be strong and then to be safe in this strong man energy. I cut my hair very short, almost bald so I could be really strong. I had a history of sexual harassment, so I was feeling not safe to be female, to be my sexuality. I was overwhelmed with this harassment growing up and keeping it a secret. So, I was contracting, thinking I am doing—have done—something wrong. Then I was going through puberty with boys all around me and really wanted to cut off this part of me, and I did it for many years. Now to be here, to nourish and be proud of my femininity. (p. 169)

Other images arose during the Open Floor movement cycles that, as embodied and described by the women, broke the bounds of the masculine–feminine duality. These energies and images often revealed the shape shifting quality of what they were experiencing as their feminine nature:

- Ocean, Tree, Bird, Woman, Goddess; she has strong roots, she flies and dissolves. Her shapes continue [in] nature and its life force. Beauty of change. Glowing, contracting, strong and quiet, Mother–Warrior: It's all okay, dancing with the change. There is a bridge between your power and your sensuality. (p. 175)

- Superwoman, Wild Woman flying—broad and strong arms, softened, softened, flying, twirling, soaring strength—and Witch Woman, cackling laughter, loose and free and expressive, slightly magical, less contained, misunderstood. Whirling Dervish. Held to the earth by wings; all the controversy, glorious personifications. Dichotomies. Challenges. I am all of it and more. Creating my own archetype. What is missing? What is hidden? (p. 176)
- Lioness rage. Organic tears weeping for the world. Red lion, golden eyes on fire, claw tearing away to the vulnerable heart; rising-up ocean; bringer of death. The objectifying self-awareness brings self-consciousness, split from my body's revelation. I am the ocean. I am the rock, sometimes the ocean breaking on myself. I hold so many, who holds me? I long to let myself be held but long ago lost the ability, now I am a rock in my aloneness. Even amidst my energy, my play, my good body, I am become old. (p. 177)
- Everyone knows who superwoman is, but the magical wild witch woman has a dark side with negativity attached to it. I was interested in morphing the two into this magical, more whimsical, slightly unpredictable wild woman who wants to engage. (p. 179)
- Some creature, a combination of female and nature, blossoming in spring. In winter she doesn't care that she loses her flowers and leaves, she is still grounded and powerful, even when change comes. As a tree she can fly, the branches have wings, she can dance with the ocean. It's really a powerful creature. . . . this creature accepts whatever comes, whatever comes is a partner. (p. 180)
- Usually I am strong but weakness in my body can bring me to another place—melting, dissolving—bringing me out of the warrior part to self-mothering and the little girl part. (p. 180)
- I was hoping for Divine Femininity, sensuality in the dance awakened that part—butterflies on my eyelashes, violet perfume for my exhale, red fringe for my elbows, aquamarine fingernails—that kind of magical creature, that can do it all and be it all. Mother, Sphynx, temptress, poet, they all seem to be the breath of my eternal body: the good, the bad, creator, destroyer; being the same person and having that be okay. (p. 181)

As we researched together, it became evident that patriarchy and female sexual objectification have profoundly limited our collective understanding of the power, complexity, and multiplicity of what has been repressed and oppressed with the categorical objectification of the feminine and the female body.

Our cooperative research revealed female sexual objectification as a normalized cultural complex that shapes women's self-image, their interpersonal and workplace relationships, their relationship with their bodies and sexuality, their sense of safety worldwide, and their strategies for social belonging and security. At least in part because female sexual objectification has been normalized, along with its internalization as a survival mechanism, little research—especially of the sort that empowers women to engage with their embodied experience and knowing—has been done on this topic.

Maryanne Comaroto is continuing her research with one-day intensives offered to female college athletes and formulated around body-centered, group inquiry (see www.corr.education). Outcome measurements for the intensive focus on students' self-reports related to the following two areas: (a) increases in their awareness of their embodied experience and intelligence as well as unconscious patterns in navigating relationships and social pressure, and (b) improvements in their sense of self and self-efficacy in relationship to their body and sexuality and to addressing social issues that concern them.

In the midst of what some are calling a cultural "epistemic collapse" (Barratt, 2010, p. 23), we believe this ongoing inquiry and research not only supports ending psychological and physical violence against women, it helps women free their relationship with their selves, bodies, and sexuality from internalized objectification, increasing their attunement to their embodied experience and knowing, and working together to make visible and end female sexual objectification. As such, we see it as crucial that women gather to gain the skills of embodied inquiry, to move into the somatic and break free of the patriarchal cultural trance. In small groups, women can find the safety, freedom, and collaborative creativity to reimagine the feminine at both personal and cultural levels. In evidence of this belief, we have witnessed that when women come together to explore their embodied experience and the ways in which they have internalized female sexual objectification it heals the split between mind and body and opens new possibilities for our relationships to ourselves, to our experience, and to our world in an emerging, non-patriarchal paradigm.

Maryanne Comaroto, PhD *is a relationship specialist and somatic practitioner with a private practice in Marin County, California. One of her core beliefs is that great relationships begin within. She's a researcher, author and teaches throughout the United States. She hosts an internationally syndicated radio program about new approaches to relationships. And has appeared on Fox, ABC, "20/20," Disney's "Soap Net," and more. She founded The National Action Organization a 501(c) 3, committed to changing the way our culture values women.*

E-mail: maryannelive@gmail.com
Website: www.Maryannecomaroto.com

Rebecca Pottenger, MA, MFT *is a Jungian-oriented psychotherapist in Fresno, California, where she also co-facilitates a monthly Jungian learning circle and leads women's retreats. She is a thesis advisor for Pacifica Graduate Institutes' Masters in Counseling Psychology program. Her research and work focus on women's issues and the archetypal feminine.*

E-mail: writingpottenger@gmail.com
Website: www.soulandearth.com

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Making Somatic Psychotherapy More Effective

Anne Isaacs and Joel Isaacs

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ABSTRACT

In our ongoing effort to make somatic psychotherapy more effective, we have identified and eliminated a number of obstacles and constraints to the therapy process as commonly practiced. Using our Bodynamic approach, this has led to consistently enhanced therapy outcomes in our work with developmental disruptions.

Keywords: somatic psychotherapy, Bodynamics, developmental disruptions, developmental trauma, (more) effective psychotherapy, (removing) obstacles to psychotherapy, enhanced therapy outcomes

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Over the years, as we continued our studies, as we worked with clients and trained other therapists, we often found ourselves struggling with how we could do more for them. Our questioning led us to ask what psychotherapy is trying to resolve. The answers we're finding and the changes we've introduced into our somatic psychotherapy modality have led to enhanced therapy outcomes. We will explore these here in the hope that parallel changes can usefully be made in the reader's own practice.

Historically, one large constraint on the general practice of psychotherapy has likely been the complex and fragmented way it evolved for over a century, beginning with psychoanalytic theory and practice. This often led to long-term discussions of childhood experiences, or attempts to evoke memories or emotions, or strong emphasis on particular aspects of experience. Generally, in the ongoing effort to make psychotherapy more effective, attention has mostly been placed on aspects that should be included. Among these are transference, counter-transference, safety, reliability, relationship, attachment, mindfulness, caring, and attunement. While all of these are important, and we do attend to them, what we will explore here is a complementary perspective. The goal of increasing the effectiveness of a process is often most directly and fruitfully accomplished by identifying and eliminating obstacles (McKeown. 2014). Our perspective going forward here will be to examine some of the constraints and obstacles to the therapy process as it is commonly practiced.

Aside from the effects of trauma per se, our perspective is that many of the issues people bring to psychotherapy are the result of developmental disruptions. These disruptions do not happen in a sudden and dramatic way like trauma, but result from the daily drip, drip, drip of misattuned connection with our caretakers. Developmental

disruptions generally affect the motor, mental, and psychological abilities coming online for the child at that time. The resources or abilities that would have allowed a child to resolve an issue or move through a related developmental stage in a healthy enough way were not available or not accepted. As opposed to experiences of trauma, which are primarily imprinted in the autonomic (involuntary) nervous system, the developmental disruptions we work with are primarily imprinted in the voluntary nervous system, in the elasticity of the psychologically related muscles, and in the corresponding implicit understanding in the mind.

As opposed to experiences of trauma, which are primarily imprinted in the autonomic (involuntary) nervous system, the developmental disruptions we work with are primarily imprinted in the voluntary nervous system, in the elasticity of the psychologically related muscles, and in the corresponding implicit understanding in the mind.

The ensuing protective behavior of the child, their attempt to preserve some measure of connection with themselves and with caretakers, is organized by unconsciously modifying these same abilities. To these ends, the abilities may never be learned, are given up (resignation), or are held back. Common results of disruptions include fear of abandonment, not trusting others, giving up sensing our needs, not expressing our impulses, primarily taking care of others and not ourselves, etc. These are aspects of the processes of self-regulation and co-regulation in the vagaries of childhood development. The resulting protective behaviors, once adaptive, are later in life the source of many contemporary issues.

Let us examine the origin of a common example of possible disruption: that of an infant being fed in a highchair. When the child senses they do not want more food right then, one of the ways they signal is by pushing the spoon away. If this action—the use of the triceps muscle in the back of the upper arm, is repeatedly respected by the caretaker, the child will learn that they can express needs and set limits. If the action is repeatedly overridden, the child may not learn to set limits, or might learn to set them rigidly. These outcomes will be imprinted in the voluntary nervous system, in the elasticity of the muscles involved, and in the mind.

Then, later in life, the person often might not be aware of their limits, or they may act rigidly about their limits and needs. This will likely show up as a problem in their relationships, especially intimate ones. When that disruption, an unconscious yet chronic way of behaving, is addressed in therapy, using the triceps muscle in an expressive way can develop a new ability to set practical limits in present-day situations. The same action also provides access to the emotional history of the issue being worked with. While this is only one example, a similar process is also true for each of the multitude of motor and psychological abilities arising as children develop. To continue our exploration, we can ask how the concept of developmental disruptions

can be used to explore the process of psychotherapy. How will it help us to recognize where constraints and obstacles to the process may arise? We can begin by formulating a *minimal statement* of the effects of these non-traumatic disruptions on childhood development. Complexity can always be added to this formulation, if and when it is felt to be needed. This minimal statement might be something like: "Developmental disruptions result in internalized constraints. These constraints affect the child's, and later the adult's, access to certain mental, psychological, and motor abilities, and also affect their relationships with other people."

Developmental disruptions result in internalized constraints. These constraints affect the child's, and later the adult's, access to certain mental, psychological, and motor abilities, and also affect their relationships with other people.

This statement on the results of developmental disruptions suggests that since the limited availability of a related resource or capacity is the origin of many issues presented by our clients, it is also one of the main contemporary obstacles to resolution of those issues. Thus, identifying the needed resource, and gaining access to it in the present, are necessary steps in eliminating this constraint. And further, that the most direct healing procedure may likely involve learning or accessing these abilities, while working on that issue in the context of a positive relationship. This change in our view of psychotherapy also correlates with an earlier insight that psychological problems are generally not solved; they are more often resolved. Something in a person has changed. The task then is to explore how we can most positively and directly access the changed state.

Not by coincidence, the modality we practice, Bodynamics somatic developmental psychology (Macnaughton, 2004), is based on a wealth of empirical research related to this task. The work of the founders empirically correlated psychological abilities coming online at specific ages with specific muscles as they come under voluntary control (Marcher, 2010). The Bodynamic model of "seven developmental stages" is a detailed account of the interaction of childhood motor and psychological development (Bentzen, Bernhardt, Isaacs; 1995-1997). It describes what healthy (resourced) development looks like, as well as the effects of disruptions that occur earlier or later in each stage. In practice, we can use this empirical knowledge to reasonably relate most psychological issues to their developmental stage of origin. By focusing on the developmental origins of the *issue,* we avoid any (historical) tendency to "characterize" the client. (Most clients have issues from a number of stages.) Once we know the developmental stage, the Bodynamic system helps us to determine, in the moment, which related abilities are not available to this client. The expressive use of the muscle corresponding to a missing ability now provides access to learning or releasing that missing but needed ability. We can then follow the client's process, without having an endpoint in mind.

A Case Study

To make our exploration more concrete, we will first present an actual therapeutic experience. Here is a vignette of the first session of a client who came to get help with how her very busy life seemed to be in charge of her. She is a high-functioning corporate lawyer, and has a lot of energy and creative impulses. However, as she keeps talking about her problem, her shoulders start to sink a bit, and her chest collapses a little. I note that this could be an indication of a collapse from a developmental time when the child is between two to four years old. She talks about a particular work project that takes a tremendous amount of energy, but is not gratifying, even though it had been so in the past. We make an agreement to explore her response to this unsatisfying project. It turns out that once she takes something on, she really does not know how to stop doing it, especially if others depend on her to continue. This response is quite common in someone who has a disruption in the time between 2-4 years. She has already told me about other frustrations with people expecting her to be the dependable one. She is now using her body in an unconscious way. At this time, I am aware that if she could consciously use these same muscles to support the change she desires, an obstacle could be removed.

She then mentions that in her early childhood, when she was 2 years old, she had also stepped into the role of helper, after her mother had a late-term miscarriage and became sad and withdrawn. As she talks about this early experience, the support muscles in her back let go more, and her body further collapses around her shoulders and chest. I ask if she recognizes what has happened in her body with this collapse, but of course it was an unconscious process. I speculate that this early time might be when she first learned to take on big tasks and care for others. I teach her a bit about how the body is developing at that age, and how the child is learning to assert herself and develop her own authority. I recognize that this collapse is a disruption in the Will Structure, ages two to four. We also talk about the altruistic response that can manifest at that time — when her mother became so withdrawn. She began to be a caretaker in a loving way, and has not been able to step out of that role.

I also share how moved I am by how hard it must have been to be so little and have her mother be so sad. She says she never thought about that or felt it, because her mother and father were so in need of help. With this relational support, she begins to feel her own pain, and deep sobs emerge. She then begins to have compassion for this early unconscious role she took on. The obstacles of not knowing how this behavior began, of having taken on a role without being able to stop it, and of being alone in this experience are being addressed. We often find that this didactic explanation of how ruptures specifically impact a young person, when told with compassion for the child, helps people to have compassion for themselves. This is also helpful in removing obstacles of frustration, blame, or shame related to the unconscious behavior the person wants to change.

I show her how muscles in her shoulders and back are active today in taking things on unconsciously. At ages 2-4, children are also getting stronger and often play by carrying or pushing heavy objects from one place to another. To do so, they use the same muscles in their shoulders and middle back that are involved in her present-day collapse. People

who get stuck in this role need help to shake off the burden of unconsciously carrying things for others. When she makes the movements that would help her with that, she feels more energy.

I explain that children in this developmental stage can for the first time make choices and plans, and follow their intentions. For the first time, they can also change directions and decide to do something different. (The preceding developmental stage is driven by impulses, without planning.) Another indication that someone has a rupture from age two to four is that it is difficult for them to change direction once they get going. I show her how certain muscles around her center and some in her lower leg and foot activate movements that can support that behavior. We take our time exploring these specific movements. Later, we go back to her present-day situation. I have her work with a movement of her shoulders to throw off the unsatisfying project at work. By not automatically carrying a burden, she has more energy to explore what would make her happy. We then work with changing direction to find what would be more satisfying for her now. Towards the end of the session, she looks and seems more alive, with energy available for herself in a different way. She says, "I feel free to let go of this project and do the ones that make me feel more alive!" I encourage her to practice using these muscles at home and at work to support herself when she changes direction, and to tell others what her new choices will be.

What we are seeing here is that when the appropriate ability is stimulated or released, in the context of a supportive and caring therapeutic relationship, the client often quickly attains a new psycho-social competency related to the issue being worked with. And our experience is that this competency is often stable and lasting. It was so in her case.

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in the context of a supportive and caring therapeutic relationship,
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Establishing A Different Framework

Now let us examine in more detail the obstacles and constraints we have recognized over time in our work, and the actions taken to remove or reduce them. One possible constraint on the therapeutic process can arise from the habitual way a session is begun. Does the client passively wait for the therapist to speak? Do they go into a protective, "reporting" mode? Do they say what they consciously or otherwise believe we might want to hear?

One way we have found to set a different framework is generally to start by discussing what the client would like to work on in this session. Clients often know what they'd like to change in their daily life, and we know ways to directly access new abilities and to initiate changes. We then ask for examples of how the issue they bring up is affecting them in their present life, and use these examples to help discern the change they desire.

Together, we form an agreement to work on that in this session. This agreement helps to focus the work and minimize diversions. (In this process we can also affirm that any issues or aspects not chosen now are possible choices for a later session.) By forming this agreement we have both decreased their dependence on us and moved towards collaboration. Additionally, by primarily focusing in the present we minimize bringing in provocative history that can more readily stimulate protective behavior. The past can be brought in if and as needed.

Forming an agreement with a client is one step in focusing our work. As we continue now to explore other possible constraints and obstacles to the process of therapy, we also attend to the back and forth of working with process versus working with the structure entailed in our Bodynamic modality. How much are we initiating, and how much comes from the client? We can then attempt to balance the two. The agreement of what to work on is a process that originates in the client's perception of their life. How much are we then influencing/limiting the client's experience by locating the issue developmentally? The muscle we might ask them to use is a response to our observation of their process, of what is missing as we explore the issue. By broadly containing their process, we are simultaneously facilitating their ability to resolve the chosen issue.

As therapists, we are aware that another primary protective mechanism is a client's wandering, diverting, or simply avoiding an issue. To deal with this type of obstacle, we endeavor to circumscribe the area in which we work with the issue agreed upon, to contain it. Over time, this has led us to a sense of the elements most frequently employed in successful sessions. We were then able to form a model for what we now call a "developmental container." The first element of this container is the agreement (discussed above) made about what we will work on. Another part comes from the detailed knowledge of physical and psychological development available in the Bodynamic system. As mentioned, this enables us to recognize verbal, physical, and psychological patterns characteristic of the specific developmental stage in which this disruption of an ability most likely first occurred. We gather this information with respect to the issue chosen, and from our observation of the client's physiological, verbal, and emotional presentation. It is then generally possible to keep our work on a particular issue focused in one developmental stage. In this way, compensating abilities from other stages are less likely to be accessed. This containment promotes a healing of disruptions in the developmental context in which they were formed. We have found that this leads to a fuller and more rapid integration of new behavior into daily life.

As we build the developmental container, all the elements (to be described further) act together to limit the client's unconscious attempts to use protective behavior from other stages, ones that could divert or defocus the work. The most direct element in forming the container is the expressive use of muscles from the related developmental stage. Once we have a good sense of this stage, we can then focus on identifying the muscles involved.

With our knowledge of the abilities that are embodied during a healthy (good-enough) experience in a given stage, we can sense and perceive when abilities are missing in a client's verbal and physiological presentation. These missing abilities often correlate with visible physiological collapse or rigidity of the related muscles, and with the psychological counterparts of these. Familiar examples of some of these psychological

functions are grounding, centering, support, self-regulation, self-assertion, energy management, as well as interpersonal skills. Each of the functions are correlated with specific muscles in different developmental stages, and each can be expressed with more precision as the child grows through the successive stages.

As the session unfolds, the client often begins to use some of the muscles from the developmental stage where the problem originated. We may then see more clearly whether the response is collapsed, held back, or resourced. Then, at an appropriate time in the context of our verbal exchange, we can have them expressively activate the relevant muscle in a way that stimulates the needed ability (if it has not been learned or was resigned), or releases it (if it has been held back). (Generally, this work can be done with or without touching the client.) Using the right muscle at the right time brings forth the very abilities whose absence led to the developmental disruption. This relieves the therapeutic constraint of the needed ability being missing, and helps a person to be released from the effects of the past. Clients are often very surprised that using a specific muscle can have such a profound impact.

Using the right muscle at the right time brings forth the very abilities whose absence led to the developmental disruption

One type of intervention we do emphasize is the tracking of small, sometimes momentary physiological, energetic, and contact changes. These are not just signs of trauma (Rothschild, 2017; Porges, 2018), but also of developmental disruptions. These include changes in a client's eyes, skin color, breathing, tone of voice, and the tone of particular muscles. These small changes are often below the person's conscious awareness, and can easily disappear. They are indications of some deeper sense of self-emerging, or a response to connecting that can be unconscious. As such, they offer a tremendous opportunity for change, as they are moments when the unconscious visibly appears, either as protection or as a new resource. At these times, we work with our client to sense and support a new resource, or to see if they are willing to explore a possibility that is different than their usual protective response. Not taking full advantage of these moments needlessly limits the process of psychotherapy.

Another concern in psychotherapy is safety, attunement, and our relationship with the client. Historically, the degree of safety and attunement that was available to them as a child is a factor that can lead to attachment disruptions or developmental disruptions in a given area. To the extent that a client has historical expectations of difficulties in relationship, there can be a corresponding constraint on their trust in the relationship with us, and to their surrender to the therapy process itself. While there are many ways to build a positive and empathic relationship, using the body offers some special opportunities. Our use of a specific muscle while working on an issue will also regularly bring up themes, feelings, and memories from the related stage. By affirmatively relating to the client around these, we demonstrate that we are familiar with the issue and their

experience of it, and that they will not be addressing it alone. We also simultaneously strengthen containment to the developmental stage in which we are working. In this new context of support and a caring relationship with us, a client's experience of these newly available abilities helps them to move past the historical constraints of 'I don't know how", I'm not able to", "I'll be in trouble if I do", "Something bad might happen", etc.

In addition to giving emotional support verbally, we may choose to give physical support. When appropriate, this is done by touching a muscle on the shoulder or the back, one that is related to support from the developmental stage being worked on. This new sense of support reduces a client's vulnerability to overwhelm, helplessness, or resignation, wandering, or other forms of protective distraction. As a client becomes able to take in this support, they can learn to generate this experience by voluntarily engaging that muscle. Further, our support and encouragement can facilitate the spontaneous expression of emotion. This can reduce their holding back of energy. A client's experience of self-support and support from us, together with this newly available energy, gives them access to more choices, more behavioral options. It also enhances their emerging experience of competency, of "I can do this." The once-sensed need for a protective response is diminished, and new and flexible behavior is felt as possible and appropriate. The constraint of not knowing how, or of not feeling able to, has been removed.

This new sense of competency enables clients to respond more flexibly and expressively, with more choice in the present. One session that illustrates this well comes to mind. I was working with a client on how she wanted to stop letting herself be talked-over by men during group meetings at her office. After giving support and working with muscles having to do with assertion and setting limits, I felt it might be empowering to have her express her feelings more forcefully. I gave her a thick cushion to place on her lap and asked her to hit into it and to speak forcefully, as she imagined being at such a meeting. She looked at the cushion, looked at me, threw the cushion on the floor, and calmly said: "I will not ever let them speak over me again!"

Meta-processing

The presence and reality of these new competencies, of these changed states, can be further anchored by client and therapist talking about the experience, i.e., meta-processing (Fosha, D. 2011). This dialog directly addresses the obstacle of change seeming like a lonely and possibly ephemeral process. For example, we might ask how they feel different now from when we started the session; or we might discuss how it was to share the experience with us; or how the new competency might be used in different areas of their life. This exchange activates other aspects of the brain, ones related to sharing and to acknowledging relationship and change. This top-down integration compliments the bottom-up experiential changes that have occurred. Meta-processing can also reduce self-questioning about the reality or the lasting ability of the change. And it can bring to awareness nascent competencies in related areas. All this helps a client to bring the changes into their daily life and anchor them there. Finally, the experience of change in a short time relieves a possible concern that change is too difficult, or not really possible.

In Summary

In summary, we have reduced or eliminated many of the obstacles to somatic psychotherapy by:

- Collaborating with the client to find the issue to be worked on, so as to avoid unconscious habits.
- Working with present-day examples of the issue to minimize evoking the past.
- Recognizing the developmental stage in which the issue likely arose, and keeping the work focused in that stage so as to minimize the use of protective responses from other stages.
- Using specific muscles from that stage to bring forth the needed but missing abilities.
- Using support muscles from that stage to reduce overwhelm and wandering.
- Supporting our relationship by using the themes from the stage in which we are working, to avoid weakening the developmental container.
- Using meta-processing to diminish any tendency to suppress or forget the new competency.

Our newer understanding and elimination of obstacles to the therapy process has allowed us to accept, and even expect, seeing significant and lasting changes in people, changes that often happen rapidly. And we look forward to eliminating further constraints to the practice of somatic psychotherapy, asking ourselves questions like: "How can we help clients to not …?", or "Instead, why don't we try …?".

Anne Isaacs, LCSW, *has taught body psychotherapy for thirty years, and practiced body psychotherapy for over forty years. Anne specializes in the integration of attachment theory, developmental disruptions, and somatic development. She helps people develop new resources that change old somatic, relational, and emotional experiences. She is a Bodynamic Analyst who has trained with Diana Fosha, Mary Main and Erik Hesse. She is a founding board member of the United States Association for Body Psychotherapy, and has been on the adjunct faculty of Santa Barbara Graduate Institute, and lectured at CIIS. She has a private practice in Los Angeles, CA, USA.*

E-mail: aisaacs@bodynamicusa.com

JOEL ISAACS, PhD, *has practiced body psychotherapy for forty years and trained other therapists for over thirty years. He has written and coauthored eight articles published in somatic journals, and was on the adjunct faculty of Santa Barbara Graduate Institute. Joel trained in Bodynamic Analysis to the Analyst level and then became a trainer. For the last ten years he has worked with his wife Anne to develop Healing Developmental Disruptions, a modality that trains practicing therapists to rapidly begin using some of the depth and power of the Bodynamic system. His scientific background and passion for improving trainings has also spurred development of ways to make somatic psychotherapy more effective. He is in private practice in Los Angeles, CA, USA.*

E-mail: jisaacs@bodynamicusa.com

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Body Dreamwork

Using Focusing to Find the Life Force Inherent in Dreams

Leslie A. Ellis

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ABSTRACT

Finding and embodying the life force or "help" in a dream is the central practice of focusing-oriented dreamwork. This article briefly introduces *focusing* (Gendlin, 1978/1981) and its application to dreamwork, and provides a case example with a transcript of how to guide a dreamer to find the life force in a distressing dream. The practice of embodying the dream's life force provides the dreamer with an embodied resource that can be an end in itself, and can also facilitate working with the more challenging aspects of dreams and nightmares. Research and clinical examples support the use of this technique in clinical practice, and demonstrate how it can provide clinically significant relief from nightmare distress and other symptoms of PTSD.

Keywords: dreamwork, focusing, nightmares, embodiment, psychotherapy

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"A dream is alive," according to Gendlin (2012), a philosopher and psychologist who developed the gentle somatic inquiry practice called *focusing* (1978/1981). He said that every dream contains life force—sometimes obvious and sometimes hidden—and that the main objective of working with dreams is to locate and embody this life force. This article describes how to do so, first by providing a brief introduction to focusing theory and practice and how it applies to dreamwork, then by grounding the theory through a clinical example of a dream that came to life. The article ends with a description of how to apply this approach to working with nightmares.

A Brief Introduction to Focusing

Focusing is a particular way of sensing into the body with patient and friendly curiosity that enables us to find and follow an intricate *felt* sense that hovers on the edge between our current immediate experience and our body's understanding of the right next step. In focusing, which is typically done in dyads, the listener guides the focuser through a series of simple steps to help them contact and inquire into their felt sense about a particular situation. Gendlin (1978/1981) wrote that the interaction between two human beings would inherently move the process forward, because the shared field between two people contains more awareness and wisdom than each alone. This "more" is what brings about tangible shifts that can lead to subtle or dramatic internal change.

Gendlin developed the focusing steps as a reliable way for people to access an inner process that he and Carl Rogers identified in their research as the key ingredient to success in psychotherapy. What characterizes this important inner process is direct, in-the-moment experiencing of one's internal sense of a situation, a fluctuating yet tangible knowledge that leads a person via their body's felt sense to a new vantage point. What clients often say after focusing is that the situation hasn't changed, but they have. To the patient, a familiar issue no longer feels as problematic, or now they feel they have a way to move forward.

Gendlin (1986) developed a method of working with dreams based on focusing, which he described in *Let Your Body Interpret Your Dreams*. The book also contains one of the most accessible accounts of Gendlin's philosophy and its relationship to dreams. He wrote that a felt sense is "more than finished'" (p. 146) because it contains both the present moment and the implied next steps. A dream, on the other hand, is unfinished, because it usually has less embodied presence. Thus, in many ways, the dream could still unfold. In Gendlin's philosophy, interaction is primary, and dreamwork is no exception. He wrote, "The step we want comes from the interaction between the dream and our responses. The dream alone need not be just 'believed'" (p. 148).

Why Dreams Are Relevant

Focusing is based on an organic, optimistic philosophy. Like a plant that naturally extends toward the sun, our bodies interact with our environment in growth-producing ways. Gendlin (1986) said that "the living body implies its behaviors" (p. 152) and that dreams are expressions of this. Therefore, what is needed now—"what is unlived or missing" (p. 155)—comes to us in dreams. The dream will stay alive and relevant for as long as the need continues, which explains why many dreams and/or dream themes recur. Gendlin wrote:

> *"Just what you need"* can come in two ways. The dream's events may picture the need, lack or problem in how you live. More rarely, the dream pictures an answer, how you would live a step toward what is unlived or missing. (p. 155)

Some dreams clearly point the way forward. More often, the solution comes from working with the dream, exploring its implications, and living the dream forward imaginally and experientially. When the dream already contains the way forward, Gendlin would say that the "missing unlived wholeness" (p. 157) comes in the dream, intertwined with the dreamer's problem.

Some dream theorists believe that dreams serve no purpose whatsoever. Others believe that dreams do their work whether we engage with them or not. Still others, like Gendlin, believe that working further with dreams is the only way to reap their full benefit, because dreams are naturally in an unfinished state, dreamt by a body that is not fully awake and is not participating in life. His belief was that the dream brings an image of missing or unlived wholeness, and that focusing brings the next step. *"Even when the step is in the dream, focusing is needed to let the whole, fully ongoing body take the step"* (p. 159).

Focusing Dreamwork: The Basic Steps

This article is primarily about the step Gendlin (1986) called "finding the help" in a dream, which he considered the most important process of dreamwork. First, I provide a brief overview of the focusing-oriented dreamwork (FOD) process. I begin dreamwork as I would any focusing session, with *clearing a space*. This is especially true when working with nightmares, because I may want to invite a dreamer who is activated by their dream material to sense back into a calm inner space before exploring their distressing dream imagery. In clearing a space, I am anchoring an embodied resource to pick up on whether or not there is obvious "help" in the dream to accompany the dreamer into the darkest parts of their dreamscape.

To clear a space, you simply ask the client to get grounded and comfortable in their body and then to turn their attention to their inner space. If the client finds it a bit crowded or intense inside, their task is to gently set aside any distractions, sensations, or worries that prevent them from feeling calm, clear, and present. It usually takes just a few minutes, and it gently prepares the person to make the shift from the outer world to inner exploration. Clearing a space can be a helpful and calming process on its own.

Next, the client is asked to tell the dream in as much detail as possible, ideally in first person, and in present tense, as if they are back in the dream and re-experiencing it. If the person is reading from a dream journal, I often ask them to read it once to jog their memory and then to retell it experientially. I invite them to walk back through the dream landscape to see if they can bring themselves back into the atmosphere of the dream, to sense things, such as the smell of the air, the sounds, and the general mood. If the words on the dream journal page bring no real felt sense of the dream, it may be better to work with another dream that remains alive and responsive. The point is to interact with the dream, taking both dreamer and dream a step further.

Once the dreamer has felt their way back into the dreamscape, I first ask them to describe the setting using as many senses as possible. This is an easy place to begin, and it brings the client into deeper experiential contact with their dream. You can tell they are truly back inside the dream if new details and images emerge that were not in the original telling. You can also invite them to explore associations to the dream, but I generally allow these to emerge on their own rather than asking for them specifically, because my main interest is in maintaining connection with the dream itself. Associations can place the dream in a context, but also take the dreamer further from their dream.

Find the Life Force in the Dream

Once the client has immersed themselves in the dream and has a strong felt sense of its unique environment, the first thing I do is begin a search for the life force or "help" that Gendlin believed was present in every dream. Often, the helpful places in the dream are obvious; you can watch for the places that energize or entrance the dreamer in their telling of the dream. New, living things, such as animals, plants, and children, are clearly sources of life force. Anything beautiful or highly unusual can be "help", as well.

Sometimes, the dream is dark and dreary, or even terrifying, and it may seem impossible to uncover any source of new energy. Gendlin (1992) suggested that even in these dreams, there will be help, because the dream itself will supply what's needed to support and provide the resources the dreamer needs to process its more challenging aspects.

> I think that if a dream brings an issue to work on, it also brings some help, some change in the usual set, something extra with positive energy – something, so that we don't just tackle a stuck issue in the way the person always does, and get stuck once more…. *Of course* we would expect such help from any novel, odd and very noticeable things that some dreams bring. For example, if there are two sculptured bowls, or some odd box with sticks coming out of it – or anything of that sort – of course we would attend to anything like that before we tackled the main issue. (p. 27)

Prior to learning about finding help, I tended to work through the dream in roughly chronological order. or to work with the most striking image first. Prioritizing the search for help has transformed my dreamwork process in a positive way. The focus on helping the dreamer locate and embody the dream's life force has made it possible for them to metabolize the dream in such a way that both dreamer and dream are changed in the process. In one unusual case (Ellis, 2019), the dreamer found help in an unlikely place in his dream. He dreamed that some miners were pushing a tube into a deep hole in the ground. The dreamer knew that the tube would explode and kill the miners, and this is exactly what happened. But as the miners were pushing down, something pushed back from deep in the earth. When I asked the dreamer where the most energy in the dream was for him, he said it was this counter-pressure from down deep, which he felt most strongly in his chest. This "push-back" feeling has become a touchstone in his life, and a place he relies on when he makes important decisions or needs to connect with himself in an authentic way.

I offer the following clinical example because it represents a dream in which finding the life force presented a challenge. Even the trees and the usual places one would find life did not seem to offer help to the dreamer at first. The dream title was given by the dreamer herself.

Japanese House Dream: The Power of Acknowledgement

> Dreamer: I am in a house by myself. This place is in some rural area in Japan. And I am sitting in this room knowing that there's a dead body under the floor. And then, it's strange to say, but the sense is that I've created it. I killed somebody, and I am hiding the dead body underneath the floor. I am so anxious and terrified that somebody will come and find it out. And the biggest thing is that the dream felt so real, I almost believed that I had actually killed somebody.
>
> Therapist: It was so vivid and realistic that for a little while you couldn't differentiate between waking reality and dream life. The first thing I would ask now is: can you tell me a little bit more about this room that you're in… the setting of the dream where you find yourself? If you can, while you're doing that, go imaginatively into

this room, and look around so that as you describe it to me, it feels like you're actually in it.

Dreamer: Okay. It has a tatami mat, which is made of a special kind of grass. So I'm sitting right on top. And the air is rather humid. It's not cold or warm, but it's humid. This house has just one square room and some windows.

T: Okay, so it's a one-room house and you're sitting on this tatami mat… and just take another minute to see if there is anything more you can say about the place.

D: This place is old. The house is old. And as is typical in Japan, it's made of wood instead of bricks or concrete. And it's rather grayish. Not a vivid color at all. Very plain, no embellishment at all.

T: So it's stark, simple, gray. I get the picture. Now, I was wondering if it would be okay to embody the actual house.

D: (long pause) I feel quite solid and well-grounded. But it lacks warmth or joy.

T: Is it possible to get a sense of what's around the house? On the outside?

D: Lots of trees. Green. But it's not deciduous. It's evergreen—cedars or spruce—the kind of trees that grow very straight and tall. The green is rather dark, and those trees are all around the house. It's remote, not near a town at all.

T: How is it to have the house, which is kind of stark and grayish and plain, to have that intensity of color around, the green and the tall trees? Is there a feeling around the atmosphere outside?

D: Not really. There's no sunshine. It's more like misty gray. And a sense that the place is nowhere, not even on the map.

T: Can you get a felt sense of the whole house, and the atmosphere around it, but not anything specific inside?

D: So the sense of the whole house… There's no freshness in this place, no sense of life, other than the trees around it. And the mat is rather sticky and it's not soft at all. It doesn't give me any sense of comfort.

T: Okay. The mat is not comfortable. Is there anything about that, anything it reminds you of? Something old and unchanging?

D: It's been always there. And I don't like it. I want to get rid of it. Because it's a smoky old stale feeling. Now I'm getting a sense of the house as a body, like a body functioning, a feeling like when I was a child. Wow, a lot of feeling comes with it.

T: Does that sound right to you that the house could be kind of representative of the body?

D: Yeah.

(This is one of those dreams where it's tricky to find a solid sense of help. But I would say that the feeling of being solid and grounded was probably the most resourced place. Before I move on to inquire into the image of the dead body, I ask the dreamer to embody the only sense so far that seems to offer help. Even the trees here seemed unpromising.)

T: So I would invite you now to start by embodying that feeling of being grounded, solid like the house, just to feel that in your body, and get a sense of that. (pause) And then, just bring your attention to this body that you know is under the floorboards that is somehow related to something you did or created. And I'm wondering if you can, in your imagination, go and visit underneath, go and see who that is or what that is. Or if there's anything you can find out about who or what has died here.

D: (long pause) The first image came to me was my own child. Even though I have never had a child, and was never pregnant. The next image that comes to me is of my mother. She is in a care facility and I am wondering how long her life is going to continue. When things get rough, sometimes I wonder when she might depart to the other side. And I feel that thought itself is morally so wrong. So I kind of bury that. I really love her, but a little bit deeper down is a sense that maybe when she goes, then I could relax and do what I need to do for my own self.

T: I see there is a lot of feeling around that. Lots of feeling. And those feelings are so forbidden in a way. You're describing really loving your mother and also that you're taking care of her and sometimes you wonder when she might depart. There's a feeling like that's not an acceptable thought to have. Some part of you feels like oh, that's not morally right. And so I'm wondering if you can, just for now, gently put that critical voice aside and just let yourself really feel into these buried thoughts, just being curious. I'm inviting you to feel into where it's okay to be curious about when your mother might depart. It's a transition that is inevitable, so maybe it's reasonable to wonder about this and see what happens if you just give that a little more welcoming space.

(This is classic focusing language, inviting the client to be friendly with their difficult feelings, creating friendlier internal relations, and putting a little distance between the person and their felt sense.)

D: I feel like I'm sitting beside it and now it feels okay to have that sense. Because I've been working so hard, and it's not easy at all. And I understand. So I can be very compassionate toward myself.

T: So when you sit beside it, you can be compassionate; it's okay to have that thought. It's been hard and you have worked hard. And you can be in a place where you are compassionate with whatever sorts of thoughts come up around this. They're perfectly understandable, acceptable. And I noticed the tears, and I wonder if you can just sit in this dream space, just with that compassion for yourself. And from there, look around the dream room with the tatami mat, the little one-room house with the trees around it, and the feeling like there's a dead body under the floorboards… just to see what's there when you visit it now.

D: Now I can open the window and let the fresh air flow in. And now I can hear the birds chirping and smell the green trees.

T: Hmm. So you're letting in all of the life that surrounds you. It doesn't feel so stale. Now there is fresh air and birds and the trees; now you can feel the life in them.

D: I do think I've come to life. And also that I'm not ready to open the box. But it's more comfortable sitting on top of it. Yeah. It feels very different. A lot more comfortable.

The dreamer said she was intrigued that she was able to experientially enter this dream from about two years ago to find that she could experience it anew, and find such relevance for her current life. Some dreams stay alive like this and can be worked with again and again. Our biggest dreams may remain relevant throughout our lifetime.

Further Experiential Steps

The dreamer clearly experienced what in focusing is called a felt shift, a completely different embodied sense of the dream. It was not a coincidence that the dream itself changed too, and became more infused with life. Gendlin would say that this would be a fine place to leave the dreamwork and that this dreamer did seem content to leave it there. She said she was "not ready to open the box." However, after such a shift, further exploration can feel easier and is more likely to be constructive. Bolstered by an embodiment of the help a dream brings, the dreamer is generally more able to venture into the dream's challenging aspects. From here, there are many experiential steps that one can take. Gendlin (1986) offered 16 questions one can ask of a dream. They are available in his book or in the Gendlin online library at http://www.focusing.org/gendlin/docs/gol_2169.html with instructions about how to use each step.

Here I will discuss the two experiential steps I tend to use most often. Gendlin (1986) said all of the 16 questions are meant to be brought into the body, not pondered in the mind. "The interpretation comes inside the dreamer or not at all.... Only the dreamer's body can interpret the dream" (p. 25). However, I would suggest that questions 8: being the dream element and 9: continuing the dream are the inquiries that most naturally take the dreamer into a deeper, more embodied experiencing of their dream. You can see in the above example that I invited the dreamer to be the house, to enter into its subjectivity, and to feel the groundedness it initially brought

her. Interestingly, she felt the house to be a body analogy, something Gendlin suggests as an avenue of exploration in question 11.

Being a Dream Element

The process of entering into the subjectivity of a dream figure or object originates with the Gestalt practice pioneered by Perls (1969/1992). He believed that everything in the dream was an aspect of the dreamer, and that by embodying these elements, the dreamer could "re-assimilate and re-own the alienated parts of ourselves" (p. 96). You may or may not ascribe to Gestalt theory. It is possible to view this process quite differently, to enter foreign dream elements because they bring a sense of other that expands our sense of self (Ellis, 2013). The process itself trumps theory; my sense is that it's valuable to try on this practice like a new suit of clothes, and just see what comes.

In one clinical example, a client brought a dream about a dark landscape littered with dead bodies. In it, a woman sat at the head of one of the bodies and in tending to it, brought it back to life. The dreamer seemed surprisingly neutral about the gruesome scene and was even able to embody the corpse without feeling very much. But then, when I asked her to sense into the dream from the perspective of the healer, she was overcome with sadness. Clearly there were distressing feelings present in the dream; it was a matter of finding and releasing them. Sometimes the emotion is carried by figures or objects quite apart from the dream ego. and also outside of what one might consider the inherent logic of the situation. Dream logic clearly differs from the rules of the daytime world.

Hillman (1979) wrote, "We cannot understand a dream until we enter it," p. 80. While this may not be true of every dream, I have found that the practice of entering a dream element is particularly helpful with those aspects of the dream that remain stubbornly mysterious. Frightening elements become a bit more familiar and therefore less scary. The purpose or meaning of strange objects becomes clearer. For example, I dreamed about swimming with a gnarly stick, and although it provided a bit of flotation, it definitely slowed my progress. Embodying the stick brought many ideas about it; the most powerful was that although it was going to take me longer, I would ultimately go further if I took it with me because it provided a bit of flotation and some company on my journey.

Dreaming the Dream Onward

I will conclude this article with one of the most powerful experiential steps one can take in working with dreams—that of re-entering the dream and allowing it to continue. I will discuss this step with respect to working with nightmares for the following reasons: these are the dreams where finding and embodying the life force in a dream might seem impossible; nightmares warrant the greatest clinical attention because they coincide with many challenging diagnoses; and, because nightmares are often treatable, though few people seek therapeutic help for them.

A version of dreaming the dream onward, an idea that originated with Jung, has become the most highly recommended non-pharmaceutical treatment for nightmares by the American Academy of Sleep Medicine. Imagery Rehearsal Therapy (IRT) is the simple practice of asking the nightmare sufferer to change their dream in any way

they wish, and to rehearse this change before going to sleep. Two large randomized, controlled clinical trials showed its effectiveness (Krakow et al., 2000, 2001), and considerable research in the past 20 years has supported and expanded upon this method. In short, the idea of imagining a new dream ending has become standard accepted practice in the treatment of nightmares.

Many people ask if it's a good idea to focus on the harrowing content a nightmare brings up. To this, I always offer the following quote from Gendlin (1978/1981):

> What is true is already so. Owning up to it doesn't make it worse. Not being open about it doesn't make it go away. And because it's true, it is what is there to be interacted with. Anything untrue isn't there to be lived. People can stand what is true, for they are already enduring it. (p. 162)

A recent study of the nightmares of Auschwitz survivors supports this idea. Owczarski (2018) analyzed more than 500 dreams of 127 former inmates and concluded that most of their dreams were adaptive on their own or had "therapeutic potential." Only 10 percent of the dreams were recurrent, repetitive dreams that replayed actual trauma memories. Most had begun to weave in present experiences or were metaphorical representations of the experience. Owczarski found that while not all of the dreams of the Auschwitz survivors had therapeutic effects by themselves, "all of them seem useful and healing in psychotherapy, so suggesting patients repress their dreams would turn out to be a serious mistake" (p. 300).

My research using FOD to treat the recurrent nightmares of refugees with PTSD (Ellis, 2016a) led to a similar conclusion. After treatment, even long-term, recurring nightmares began to shift toward more healthy dreaming, and coincided with a 50 percent reduction in PTSD symptoms. So the question is not whether to work with such dreams, but how?

What If No "Help" Can Be Found?

Even in the worst nightmares, there can be glimmers of help. For example, in the first dream presented here, there was a general gloom but also a solidness in the Japanese house. And in the dream littered with corpses, there was a person bringing one of them back to life. If a nightmare has begun to weave in elements from the present or can be understood as metaphorical, this marks the beginning of trauma recovery, and those elements that depart from the actual trauma event are clear sources of help.

If a dream has no light in it whatsoever, then the help in the dream is not present but implied in its continuation. The refugees in my study, for example, often dreamed of the worst moment in their traumatic history, such as the time and place where they feared for their lives or their children's lives. Yet these resilient people clearly had escaped that fate, and in suggesting they dream the dream onward, they could incorporate into their dreams the events that happened next. In imagining their successful escape or rescue, they were allowing their unconscious to catch up with actual life events, and it is these kinds of changes that were then incorporated into their dreams. In general, they moved toward the more active end of the threat response continuum, from freeze to flight to fight. Over a longer period of time, the threat can

dissipate further, and dreamers may begin to interact with their aggressors, who then often change into something less threatening.

To keep the process safe and aligned with the principles of good trauma work, I begin such sessions with the practice of clearing a space. When the process becomes difficult, I invite the dreamer to revisit the calmness of the cleared space before continuing to explore the nightmare. The process can be challenging, but the results are usually welcome. In my study, and in general, nightmare distress is reduced, as are the other PTSD symptoms of memory intrusion and flashbacks.

To give a case example, a woman from Congo dreamed repeatedly of the moment she feared her attackers would kill her. In dreaming the dream on, she imagined a man helping her escape to a safe place, which is what truly happened. After this, she stopped having the nightmare. In another example (Ellis, 2016b), a client experienced a similar nightmare almost every night, of being pursued through a series of rooms in a tall building. She would always end up trapped and terrified, certain of her capture and torture. In her imagined new ending, she was able to become invisible and escape. Then, within the dreaming, she developed what she called her superpowers: the ability to vanish or to fly. This coincided with a dramatic reduction in the distress caused by her dreams, because the fear was largely replaced by excitement.

Conclusion

Finding help in a dream is a powerful, embodied experiential dreamwork practice that provides a focus for the process of dream exploration and allows the dreamer to embody resources that make their further exploration possible and more constructive. Even in dreams where no apparent help can be found, finding and embodying the dream's life force can be achieved by anchoring an inner resource of calm, and then allowing a frightening dream to continue toward a resolution. This practice not only improves dream life, but also coincides with positive changes that extend to the dreamer's waking. It can be a particularly helpful way to work with nightmares and related symptoms.

Leslie Ellis, PhD, *is a teacher, author and psychotherapist. She offers online dreamwork instruction based on her book, A Clinician's Guide to Dream Therapy. She also offers individual dreamwork sessions and training in somatic approaches to psychotherapy. Leslie has a PhD in Clinical Psychology from the Chicago School of Professional Psychology and a Masters from Pacific Graduate Institute. She is adjunct faculty at Adler University and Vice President and a Certifying Coordinator with The International Focusing Institute.*

E-mail: lae2317@gmail.com
Website: https://drleslieellis.com

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Bodymap Protocol

Integrating Art Therapy and Focusing in the Treatment of Adults with Trauma

Darcy Lubbers

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ABSTRACT

Darcy Lubbers' doctoral research is presented, investigating the lived experience of participants receiving an integrative Bodymap Protocol (BMP), with study outcomes indicating positive, therapeutic effects on participants' trauma conditions. The BMP integrates the modalities of focusing and therapeutic art expression, and utilizes the outline of the body as a container. It was administered to nine adults, each of whom was receiving ongoing therapy for trauma at the time of the study. Following the administration of the protocol, individual semi-structured interviews were conducted to explore each participant's artwork and lived experience of the BMP. Interpretive Phenomenological Analysis (IPA) was applied to transcripts of the semi-structured interviews and the artwork. NVivo-Pro 11 software was utilized by the researcher to explore the predominant themes that emerged. The study resulted in positive outcomes, as expressed through participants' semi-structured interviews and artwork, thereby providing a foundation and motivation for continued trauma studies with this protocol.

Highlighted aspects of body psychotherapy include: 1) neuroscience: underscoring the effectiveness of nonverbal modalities in trauma treatment; 2) facilitating embodiment, self-regulation, and access to unconscious material through an integrated protocol; 3) providing a safe container for emotional/physiological healing; 4) moving beyond symptom reduction in healing trauma.

Keywords: art therapy, body psychotherapy, somatic psychology, focusing, trauma

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This paper presents a doctoral research study conducted by Darcy Lubbers (2017) with a discussion of the implications of research findings for the fields of somatic psychology and art therapy. The study investigated participants' lived experiences of receiving the Bodymap Protocol (BMP) and whether there was a perceived therapeutic effect in relationship to their trauma symptoms. The BMP is a one-time, integrated protocol designed by the researcher, which incorporates the modalities of focusing (Gendlin, 1981) with therapeutic art expression. The BMP utilizes the body outline as a container for felt sense impressions, which are expressed through visual art.

Neurobiology highlights the usefulness of trauma treatment methods that target non-verbal memory, including art therapy and somatic methodologies (King, 2016; van der Kolk, 2006). Traumatic memories are most often stored in implicit memory, and are therefore usually not accessible through the explicit memory system, which is mediated by the hippocampus (Chapman et al., 2001). The overly-stimulated and incomplete traumatic memories primarily affect the limbic system and nonverbal areas of the brain, becoming locked in the body as incomplete biological responses to perceived or actual threats (van der Kolk, 2006).

The body psychotherapy literature supports the immense potential of working with, and through, the body as a nexus for healing trauma (Levine, 2010; van der Kolk, 2006). The potentially profound effect of trauma on the body, including the disruption of normal physiological responses, with the resulting broad range of trauma-related symptoms, is well supported in the theoretical literature (van der Kolk, 2006). In utilizing body psychotherapy modalities, the process of healing and transforming traumatic responses and patterns is facilitated by a reconnection and reintegration to bodily felt sense, sensations, feelings, implicit memories, and spontaneity (Gendlin, 1996; Ogden et al., 2006).

The art therapy clinical and research literature additionally underscores the potential of therapeutic art expression for resolving trauma (King, 2016). Art expression offers a well-documented pathway for revealing, expressing, and transforming the implicit experience (Hinz, 2009; Lusebrink, 2004; Malchiodi, 2012).

In both the art therapy and body psychotherapy fields, however, more credible, empirical research is greatly needed (van der Kolk, 2006; Kapitan, 2010). Rationales cited by Lahad, Farhi, Leykin, & Kaplansky (2010) also support the development of integrated trauma treatment methods that include art/imaginal work as part of the treatment method. Gendlin similarly invited the integration of other modalities with focusing, asserting that focusing can be used to deepen the experiential component of any therapeutic approach. "Focusing is an entry into a crucial mode of sensing. Every other method works more effectively when focusing is added" (Gendlin, 1996, p. 65). This opinion is corroborated by Rappaport (2009) and Nokes-Malach (2012).

Purpose of the Study

This research study was designed to address the following assertions:

1. The development of clinically effective and cost-effective methodologies for the treatment of trauma is critical, due to the pervasive and destructive nature and impact of acute, chronic, and developmental traumas in the world.
2. Advances in neurobiology highlight the usefulness of psychotherapies for trauma treatment that specifically target nonverbal memory. The connections emerging between neurobiology and the fields of art therapy and somatic psychotherapy point to the potential promise that each of these fields holds for working with traumatized individuals.
3. There is a critical need for more empirical, credible research in each of the fields of somatic psychology and art therapy.

4. There is a dearth of protocols that integrate the strengths of each of the fields of somatic psychology and art therapy for the treatment of trauma. This is a new area of research that shows great promise, due to the potential strengths of each field in trauma treatment.
5. Testing the BMP in a qualitative research study is an important first step toward verifying its efficacy.

Definition of Key Terms

These definitions of terms were intended as working definitions for this research. They were not meant to be all-inclusive.

Art therapy: clients, facilitated by an art therapist, use art media, the creative process, and the resulting artwork to explore their feelings, reconcile emotional conflicts, foster self-awareness, manage behavior and addictions, develop social skills, improve reality orientation, reduce anxiety, and increase self-esteem.

Bodymap: full-size, visual image of soma, or *living body,* created with felt sense as an internal reference point for their visual art expression. A bodymap, as referred to by this researcher, begins with a life-size, drawn, or painted image of an individual's body outline as a symbolic container for their lived experience.

Clearing a space (CAS): method of accessing a space to separate a problem or issue from any identification with—or attempt to influence—it, and thereby allowing a fresh felt sense to form. A place of wholeness, separate from our problems (Gendlin, 1981; 1991; 1996).

Felt sense: bringing awareness to the body and sensing an issue in a fresh way; it can also be viewed as a *bodily felt sense.* Felt sense is distinctly felt, however conceptually unclear, and carries a multiplicity of potential meanings. Paying attention allows meaning to become clearer as an interaction occurs between *felt meaning* and emergent symbolization, and elicits a central change process in focusing/FOT (Gendlin, 1981; 1996).

Somatic psychotherapy: bodily experience is highlighted as correlative, causative, and caused by psychological experience. "It is grounded in the belief that not only are thought, emotion and bodily experience inextricably linked (creating a *bodymind*), but also that change can be brought about in one domain of experience by mindfully accessing another" (SomaticPsychotherapy.ans.au, n.d.).

Trauma: "A circumstance in which an event overwhelms or exceeds a person's capacity to protect his or her psychic wellbeing and integrity" (Cloitre, 2006). Trauma is viewed as the biological and physiological response to event(s) or circumstances, rather than the actual events or circumstances (Levine, 2010; van der Kolk, 2006).

Research Design and Method

Research Questions

1. What is the lived experience of adults with trauma who are administered the BMP?
2. Is there a perceived therapeutic effect of the BMP experienced by the participants in relationship to their trauma condition, as expressed through their semi-structured interviews and artwork?

Research Design and Method

This research study investigated the nature and quality of participants' experiences with the phenomenon of the BMP through 1) expressing what arises in the body, 2) utilizing the medium of art expression, and 3) witnessing and free-associating to the completed art production. The researcher believed that a qualitative and phenomenological approach was best suited to the research objectives.

A purposive sampling method was chosen for this research, in order to best meet criteria for providing emotional safety for participants (Goodwin, 2010). Nine eligible applicants were selected to participate in the study on a voluntary, first-come, first-serve basis. If an applicant was deemed eligible for the study and chose to participate, a time and date were scheduled to conduct the research. The following steps were followed in soliciting participants:

1. Applicant referrals were solicited by contacting Los Angeles area psychotherapists who utilized art therapy or somatic therapy in their practice, through postings on www.linkedin.com and www.facebook.com special interest groups.
2. Therapists were asked to post recruitment flyers in their waiting rooms, which included information about criteria for inclusion and exclusion in the study, along with the researcher's contact information.
3. Applicants were provided with information about the nature of the initial meeting, including the process of evaluation for acceptance into the study.
4. A 30-minute in-person screening meeting was scheduled with the researcher.

Applicant Screening

Acceptance as a participant in the study was determined by the following factors: 1) inclusion criteria, 2) exclusion criteria, 3) researcher's observation of applicant, 4) score on the impact of events scale (IES-R; Weiss and Marmar, 1996).

The parameters provided in the inclusion and exclusion criteria and the IES-R were intended for the applicant's safety. To minimize harm or risks to participants, individuals who had experienced severe trauma, as defined by the exclusion criteria, were excluded from the research. The researcher also reserved the right to deny an applicant from participating in the study based on her observations during the screening interview.

Inclusion Criteria

The researcher assessed the following inclusion criteria—that is, that the applicant was:

1. An adult with a history of trauma
2. Currently in ongoing psychotherapy
3. Willing to seek treatment with their psychotherapist if psychological difficulties arose during their participation in the research, or should they choose to withdraw
4. Local/available to the area where the BMP and semi-structured interview were administered.

Operationally, the type of trauma that a participant experienced was restricted by

the exclusion criteria listed below. The degree of trauma experienced was an additional factor in determining whether an applicant was accepted into the study.

Exclusion Criteria

To minimize harm or risks to participants, individuals who had experienced severe trauma, as defined in the questions listed below, were excluded from the research. An applicant who answered "Yes" to any one of these questions was deemed not eligible to participate in the research.

1. Has your traumatic experience occurred less than one year ago?
2. Have you experienced the following traumatic events, involving death or threat of death or serious injury (whether personal, witnessed, and/or experienced by a family member): exposure to a natural disaster, terrorist attack, or combat/war?
3. Have you experienced any of the following within the last five years: assault, robbery, major car accident, major medical procedure?
4. In the past year, have you had thoughts of seriously harming yourself?
5. Are you currently having such thoughts?
6. Have you recently or currently been experiencing states of high physical arousal—often experienced as trembling, increased heart-beat, or panic attacks?
7. Have you recently or currently been experiencing flashbacks or nightmares about the trauma?
8. Have you recently or currently been experiencing symptoms of psychosis such as hallucinations, persecutory thoughts, delusions, or feelings that you are not real?
9. Have you recently or currently been highly dissociated—often experienced as being unable to feel any sensations in your body?
10. Do you have a pattern of using alcohol or another substance or behavior that is problematic for you and results in impairment in your daily life, or in noticeable distress?

Researcher's Observation

During the screening interview, the researcher observed and assessed the applicant's ability to function, speak coherently, and regulate their breath, and have sufficient coping skills to regulate him or herself. Incoherent speech was defined as the inability to complete a sentence.

Impact of Events Scale-Revised (IES-R)

The IES-R (Weiss and Marmar, 1996) was included as an additional safeguard for applicants to aid in assessing the degree of symptomatic psychological and physiological impact that had resulted from a traumatic experience (or series of experiences). Due to the subjective lens through which an individual's experience of trauma is focused, the researcher believed that the IES-R would provide an appropriate measurement of the degree of arousal and dysregulation that the individual was currently experiencing.

Additionally, the 22-item self-report measure focused on both somatic/physiological and psychological/cognitive manifestations of distress resulting from traumatic experience, including such symptoms as digestive problems, headaches, intrusive thoughts, flashbacks, and nightmares. Due to the somatic focus of this research, this measure was a good fit for the research as an additional applicant-screening tool.

The IES-R has a scoring range of 0-88. Applicants with mid-range scores (9-37) on the IES-R were accepted for the study. This indicated that their current symptoms were neither too low to register any significant psychological impact of traumatic event(s), nor in the highest ranges, which indicate a probable diagnosis of PTSD, and specify that trauma symptoms are likely to suppress immune system's functioning even 10 years after an impact event or events.

Bodymap

Safety Measures

- **Orienting.** Participants were directed to sit comfortably and to orient to the space around them, including letting their eyes gaze and look around the space, noting pleasant colors, textures and/or light quality, and allowing their eyes to linger on these pleasant sights.
- **Grounding.** Participants were invited to bring their awareness back to their body and to observe the flow of their breath, to become aware of their feet on the ground, their body in the chair, and to notice any feelings of physical comfort and/or support.
- **Warm-up drawing: Safe place.** Participants were offered drawing materials to choose from, including oil and chalk pastels, magic markers, and colored pencils, and directed to draw an image of a safe place. The safe place could be somewhere the participant had actually been, or simply a place that he or she imagined in their mind's eye. Participants were asked to feel into (Gendlin, 1981; 1996) the experience of being in this place—to imagine actually being there.

Bodymap

- **Step 1: Clearing a space (CAS).** Participants were guided through CAS (Gendlin, 1981). They were instructed to bring their awareness toward the center of their body (torso), and to ask themselves: "What is going on with me right now?" and/or "What have I come in with today?" They were guided in setting aside other issues without examining them closely in order to make room to focus on a particular trauma healing issue. Participants were instructed to ask themselves, "Except for these things that I have set aside, am I OK now?" (Gendlin, 1981). When the answer was yes, they were ready to proceed to the next step.
- **Step 2: Healing issue.** Participants were directed to bring their awareness to a healing issue or intention connected to a traumatic life event or events that they wished to focus on for their bodymap, to refine their language against their felt sense until they experienced a sense of "yes–that is it" or "this feels right."

- **Step 3: Bodymap.** Participants were directed to create a full-size visual representation of their body, with the felt sense of their healing issue as a reference point for their art expression. Colored pencils, oil and chalk pastels, magic markers, acrylic paints, watercolors, poster paints, and collage materials were provided.

As participants represented the outside edges of their body and filled it in with imagery, they were directed to check in with their bodily felt sense of their healing issue, beginning with their torso. They were instructed to observe any feelings, sensations, or memories elicited as they moved back and forth between attending to their issue and their body. They were encouraged to be mindful and spontaneous as they created their bodymap, intuitively choosing colors, shapes, textures, symbols, and images to represent emergent feelings or memories and corresponding somatic sensations. They were directed to bring their awareness slowly throughout their body, and continue pendulating between noticing sensations and reflecting on their chosen issue, continuing this process until they experienced a sense of completion.

Participants were then guided to step back and observe their completed image and notice any immediate impressions. They were given 3-5 minutes to jot down notes about their impressions of their imagery. Participants then scheduled a semi-structured interview (within 24 hours) with the researcher. They were asked to make note of feelings, thoughts, impressions, insights, questions, and/or dreams that emerged from the experience.

Semi-Structured Interview

The purpose of the semi-structured interview was to observe and discuss, qualitatively and in depth, each participant's experience of the BMP. Questions in the interview were open-ended. Participants were given the opportunity to notice somatic impressions, feelings, memories, insights, or other senses activated by the BMP. Interview questions were designed to cover the breadth of the participant's experience with the BMP, and any emergent associations in relationship to their healing issue as they viewed their artwork with the researcher.

Participants were encouraged to observe, witness, and associate to their symbolic language in the embodied (art) images that had emerged. Responses to their process during the BMP and to their completed artwork were a primary focus.

Interpretive phenomenological analysis (IPA; Smith et al., 2009: Willig, 2008) was utilized to analyze the qualitative data that was obtained. The theoretical perspective of IPA is in alignment with this study's objectives, with its emphasis on utilizing the richness of participants' somatic and imaginal expressions, and its aims of elucidating individual experience and meaning. The participants' perspectives and individuality of their experiences—as well as their overall experience of the protocol—were sought by the researcher. Essential meanings were attended to through what emerged in their body maps, their associations to their artwork, and their description of their qualitative experience.

Interviews were audiotaped and transcribed, and participants' artwork was photographed. The IPA analysis followed the following steps:

1. A thorough encounter with each transcript through reading it multiple times
2. Identification of themes
3. Clustering of themes, including parent and child themes
4. Integrating the cases by listing themes with relevant quotations. (Willig, 2008). NVivo-Pro 11 software was utilized to help with the identification of themes by organizing and coding themes in participants' transcripts.

Results and Discussion

The BMP was administered to nine adult individuals: six women and three men. They ranged in age from their early 20s to 70 years. Each of the participants' lived experiences of the BMP was positive and meaningful. Each perceived a lessening of their trauma symptoms from participating in the BMP. Although participants' experiences were individual and unique, the ways in which the BMP was identified by participants as providing therapeutic change and benefit brought forth four common themes.

Emergent Themes

The BMP facilitated:

1. A safe container for expression of feelings, with resulting emotional and physiological release, and the freeing up of life energy
2. Access to unconscious material, bringing it forward into greater conscious awareness, with resulting shifts in insight and meaning-making
3. A transition toward a physical, physiological state of greater embodiment and self-regulation
4. The emergence of healing imagery and an experience of integration

Each of these thematic aspects served an important role in healing participants' trauma symptoms, and interrelated with one another with associated benefit. Each theme relates directly back to the purpose of the study and the initial research questions, affirming positive findings for the study. Each is well-supported in the extant clinical and research literature in the somatic psychology and art therapy fields. These thematic results support the efficacy and viability of the BMP as a vehicle for therapeutic change and transformation.

1. Safe Container for Expression of Feelings

Somatic psychology posits that one's body is viewed as their *emotional container*. When an individual experiences trauma, that container no longer feels safe as one moves through a process of instinctual fight/flight and/or freeze. As a result, an individual becomes distanced from their emotions and from their inner creative life, along with their ability to be present in the moment (Levine, 2010).

In this study the BMP provided a safe container symbolically, with its drawn outline of the body that was then spontaneously filled in with felt-sense impressions. The outline created a structure for the protocol that allows for the safe expression of feelings, and for unconscious material to emerge.

Participants shared their appreciation for the BMP format and that it allowed them to express difficult or out-of-reach feelings safely, often with an outcome of experiencing relief. Great depth of feeling was expressed by participants in the bodymap imagery, some of which they had not expressed before, either due to lack of safety in other forms of expression/communication, or due to lack of access to those feelings.

Edgar expressed deep feelings of pain through his art depictions in his bodymap (Figure 1), and described his experience as deeply healing. He spoke about the safe container provided by the BMP, and by each step of the process. He included the semi-structured interview as part of the container, noting it as a time of reflection and integration for the whole process.

Remarking on his fluid use of art materials and his bodymap, Edgar shared, "I didn't want to spend time fussing, I came up with a really close version of what feels right to me. I got to use collage in a way that it's meant — it feels really powerful, like, things became other things, they interact. I'm just really happy about it — and I feel so much emotion moving as I'm telling you about it; I feel grief."

Figure 1. *Bodymap – Edgar*

Figure 2. *Bodymap – Elise*

Elise [pointing to the red "throw-up" coming from mouth] (Figure 2) shared; There's been a lot of rage, you know. When I see the drawing, I see it as rage, a real spewing. "'Create miracles' is underneath the spewing." She noted her depiction of her eyes: "They're closed, but it's going inward. Yes, an inward glancing. This, to me, is the real witnessing; observing, being mindful of the emotionality as opposed

to just peaceful — just present to whatever might be coming up or emerging." Elise also identified, "there's a kind of a blockage there [pelvis] and I think some of that is probably just about 'Don't be a girl' or 'If you're feminine, this isn't okay to express.'"

2. Facilitating Access of Unconscious Material

Each participant reported experiencing healing benefits, due to shifts in awareness and new insights that emerged as unconscious material came forward. Jason shared that he had been physically and emotionally abused as a child by his father. The focusing steps brought this healing intention forward:

> "I wish to be free of, or to integrate in such a way that, my body's fearful memories of being seen, being physically abused, being hated by my father, become transformed and no longer interfere with my day-to-day and long-term freedom of self-expression, ease, creativity, and my ability to access my inner wisdom and guidance."

Jason experienced a healing shift through emergence of unconscious material during the process of drawing his safe place (Figure 3) and creating his bodymap (Figure 4). He described his safe place, "where I can sit in a hanging hammock chair and swing back and forth and feel the breezes of fresh sweet air enfold me." He shared, "I feel held here, in the arms of nature… And thus I am more in touch with my inner self, my sense that I feel whole."

Figure 3. *Safe Place — Jason*

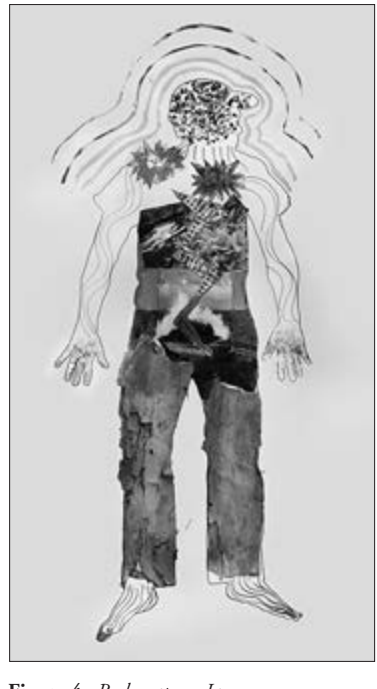

Figure 4. *Bodymap — Jason*

Jason noted, "I was able to have a sense of my body that was less intellectual and more in touch with the positive feelings that I associate with being in my body." His internal landscape and felt sense shifted to one of peacefulness and "feeling held" by nature: "I come back to myself in nature in ways that I can't in other places." His experience of the safe place drawing created an internal shift with "a feeling-tone of less anxiety and being able to be in the moment." He imparted that his insights regarding the unconscious information that emerged were not present while he was immersed in the process of creating his bodymap, but that they emerged as he reflected on it:

> "I just want to reiterate that all of the explanation I've done in the last 30 minutes or so was not in my mind when I was making this map. I was literally very much into the tactile feeling of, 'Okay, that [tree] bark has to go on my legs,' or 'that ocean image has to go here' or 'No, I've got to draw this lightning bolt here.' And I literally followed your [researcher's] instructions in terms of keeping my mind very open to the sensing of the moment. And that was very much in my feeling about it. I didn't make the connections I'm making now while I was doing it…I was just doing it."

Jason described, "The heart blast there is the wound. The 'ow' is one of the places where he [father] used to hit me which resulted in my confetti brain, which is what's up there." Jason connected with an important resource — his memory of how healing nature is for him. "So I love the ferns and the ocean." He remembered what he had forgotten — that going into nature was his healing resource, while enduring abuse from his father. He recalled spending hours by the rivers and woods near his home, which engendered feelings of safety and nurturance.

After his interview, Jason appeared energized, present, and connected. He summarized, "So, I'm very moved by just looking at this image — I can't stop looking at it actually. It's very powerful." He reflected: "They [life energies] are moving. You know, my vitality [in childhood] was not erased; it remained." And in regard to the BMP, he reflected, "I have to tell you, this works [LAUGHTER].

Figure 5. *Bodymap — Hayley*

3. Greater Embodiment and Self-Regulation

A shift toward a state of greater embodiment and self-regulation through receiving the BMP is also supported in the extant literature. Both art and somatic modalities have the potential to aid individuals in moving into a more embodied state of awareness — something that is lost through the experience of trauma. Participants reported experiences of breakthrough, of moving from either a more vigilant *fight/flight*, or a more dissociated or frozen pattern of awareness, into an experience of greater embodiment.

Expressing anger for the first time about a childhood molestation she had kept secret throughout her life, Hayley (Figure 5) stated: "Yeah, with a big fireball [in the chest] that's wanting to come out and hasn't come out because I've suppressed it for so long; you know what I mean?" She also reflected on having "X'd" out her pelvic area, symbolizing her numbness following her sexual abuse. Hayley reported an experience of releasing held energy, and of greater connection to her body following the BMP.

4. Integration: Emergence of Healing Imagery

All of the participants experienced the nature imagery in their safe place drawings as healing. They each also identified healing colors and/or images in their bodymaps. The researcher noted the organic way in which healing (and resourcing) images also arose naturally in the bodymaps. Participants were able to intuitively envision the change they sought, and to begin creating healing and integration for themselves in their imagery. The bodymaps in their entirety can also be viewed as healing images, with the healing occurring organically through the process of creating them, in different ways for each participant.

Jason included an image of his "healing hands" (Figure 4), and Elise included a healing image of "rainbow legs" (Figure 2) which she described as "a feeling of just really being embodied in my legs — and they do have all the colors, different emotions and, you know, I carry them all." She also described her use of purple paint as healing. In Edgar's interview, he identified his placement of a "Buddha" collage image above a "Kali" image as representing a healing quality and message for him (Figure 1). It represented the Buddhist "acceptance of what is," a quality that he longed to have more of in his life.

Edgar's image of two "Asian lovers" collaged on the heart of his bodymap expressed deep conflict regarding predominant culture's — and his own — rejection of his "inner feminine." However, during his interview, he had an "aha" moment of a "deep inner shift" that he described as inexplicable to him. He described it as an emergent feeling of love moving into his heart. It elicited an experience of "self-love" and "self-acceptance." He further described it as an integration of the masculine and feminine polarities occurring within as his awareness shifted to include a perspective of the two images looking at, and loving, one another.

Researcher's Reflections

Sequencing of Protocol Steps

In reflecting on the two research questions for this study, the data has highlighted the uniqueness, individuality, and richness of each person's lived experience through each of the steps of the BMP, and through the integration of the protocol steps as a whole. In the process of sharing each participant's artwork and reflections, the data has served to elucidate their relationship to their trauma condition, and their experiences of positive and healing changes as a result of participating in the BMP. Participants' reflections have supported very positive, encouraging findings to both questions.

In their ISTSS task force research survey, Cloitre et al. (2011) cited consensus among respondents in regard to "the added benefits of sequential interventions for treating complex trauma." They identified the importance of a first phase of "establishing trust and safety" (Cloitre, p. 625).

In the BMP study, the researcher found that the safety provided by the sequencing of the initial steps of the BMP facilitated positive resourcing for each of the participants (Levine, 1997; 2010). Orienting, grounding, and the safe place drawing provided a bridge for accessing each participant's inner feelings of comfort, strength, optimism, and safety. Through the perspective of the BMP, this is the ground upon which an individual can begin to take the steps that lead to a restoration of balance and stability. These are not simply abstract mental states; the positive feelings engendered are embodied experiences (Payne et al., 2015).

According to the survey results of Cloitre et al. (2011), the first phase of treatment ideally precedes a second phase of "focusing on processing the unresolved aspects of the individual's memories of traumatic experiences" (p. 625). This second phase emphasizes "the review and re-appraisal of traumatic memories so that they are integrated into an adaptive representation of self, relationships and the world" (Cloitre et al., 2011, p. 625). As characterized in the emergent themes of this study, the BMP facilitates the movement of implicit material into explicit awareness, of its safe, effective communication and symbolic transformation, and a shift toward greater embodiment and self-regulation (van der Kolk, 1996).

The ISTSS survey identifies the "consolidation of treatment gains to facilitate the transition" as the third phase of treatment (Cloitre et al., 2011, p. 625). This corresponds with the integration phase of the BMP, evidenced both by participants' descriptions of their unique experiences of felt shift, arising out of new felt meanings (Gendlin 1981; 1993; 1996), and by the spontaneous emergence of healing imagery in their artwork as they moved through the steps of the protocol.

Embodiment: Somatic Indicators

The researcher noted moments when witnessing their numbness and depicting it (consciously and/or unconsciously) in their art, and then reflecting on it during their interviews, elicited a sense of relief for participants, and resulted in a more embodied presence during the course of their interviews. She also noted participants' somatic responses, which served as indications of the discharge of held tensions, with greater resiliency and self-regulation (Levine, 2010). One of the most prevalent of

these was the emergence of laughter at points in which new meanings emerged for participants due to unconscious material surfacing, with new self-understanding and deeper integration of trauma narratives. This laughter appeared to the researcher as lighthearted and relieving.

Other somatic responses that were indicative of a natural release of tension were tears, sighs, yawning, taking a deep in-breath, exhaling after a period of holding the breath, and bringing hands to the heart. Each of these spontaneous biological activities led to the restoration of balanced autonomic tone (Levine, 2010; Payne et al., 2015).

At times, the researcher was aware of her own somatic sensations as material was shared by participants. This occurred as Edgar related the spontaneous imagery that arose in response to reflecting on the symbolic cleaver over his head in his bodymap (Figure 1). The researcher noticed that she had goose bumps as he described his *disempowered left arm* releasing the *writing pen,* and reaching up to grab the cleaver in a gesture of great self-protection and empowerment.

This also coincided with a moment of physiological release for Edgar, in which he took a sudden deep in-breath and then released it. His shoulders dropped, releasing tension; his face became more flushed; he made eye contact with the researcher, and laughed with relief. As described, the movement from a less embodied state to a more embodied state through participating in each of the steps of the BMP emerged as a healing theme in the study. Participant accounts reflect an experience of *breakthrough*, of renewed vitality, and of greater connection to self.

Additionally, the experience of the BMP as a safe container for the expression of feelings suggests that individuals with dissociation are able to experience particular therapeutic benefit from participating in this protocol, as are others with traumatic responses where their energy is held in a fight/flight or vigilant, response. For those dealing with dissociation, it appears to potentiate an important healing step towards reclaiming their relationship with their bodies by first bringing awareness to their experience of numbness through the integrated somatic and art expression steps of the protocol. As Gendlin described,

> We experience our felt meanings implicitly, when they are vague and unclear, before we make them explicit by referring to them with words or mental pictures. When we focus on an implicit felt meaning, and symbolize it (by attaching to it words or mental pictures), we use its bodily felt sense as a direct referent and transform it into an explicit felt meaning.
> (1962, p. 5)

Clinical Applications of Research

A number of participants shared with the researcher that going through the BMP was helpful for opening up potential new avenues of exploration with their current therapist. They cited areas where they had previously felt blocked or hesitant to move forward due to fears about re-triggering their trauma symptoms by bringing them up in their therapy sessions. In approaching the therapeutic process from an integrative perspective, the potential for using the BMP as a safe and efficient method for addressing trauma in clinical work is supported. Cloitre et al. (2011) point to

individual therapy as a possible and effective first phase of their recommended three-phase trauma treatment strategy.

Therapists may find benefit in utilizing the BMP with their clients as a safe container for expression of feelings, for eliciting unconscious material, and to support individuals who are experiencing states of fight, flight, or freeze in order to facilitate self-regulation and embodiment. The safe container provided by the BMP allows for a potential deepening of the therapeutic relationship due to the safety of the container and the richness of the material that may emerge for the client.

As a number of participants in this study expressed, the BMP can provide a valuable map of their conscious and unconscious process, which can be referred to in therapy sessions with the possibility of creating a follow-up map created at intervals—for example, every six months. As more psychotherapists are seeking cross-disciplinary training, this integrated protocol provides a time-and-cost-effective approach for working with clients with trauma, particularly for therapists with training in both the art and somatic fields.

Researcher's Note of Caution

Staying within one's scope of professional practice is important in considering the use of the BMP for treating trauma. For those who do not have cross-disciplinary training, collaboration, consultation, and supervision are recommended. Somatic therapists may wish to work in conjunction with art therapists, and vice versa, in both the administration of the BMP and the review of the findings.

The safety precautions that have been utilized in this protocol are also critically important to include in potential future research with the BMP, and also in clinical work. The study participants were in ongoing therapy, and had the opportunity to process material that emerged during the BMP with their therapist. The inclusionary and exclusionary criteria are also important to consider for participants' safety, as is the IES-R measure.

It is likely that anyone who has experienced trauma will also have aspects of self that are dissociated, particularly in cases of complex trauma. It will be important for clinicians who wish to use this protocol to observe the presence of dissociation as well as the intensity of the emotion that emerges as an individual moves out of a freeze state. Incorporating the initial safety steps of orienting, grounding, and the safe place drawing are of critical importance. The researcher strongly suggests that clinicians make certain that participants are self-regulated at the close of the protocol, before they leave the therapy site, just as they would with any clinical process.

Limitations of Study

As a result of the purposive sampling method proposed for this research, participants were limited to adult individuals who lived in the Los Angeles area or who were able to travel to the Los Angeles area to receive the research protocol. The sample was also limited to individuals who were currently in psychotherapy. This also limited the transferability of the study.

The participants were noted by the researcher as being remarkably open and engaged with the entire process of the BMP, including sharing very personal material both in their artwork, and in their semi-structured interviews. Although the researcher believes this occurred due to the safe container that the BMP provided, it was not possible to rule out the researcher's personality as a factor, even though she endeavored to be neutral and consistent in her approach with each of the participants.

Additionally, although the researcher strove for neutrality and to set aside her professional identity as a clinician, her training helped her to observe the participant data in ways that were reflective of her background as both a somatic therapist and an art therapist. Researchers who wish to further investigate this protocol by conducting additional studies would likely benefit from having training in somatic therapy, art therapy, or mindfulness, or a combination of these modalities.

The qualitative, phenomenological IPA research design, although desired for this study, generated descriptive data, but not statistical evidence. It was designed to test the BMP qualitatively before considering the possibility of testing a hypothesis that was generalizable. It was hoped that qualitative results from this research would provide an impetus for further research that would expand on this study design. One option with the same design would be to administer the IES-R measure both before and after the administration of the BMP, and note any changes in the scores. Another possibility would be to administer the BMP more than once, over time; for example, every three months for one year for a longitudinal study.

A quantitative component could be included in the research design in order to test for significance in regard to the lessening of trauma symptoms resulting from utilization of the BMP. However, it is expected that a larger quantitative or mixed methods study would likely present other challenges that were avoided in this study. The individual, lived experience at the heart of this study would perhaps not be as easily captured. Another challenge is that it could require several facilitators, rather than one. The participants' responses to their particular administrator of the protocol might, as a result, present a confounding variable.

Recommendations for Future Research

Conducting a qualitative study was appropriate for the ideographic and thematic findings sought by the researcher. It was an important starting place to initiate investigation of this integrative protocol for the treatment of trauma.

The potential significance of the BMP study is in integrating the work that is beginning to occur in the art therapy and somatic fields by providing a protocol that effectively uses the strengths of each field in a synergistic way, with its potential for greater efficacy than using either modality on its own. Additionally, the researcher believes that providing both clinically effective and cost-effective methodologies for the treatment of trauma is an important issue to address in future research.

The positive outcomes for this study are very promising, and this study can serve as an integrated model for trauma treatment upon which future studies can be based. One possibility would be to conduct an additional qualitative study with a similar

sample size, or with a larger sample size in which more researchers participate in administering the protocol. Another possibility would be to research this protocol with individuals with other specific presenting issues; e.g., depression, eating disorders, or specific kinds of trauma; or with clinicians and health practitioners, or different age groups such as children, teenagers, or the elderly.

With the results of this study illuminating how profound the experience can be for individuals, another possibility for researching this protocol would be to investigate the administration of the protocol in a group format. There were specific reasons for not conducting this first study of the protocol in a group format, including the confidentiality risks for participants. It is not possible to guarantee that participants won't speak about each other after the study, even with a signed confidentiality agreement. However, there may be a way to structure the research design to mitigate the confidentiality risk; for example, to administer the protocol in an already existing group. Another would be to have a purposive sampling method in which it becomes highly unlikely that participants will cross paths again.

The researcher has administered this protocol in group settings (outside of a research setting) with very positive feedback from group members. Yalom (2005) cited multiple benefits of group therapeutic process, including universality, along with validation of individual experience, lessening of isolation, instillation of hope, and raising self-esteem. One of the potential benefits of investigating the protocol in a group format is that being able to conduct the protocol in groups ultimately would ultimately result in an even more efficient and cost-effective treatment to administer. It could allow more people to receive an intervention for their trauma condition at the same time, and the BMP could then potentially be used as a treatment model for traumatic events that affect whole communities. Broader scale mixed-methods research could also be looked into in a large community setting, such as a hospital or educational setting, administered to either individuals or groups.

Summary and Conclusion

The importance of providing both clinically-effective and cost-effective methodologies for the treatment of trauma is a critical, timely issue. The theoretical and research literature suggests that a large percentage of the population has been impacted by traumatic events (Ross, 2010; van der Kolk, 2006).

This study utilized a phenomenological research design to investigate participants' lived experiences of receiving the bodymap protocol (BMP), and to identify whether there was a perceived therapeutic effect for them in relationship to their trauma symptoms. The BMP is an integrated protocol that incorporates the modalities of focusing and therapeutic art expression, with an approach of mindfulness as an integral component to each of the somatic and therapeutic art steps of the protocol.

The BMP was administered individually to nine adults, six women and three men, who ranged in age from their early 20s to 70 years of age. Each of the participants was receiving psychotherapy for trauma at the time of the study. Semi-structured interviews were conducted to explore each participant's lived experience of the BMP, and to review the artwork they created during the protocol. The interviews and

artwork were analyzed for ideographic and thematic data by the researcher with IPA, utilizing NVivo-Pro 11 software.

Each of the participants' lived experiences of the BMP was positive and reflected a perceived therapeutic shift. The steps of the protocol supported an integrative experience for participants, and each shared experiences with the researcher of a personal breakthrough, and a shift toward greater embodiment, self-regulation, and resilience. Four common themes emerged through the IPA of the data. The BMP facilitated: 1) a safe container for expression of feelings, 2) access to unconscious material, 3) a shift toward a physical, physiological state of greater embodiment and self-regulation, and 4) the emergence of healing imagery and an experience of integration.

Each of the four themes relates directly back to the initial research questions, and to the purpose of the study, with very positive findings. The themes also relate directly to the extant literature within the fields of somatic psychology, clinical art therapy, and neurobiology. This study has demonstrated the therapeutic effectiveness of the BMP as a one-time protocol for the treatment of trauma. It has evidenced trustworthiness, with credibility, transferability, dependability, and confirmability.

It is the researcher's hope that this study will contribute to the professional fields of somatic psychology and clinical art therapy, and that it will provide a useful and viable integrated approach for trauma treatment. The positive outcomes for this research study provide a foundation and motivation for further research.

Darcy Lubbers, PhD, *attended Brown University for her undergraduate studies, Loyola Marymount University, Los Angeles, for her masters' studies, and Santa Barbara Graduate Institute and The Chicago School of Professional Psychology, Los Angeles, for her doctoral studies. She completed her doctoral research at The Chicago School of Professional Psychology. In addition to her private practice in Santa Monica, California, Dr. Lubbers currently provides art therapy, somatic therapy, and family therapy services for PCH Treatment Center in Los Angeles. Her publishing credits include Adult art psychotherapy: Issues and applications, and articles in the Depression and Bipolar Support Alliance magazine.*

Website: darcylubbers.com

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Integration of Traumatic Memories

Homayoun Shahri

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ABSTRACT

In this paper, I will discuss a short review of traumatic memories based on neuroscience and information theory. Based on neuroscience and information theory, I will present a new technique that may integrate fragmented traumatic memories. The presented technique is based on slowing down the process of recall of the traumatic memory as well as adding new information at the time of recall, which may result in re-encoding these memories during the reconsolidation phase. The resulting rewritten memories seem to last for a very long time.

Keywords: neuroscience, trauma, memory, information theory, re-encoding, reconsolidation

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In a previous paper (Shahri, 2018), I briefly discussed traumatic memories from the perspective of neuroscience and information theory. Based on neuroscience and information theory, I presented a new technique that may rewrite traumatic memories during reconsolidation. The technique presented in this paper is based on slowing down the process of recall and adding new information based on elaborative repression. This adds new information at the time of recall of the traumatic memories that may result in re-encoding these memories during reconsolidation. The resulting rewritten memories seem to last a very long time.

Memory, in its most general sense, is defined as what we consciously recall from past events. But memory is more than what we consciously recall from the past (Siegel, 1999). In particular, if a certain neural pattern has been activated in the past (in response to external or internal stimuli), then the probability of activating a similar pattern in the future is enhanced. This is how we remember and learn from the past. "The increased probability of firing a similar pattern is how the [neural] network remembers" (Siegel, 1999, p. 24). Siegel further writes, "Memory storage is the change in probability of activating a particular neural network pattern in the future" (Siegel, 1999, p. 25).

Our brain generally does not encode and save every experience as explicit memory, or else we would be inundated with so much information so that we would not be able to function. It seems that the more emotionally intense our experience is, the higher the probability of its encoding and recall. The event is labeled as important by the amygdalae, which are parts of the limbic brain involved in experiencing emotions. Likewise, less emotionally

intense events have a lower probability of being encoded and saved (Siegel, 1999). It is important to note that events that are filled with fear or terror, or are overwhelming, may not be encoded by the hippocampus, another part of the limbic brain involved in memory and emotions. Several factors such as amygdalae discharge, or the release of various neuroendocrine hormones, including noradrenaline and corticosteroids, may inhibit the functioning of the hippocampus, thus blocking the encoding of the event and later recall. However, although explicit memory is impaired, these events may be stored as fragments in implicit memory (Siegel, 1999). Implicit memory stores the emotional dynamics of events, not their contents. Therefore, when implicit memory is reactivated, it is not associated with a sense of time, place, and sense of self in time, nor is there a sense that something is being recalled. Although implicit memory can be online from early infancy and even prenatally (mainly stored in the limbic system), it is only after roughly the second year of life that the hippocampus is developed enough to encode explicit memory.

It is important to mention that the recall of (degraded) past memories recovers some parts of these memories, and may further augment these memories for meaning (elaborative repression), in an effort to reduce the uncertainty and increase predictability to reduce arousal (Erdelyi, 2006).

A Neuroscience Perspective

Human memory formation is associative, which means that new information is better remembered if it is associated with previously encoded events or memories. The more emotionally meaningful the association, the more effective the encoding of new information will be. Because of the associative nature of memory, encoding can be improved when new information is associated with other information already encoded in long-term memory. This results in the formation of a coherent narrative that is already familiar (Mastin, 2010).

LeDoux (1996, 2002) argues that the only memories that are unchanged are memories that have never been recalled. When a memory is recalled, it goes through changes. This is due to the associativity of memory. Thus, when a memory is recalled, it is associated with stimuli in the environment and then reconsolidated. LeDoux (1996, 2002) further argues that this gives us the opportunity to modify memories during the recall and reconsolidation.

In a separate study from LeDoux's laboratory, Diaz-Mataix, et al (2013), write: "Traumatic fear memories are strong and persistent and form the basis of several pathological disorders, including post-traumatic stress disorder (PTSD) and anxiety disorders. The search for procedures that may render these memories sensitive to pharmacological or behavioral treatments is thus critical. It is known that after memories have been consolidated into a long-term state they can enter a new labile state when reactivated prior to being reconsolidated. During this lability window, it is believed that memories are updated and new elements are incorporated." In this study, the authors indicate that while in the labile state, memories can be modified by the introduction of new information during reconsolidation. This modification takes place due to the associativity of memory, which essentially indicates that recalled memory will be associated with the additional information during reconsolidation, and may thus modify the original fear-based and aversive memories.

An Information-Theoretic Perspective

Neural connections, via their axons and dendrites, can be viewed and considered as communication channels with limited capacity. This indicates that the firing of neurons and the production of action potentials or spikes (Shahri, 2017) are governed by fundamental limits that can be quantified. Figure 1-A below shows a discrete grid (marked by dots in the picture) laid over a picture of salamanderfish, which is used to measure the response of one ganglion cell (responding to darkness) of the salamanderfish when moved on the discrete points of the grid. In this experiment, a ganglion cell that responds to darkness (a cell in the retina) of a salamanderfish is placed over the location of the dots in the picture, and then the response is measured. Figure 1-B shows the firing of the ganglion cell when moved across a column (over the location of the dots) marked by arrows. Figure 1-C shows the reconstruction of the captured image of the salamander based on the latency of the spikes (action potentials); that is, the earlier the firing, the darker the actual scene is. Figure 1-D depicts the reconstruction of the captured image of the salamander based on the spike counts. One can appreciate that sensory processing is limited by the firing of spikes. That is, if the firing of ganglion cells cannot keep up with the stimulus, the sensory information will not be encoded in its entirety, and information will be lost. This argument is essential to the understanding of the nature of traumatic memories. Specifically, when sensory information is massive and beyond the capacity of neural firing (action potentials or spikes) to fully capture it, information is lost, and the narrative related to the sensory stimuli can at best be preserved in fragmented and dissociated forms. Traumatic memories, in essence, can perhaps be memories that correspond to events that could not be fully captured and coded in their entirety, due to fundamental limits on the rate of firing of spikes and action potentials. Furthermore, since a coherent narrative is not constructed that integrates the fragmented traumatic memories, these memories will contain a high amount of information (unpredictability).

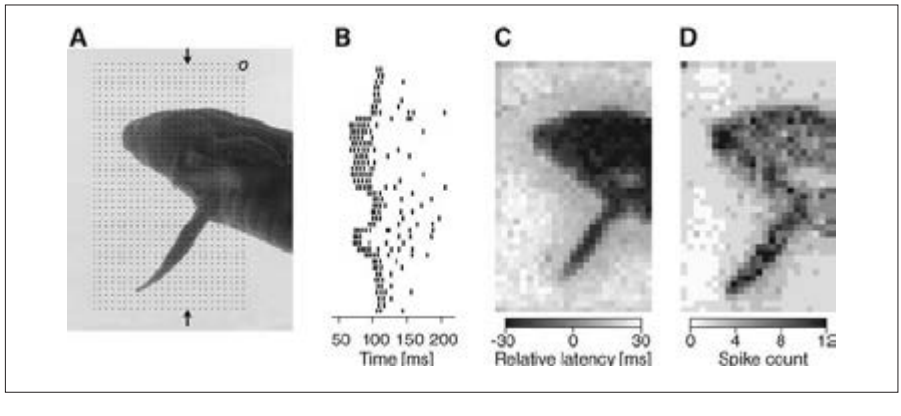

Figure 1. *Response (Spikes) of Ganglion cell of a Salamander (Gollisch & Meister, 2008)*

The encoding of sensory information in the brain must be efficient, and neurons must express their full output capacity in order to encode sensory information (with little loss of information), subject to fundamental limits. In the field of neuroscience, this is known as the *efficient-coding hypothesis*. Loh and Bartulovic (2014) write: "The Efficient Coding Hypothesis, suggests that sensory relays recode sensory messages, so that their redundancy is reduced, but little information is lost. Coding to reduce redundancy eliminates wasteful neural activity, and also organizes sensory information such that an internal model of the environment causing the past sensory inputs to build up, while the current sensory situation is represented in a way that simplified the task of the part of the nervous system which is responsible for learning and conditioning." The efficient-coding hypothesis, also known as the redundancy-reducing hypothesis, was introduced by Barlow (1961).

Barlow's Redundancy-Reducing Hypothesis (1961)

Horace Barlow (1961) argued that laws of nature are such that they bring order and simplicity to our complex sensory experiences. He further argued that the communication and coding of information in the brain should be fast, precise, and minimally redundant (efficient), and should work regardless of interference in the communication channel. The associativity of memories can be considered as a direct corollary of Barlow's hypothesis, in that by encoding associative information (memory) together, redundancy is reduced, as memories are not encoded in separate and redundant parts. Another corollary of Barlow's hypothesis, which I will emphasize, is that when a memory is recalled, then all associated previously encoded memories are also primed for recall, and thus have a higher probability of being recalled. Due to the associativity of memory, correlated sensory information and events are encoded together. It is also important to note that the brain does not simply compute the correlation between sensory inputs corresponding to event X and all events Y that occurred in the past. It starts the computation with events that have higher information (emotional) content, and are thus more significant. Not only does neuroscience prove this assertion, but it is also important to note that this would have had significant evolutionary advantages, in that previously encoded events with high information content was generally more important and more relevant to the survival of our species.

A corollary of Barlow's hypothesis is that our nervous system moves toward predictability and avoids "high information" and unpredictability. Viewed somewhat simplistically, our brain can be thought of an information-processing machine constantly trying to reduce the unpredictability of sensory input by correlating and comparing sensory input to encoded events with high information content that occurred in the past, and finding the closest match, thus reducing redundancy in the encoding of the sensory input. Pfaff (2006) relates brain arousal and emotion to information. Events that contain more information are less likely to occur, and can result in emotional arousal. The converse is also true in that emotionally significant events contain more information, and are more unpredictable. To illustrate this point, the interested reader could look at the checkered figures depicted on the right side of

Figure 2, and notice which figure results in more arousal (attracts attention). As our vision is peripheral, figures that are more horizontal carry less information, have higher probabilities of occurrence, and thus contain less information, while figures that are more vertical carry more information and have lower probabilities of occurrence, and thus result in higher levels of arousal and emotional response (the probability of occurrence of an event is inversely proportional to its information content). The figures on the left of figure 2 depict the firing of action potentials of ganglion cell of a Rhesus monkey. The interested reader should observe that the ganglion cell responds with more spikes and action potentials to the vertical figure, and not as strongly to the horizontal figure, as the Rhesus monkey's vision is also more peripheral.

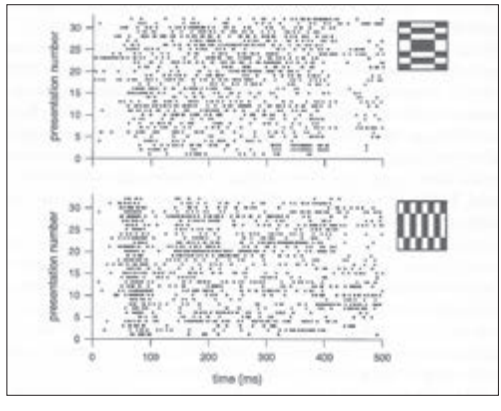

Figure 2. *Rhesus Monkey's Ganglion Cell response to different patterns (Rieke, Warland, van Steveninck, & Bialek, 1999)*

In this section, I discussed and showed that traumatic memories correspond to events with high information beyond the capacity of the firing rate of neurons to be represented and associated with previously encoded memory. Traumatic memories may thus be encoded as dissociated and fragmented part-memories that contain high amounts of information (unpredictability - less likely to occur), and are more emotionally significant. This explains why traumatic memories are state-dependent, and can be easily triggered and result in emotional dysregulation. The treatment of trauma then requires the integration of highly emotional (high information content) fragmented memories and reduction of their information content (unpredictability - less likely to occur).

In the next section, I introduce a technique that seems to be highly effective in the integration of fragmented traumatic memories. This technique reduces the unpredictability of traumatic memories, possibly resulting in the integration of these memories.

Reprocessing of Traumatic Memories Before Reconsolidation

In the previous section, I discussed a neuroscientific as well as an information-theoretical perspective regarding the formation of traumatic memories. I also laid the theoretical foundation and groundwork for the technique that I present in this section that may integrate fragmented traumatic memories during the reconstruction phase.

My approach to the potential integration of traumatic memories is based on slowing down the reprocessing of traumatic memories so they can be re-encoded, but this time with less unpredictability. This re-encoding of high arousal and emotionally charged memories results in the conversion of these aversive memories, through elaborative repression (Erdelyi, 2006), to more predictable and less emotionally charged and benign memories. The efficacy of this proposed technique is predicated on a strong therapeutic relationship, which functions as a predictable holding environment and safe container.

The Technique and its Application

I indicated above that our nervous system tends to move toward predictability and reduction of entropy (uncertainty). The technique that I present in this section precisely aims at the reduction of uncertainty.

In working with clients' traumatic memories, I sit across from them (Figure 3). I then ask the clients to recall the traumatic memory, but I ask them to recall it very slowly - one frame at a time (slow motion), and I further ask them to connect with me when they need to, that is, if the recalled material is overwhelming, and they need to feel my presence and support. Prior to the using this technique, I introduce the clients to what I mean by "connecting with me." I do this by asking them to be aware and feel the space between them and me. Awareness of this space is the somatic correlate of the connection between us. When they recall of traumatic memories in this way, they are less overwhelming, as the brain can process the high information (emotion) content of these memories, and possibly add extra information (elaborative repression), if need be, to make sense of the traumatic memory and integrate it. My presence with them and their connection with me serve to reduce arousal so that the brain can process the recalled memory, and the possible elaborative repression can fill in the gaps in the recalled memory.

I introduce the clients to what I mean by "connecting with me." I do this by asking them to be aware and feel the space between them and me. Awareness of this space is the somatic correlate of the connection between us.

When the change has occurred, I can usually observe it in the clients' faces. When these early memories, which are the blueprint for many future behaviors, are re-encoded and rewritten, clients generally feel freer, and do not function from their early traumas as often and as intensely. Please note that Barlow's redundancy-reducing hypothesis (Barlow, 1961) suggests that behavior, to a great extent, is based on earlier experiences; thus, when the adverse early memories are re-encoded, so are the future behaviors that are based on them.

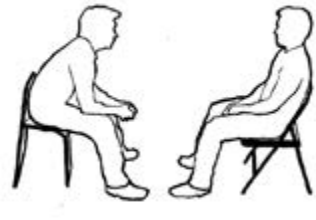

Figure 3. *Staying and connecting with the therapist*

In the following two case studies, I illustrate how I worked with two clients who suffered from traumatic experiences. In both cases, the intrusive memories have not returned (as reported by clients). I worked with these two clients more than twelve months prior to this writing, and there are no signs that these two clients are troubled by their traumatic memories of the past.

The Case of Kate

Kate was a woman in her late forties. She initially came to see me because of issues with her teenage daughter. Later in her work with me, she indicated that she would get very anxious and almost panic-ridden when she showered, and that she also could not go into a swimming pool or the ocean, and that even the thought of being in a swimming pool or the ocean would give her severe anxiety. In working with Kate on this issue, I asked if she remembered anything from her distant past that might have had some similarity to what she was feeling, such as being submerged in water, etc. Due to the associative nature of memory, I have realized that distant traumatic events responsible for the present-day behavior are frequently primed for recall when this question is asked. Kate mentioned that when she was about eight years old, she and her family, including her younger cousin, had gone to the beach. Her younger cousin went in the ocean without an adult watching her, and Kate felt that she might have been drowning. Kate went into the ocean to reach her cousin and save her, and in the process, she went underwater, as the water was deeper than her height. She indicated that she felt that she was going to die and was very scared. They were, of course, both rescued by a bystander, but the effects remained with Kate! In working with Kate, I asked her to recall what had happened, but slow it down to "one frame per second" so the events were happening very slowly. She did not need to talk about the recalled memory. I also asked her to stay in contact with me, and make connection with me when she needed it. During the course of the work, she connected with me several times (looked into my eyes and felt the space between us). After several minutes, the expression on her face changed, and she smiled. I asked her what had just happened. She replied that she saw herself going underwater, down to the bottom of the ocean, and imagined that I was watching her and that she was safe. She mentioned that when her feet touched the ocean floor, she gently pushed against the ocean floor and came up, and felt that it was like a game and somewhat enjoyable! She also indicated that she no longer felt anxiety when she thought of going into a pool or the ocean. During the next several sessions, I asked if she felt anxious when she took a shower or thought of going into the pool or the ocean. She responded that she did not feel anxiety related to water anymore. Many months have passed since our work, and she reports that she no longer feels anxious about being in a body of water nor about taking a shower.

The Case of Misty

Misty was a forty-year-old woman who came to see me because she was involved in a car accident, after which she was not able to drive and had a difficult time sitting in a car. She would get extremely anxious if she sat in a car, she reported. Misty mentioned that she was sitting in the back seat of their family van with her mother-in-law and

her five-year-old son. Her husband was driving, and her father-in-law was sitting on the front passenger side. She indicated that they were driving on a freeway and were hit on the side by another car that had lost control. The van rolled over a few times and eventually came to a stop. When Misty came out of the initial shock she noticed that her son was not in the car, but found him outside of the car, standing in the freeway. Miraculously, no one in the car was badly injured, except for a few bruises. Misty was desperate and wanted to be able to drive again, and not feel so anxious when she sat in a car. The car accident that Misty was involved in had happened so quickly that her brain could not process what had happened, and the memory of the accident was very fragmented, causing arousal of her nervous system. My work with Misty involved the integration of the memory of the accident. I had to coach Misty on learning about connection and connecting with me. She learned fairly quickly, and was able to feel safe and connect with me. I then asked Misty to recall the memory of the accident, but one frame at a time. I also asked her to connect with me if she felt overwhelmed and scared, or if she just needed my support. She proceeded to recall her memory of the accident very slowly (one frame per second). During the course of her recall of the accident, she needed to make contact and connect with me, and she was able to fill the gaps in her memory that were left void due to the amount of information that needed to be processed by her brain, which was simply beyond its ability at the time of the accident; the neurons in her brain simply could not fire quickly enough to integrate all the sensory information. She was able to see her son being thrown out of the front window of the van, and then saw him landing on his feet safely on the side of the freeway. She was also able to see that everyone in the van was safe, and that no one was seriously injured. The gaps in her memory were filled by the addition of new information through elaborative repression. During the course of recalling this memory, another memory from her early childhood was recalled that we later processed using this same technique. Fourteen months have passed since she had this session with me, and since then she has been able to drive and otherwise function fairly normally. Although she first started sitting in the car, after a week or so she was able to drive in urban areas, and after a few weeks she was able to drive on freeways. To my knowledge, she has been functioning normally and her panic and anxiety are essentially gone.

Conclusion

In this paper, I briefly reviewed the formation of traumatic memories based on neuroscience and information theory, and presented a new technique that might integrate fragmented traumatic memories during the reconsolidation phase. This technique is based on slowing down the recall of traumatic memory, and adding new information through elaborative repression, which serves to fill the gaps in the traumatic memory. I discussed the theoretical validity of my approach using neuroscience as well as elementary information theory. I also presented two case vignettes to demonstrate how I apply this technique. Based on my clinical experience so far, it seems that the resultant rewritten memories may last for a very long time.

Implications for Practice

In this paper, based on neuroscience and information theory, I discussed how traumatic (and especially shock trauma) memories may be formed, and laid the groundwork for understanding the nature of traumatic memories: their fragmented and dissociated nature. I also discussed a technique that can be effective in the integration of traumatic memories. The technique slows down the recall of the traumatic memories within the safety of the therapeutic relationship. I would like to stress that this technique is by no means unique, and indeed any approach that can slow down the recall of traumatic memories in a safe therapeutic container may be effective. I discussed that based on Barlow's and the efficient coding hypotheses, the brain seeks predictability and reduction of entropy (uncertainty). The process of slowing down the recall of traumatic memories gives the brain the chance to possibly create a modified narrative (to fill in the gaps), a safe one this time, based on elaborative repression. The newly constructed narratives tend to persist, as they are more predictable and less arousing. I would also like to add that the presented analysis of traumatic memories may shed light on how various approaches to healing trauma work. My hope is that this analysis and theoretical discussion may pave the way for the development or refinement of current and future techniques that can be effective in the integration of traumatic memories.

Acknowledgement

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Homayoun Shahri, Ph.D., M.A., CBT, LMFT, *received his PhD in electrical engineering specializing in coding and information theory from Lehigh University in 1990, and his MA in clinical and somatic psychology from Santa Barbara Graduate Institute (now part of The Chicago School of Professional Psychology) in 2012. He is a licensed marriage and family therapist and has a private practice in Irvine, CA, USA. Homayoun is a Certified Bioenergetic Therapist and is a member of the International Institute of Bioenergetic Analysis (IIBA) and the Southern California Institute for Bioenergetic Analysis (SCIBA). He is a member of the United States Association of Body Psychotherapy (USABP) and is on the peer review board of the International Body Psychotherapy Journal.*

E-mail: homayoun.shahri@ravonkavi.com
URL: http://www.ravonkavi.com

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Working Safely With Trauma

Abused and Still Alive

Will Davis

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ABSTRACT

There are two related themes in working with trauma patients in a safe manner. First, I introduce how a functional approach allows for the possibility that it is not necessary to work through, re-experience in a safe therapeutic environment, or have knowledge of the trauma in order to be freed from it. It is possible to treat trauma patients below defenses, working with the "undamaged" endo self that exists before the trauma. The second theme is a functional model of how to understand this unlikely phenomenon, considering that it seems to go against the basic therapeutic principles listed above.

Keywords: Reich, instroke, trauma, endo self, dual nature of relationships, functional model

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Over 30 years ago I began to witness an unusual phenomenon. While working with the instroke—the gathering, self-oriented movement of the life pulsation—patients spontaneously moved into quiet, calm, deep contact with themselves without expressing emotions or movements. While I was doing a gentle touch technique, they would often turn on their side and curl up on the mat. While I had the impression that nothing was happening, patients reported that profound events occurred. Simply stated, patients were able to reorganize primary object relations with no new additional information, no elaboration of their history, and no further intervention from me. They were doing this by themselves, and when reporting the changes later, some commented how easy it was. They created a different version of the same historical, sometimes traumatic event, finishing with it, and moving on in their lives. This was particularly confusing, for it fit none of the therapy models I had learned. Of course, the reorganization of a primary object does not go against any of the principles of psychotherapy. But what was new was the way in which this was achieved; that is, working without the drama of re-experiencing the trauma, and the patient achieving this change spontaneously within themselves.

In some cases, the patient had not mentioned the trauma, and therefore it was never worked on. For example, by the beginning of the last of a series of nine sessions with a patient in a week-long workshop, there had been no revealing discussions, movements, or emotions. He was lying on a mat on his abdomen, and I was gently touching his back.

He started crying quietly and deeply. He later explained that he realized his stepmother loved him. "I always thought that the things she did to me were because she didn't love me. Now I see that this was her way of showing she did love me!" Additionally, there had been none of the typical vegetative signs of trauma emerging: rapid heart rate, hot or cold sensations, panic or fear, sweating, shivering, shaking, or splitting off. Yet he cleared this trauma by himself (Davis, 2012, p. 71).

In other cases, people passed through their traumatic history between sessions, during training workshops while I was demonstrating techniques, or when other trainees were learning and practicing the techniques with each other.

The Phenomenon

The case below is an example. After an introductory workshop I received the following email.

> *Something changed in me during this training. I wasn't able to define it back then, but in the last days I just observed myself and a new feeling of relief and calmness deep inside me emerged. Many memories popped up, memories that I had locked deep down and tried to ignore. Before coming to you I have read carefully the materials you suggested. I have understood intellectually the concepts of the endo self and the Instroke. But they were just the next concepts, the next smart words. In the workshop, I experienced it. I felt this place inside me where it is all fine, calm and peaceful. I didn't understand it at once, but then those memories that came back made me recall that I used to know this place.*
>
> *During the instroke exercise, I saw my dad. He died in my arms when I was 13. And that was the moment I lost the way back to myself and I did it on purpose. In the last days I remembered how my dad used to take me to a river, or up in the mountains when I was a child and we just sat in silence. He used to tell me that this is a way to find peace within, to find strength. He taught me how to listen to my inner voice, how to feel my body, how to find the strength in me. And when he died, I was so angry at him that I just blocked it all, I threw away the key for inside and started to live only by "going out".*
>
> *I have worked on my anger, and my sorrow and so many other emotions in my personal therapy. I do yoga and numerous kinds of meditations. And all I was looking for, all I was struggling to find is exactly that feeling of calmness and "it will all be fine" that I knew so well in my childhood. The insight that I just have is so powerful. I feel on the right path for the first time. I want to reconnect to myself. And this changes so much…"*
>
> *In this passage, we read the major themes of the phenomena I have described. There was no specific focus on the traumatic event. There was no specific release or insight that happened while the trainee was practicing the technique. There were also the classic signs of the endo-self state (Davis, 2014): all was fine, calm, and peaceful, and she already knew this state. She was returning to it, returning to herself. As Merleau-Ponty pointed out: "At the root of all our experiences, we find, then, a being which immediately recognizes itself...not by observation and as a given fact, nor by inference from any idea of itself, but through direct contact with that experience." (in Pagis, 2009, p. 267)*

Further, she did not describe any classical trauma signs. She was realistic and she took responsibility: angry, "throwing away the keys," going away from herself. And, she acknowledged what a loving father he was. In addition, she processed all of this *after* the workshop, *by herself,* even though she had already worked on her anger, sorrow, and other emotions in her therapy.

Colleagues have suggested that this was a result of her previous therapy. But if this is true, then most patients who have long-term therapy should spontaneously undergo this sort of experience. I had not seen this phenomenon during the first 15 years of my practice while doing encounter groups, Gestalt therapy, and then Radix neo-Reichian therapy. It did not appear until I became proficient in helping patients mobilize their instroke process and deepen their contact with themselves. And in the example of the transformation in a patient's perception of his stepmother, the patient was a "beginner." It was clear that something else was happening that I had not learned in my therapy trainings. Additionally, I have since trained therapists who report similar phenomena. What we are witnessing is a complete restructuring of a negative, lifelong primary object relation or experience that is happening intra-psychically, sometimes alone, with no new input available to the patient. How is this possible?

To answer this question, we begin with the Gestalt principle of figure-ground. The neurologist Kandel (2013) described the self-referential nature of perception, and how we create our own reality. Throughout his discussion of visual perception, he emphasized that "the eye is not a camera" (Kandel, 2013, p. 234), "every image is subjective" (Kandel, 2013, p. 200), and "there is no innocent eye" (Kandel, 2013, p. 200). This is true for touch, hearing, taste, and smell as well.(Kandel, 2013). Our perception of the physical world is "... an illusion created by our brain" (Kandel, 2013, p. 203), which is why we can view the same painting over many years and see and feel different things each time. This also accounts for our varying response to the same object/other. This ability is the basis of how we can restructure a primary relationship years later with no new input, and how the changes experienced in depth psychotherapy are achieved. The object remains the same. The story remains the same. It is the patient's experience that changes. In the phenomenological point of view, "The learner remains unchanged. It is his *experience* of the situation which changes." (Syngg, 1941, p. 406)

To illustrate his point, Kandel (2013) used the Gestalt drawing that appears to be a rabbit or a duck, depending on how one looks at it. The first point is that the visual image on the page doesn't change. What changes is the interpretation of the image. In therapy, it is the patient's experience of the historical data that changes.

Kandel's second point was that we "decide" unconsciously what we see, and these decisions are based on hypothesis testing, grounded in a combination of our innate neural recognition patterns and our past experiences. It is important to note that in conscious perception, there cannot be ambiguity. It is either a rabbit or a duck. On the cognitive level, we *have* to make sense of everything.

But, on the unconscious level, we are capable of maintaining a number of coherent, often contradictory, interpretations. (Kandel, 2013; Raichle, 2010; Schore, 1999) The unconscious can tolerate ambiguity, which gives it access to more information, more possibilities, and offers an alternative interpretation for the conscious mind when it is ready to "see" that.

> Conscious thought works from the top down and is guided by expectations and internal models; it is hierarchical. But unconscious thought works from the bottom up or non-hierarchically and may therefore allow more flexibility in finding new combinations and permutations of ideas. While conscious thought processes integrate information rapidly, unconscious thought processes integrate information more slowly to form a clearer, perhaps more conflict-free feeling. (Kandel, 2013, p. 469)

This helps to explain how the original data — the patient's history — can be reorganized, resulting in a restructuring of a primary object or event, with no new information added. The same phenomenon was recorded in pupillometry.

> During changes in perception, nothing changes in the world of environmental input, so any change in perception must be attributed to an internal change of the state of the brain that results in interpreting the same world state as a different event. (Laeng, Sirois & Gredebäck, 2012, p. 22)

Coming back to the rabbit/duck image, there is only a single two-dimensional image on the page. In fact, there is no rabbit or duck there. But on the conscious level, we need to classify and organize the input in order to make sense of it.

In addition, Laeng, Sirois, and Gredebäck (2012) indicated that pupil responses to images, thoughts, and emotions are the same. Imagination and perception are based on the same neural processes: the same brain state is activated. Your body is reacting as if you are there. Changes seen during imagination of an object "are a result of an active process of imagining and not as an after effect of episodic trace of a previously seen picture. In other words, what is happening in the imagining phase is actually happening, and not something left over." (Laeng & Suluvedt, 2013, p. 4). We will return to this theme in the section "A Functional Model."

The fact that we are creating all these objects explains why we can continually misinterpret and see the same object "incorrectly" again and again — for example, in transference or with a "bad" stepmother.

This idea is also supported by the neurological research of Raichle (2010) and Buckner, Andrews-Hanna, and Schacter (2008) concerning the default mode network. Raichle has shown that there is a subcortical system involving different brain areas that unconsciously organizes all incoming information without conscious awareness, and then informs cognition as to what it has "decided."

> [T]he default mode network is a specific, anatomical defined brain system. It is active when individuals are not focused on the external environment. It is active when individuals are engaged in internally focused tasks including autobiographical memory, envisioning the future, and *conceiving the perspectives of the other.* ([Italics added], Buckner, Andrews-Hanna, & Schacter, 2008, p. 1)

There is no objective object. (Davis, 2015 p. 14-18). Campbell's Psychiatric Dictionary (2004) described introjection as "The incorporation into the ego system of the picture of an object as *he conceives the object"* ([italics added] p. 348). Idealization is an extreme example of a self-created object. In idealization, the internal object representation could have none of the characteristics of the "real" external object. This is a result of the earlier

mentioned necessity for the conscious mind to organize and make sense of what it is experiencing. It also is the basis of the narrative the patient creates about past traumatic events.

Investment

In creating our objects, the self invests a specific quality into the object, a charge of energy. Most theorists argue that it is not the object in itself that is important, but the investment made in the object by the subjective self. Mitchell (2000) commented that the mother and baby co-create each other. Loewald suggested that objects "… do not exist independently of the subject. Objects are created by being invested with significance" (Mitchell, 2000, p. 38). Kohut (2001) took a similar view: "Narcissism is defined not by the target of the investment, but by the quality of the investment." (Kohut, 2001, p. 26) Social psychology showed that "It is the quality that determines functional significance rather than the particular event or object." (Ryan, 1991, p. 220) As well, in a quantum model of transformative processes. "The essential element is not the amount of energy involved but its quality; if it is able or not to trigger an information process of phase coherence." (Casavecchia, 2016, p. 10) The subject chooses what to focus on. It is not what was done to the patient by the other, but the patient's experience of the other/event.

Green (1999) criticized object relations theorists as being too focused on the object to see the objectalizing function of the life drive. They do not appreciate the endo-psychic strivings, the investments by the self in creating objects and then relationships to satisfy itself. For Green (1999), the object does not create the drive; it only reveals the drive toward the object. In this same manner, Damasio (1999) described the object as an emotionally competent stimulus, capable of meeting a response but not creating it. The role of the drive is:

> …to form a relation with the object but it is capable of transforming structures into an object even when the object is no longer directly involved. To put it another way, the objectalizing function is not limited to transformations of the object but can promote to the rank of object that which has none of the qualities, characteristics and attributes of the object, provided that just one characteristic is maintained in the psychic work achieved, i.e., meaningful investment. (Green, 1999, p. 85)

He even suggested that the self will create objects in their absence! We create what isn't there out of our desires, needs, and beliefs based on our own experience of events, not the external "reality" of those events. Loewald brought this discussion to a final point:

> I am my objects and my objects and I are always inseparable. They can never be expelled. This suggests that what happens in psychoanalysis is not a renunciation, or exorcism of bad objects, but a transformation of them (in Mitchell, 2000, p. 44).

Objects don't change. We transform them. More precisely, we transform our experience of them. This is also exactly what happens in a healthy development process. As the child goes through a progression of developmental stages, it continually reorganizes the representation of the mother object into adulthood. The mother is not so much changing as the child is experiencing the mother's various aspects as he transforms and develops himself further.

But Who is Transforming What?

The following is a typical representation of the basis of effective psychotherapy. "By confronting these fears from the past with open eyes in the now a person can find the strength to overcome most of his/her psychic and somatic dysfunctions in everyday life." (Adler, Gunnard & Alfredson, 2016, p. 8) A specific example of this comes from Epstein (2014):

> "Miriam came from a remote, former Soviet Union, a harsh reality of survival and everyday difficulties - both externally - as a Jew in an anti-Semitic society, and at home where she was treated violently, and taught to serve her parents, to be a good, obedient, and useful citizen - and later as a woman who takes good care of her husband. She was a nurse; for her entire life, she served others. She received long and rigorous training in self-deprecation. Worth and temporary calm came only in serving others. She knows almost nothing of herself, her desires, her wishes, and passions. (Epstein; 2014, p. 73)

Yet, at 40 years old, one day "something woke up in me," and she came to therapy to help herself.

But what "woke up" in her? Where does the force to confront and the strength to overcome come from if the organism has been so severely damaged? And in the specific theme of this paper, how is it possible for a severely damaged person to not only be able to find this but to restructure herself, often by herself, in a calm and clear manner? The answer is the part of the psyche that has not been damaged by the trauma; the endo self. (Davis, 2014)

The endo self describes an early, self-organizing, embodied, coherent sense of self whose unique quality is that it exists prior to relationship; an autonomous self, grounded in relationship (Davis, 2014). Besides the earlier reference to Merleau-Ponty, Maslow's (1968) "being states," Reich's (1967) "core," Guntrip's (in Buckley, 1986, p. 467) "inner core of selfhood," Winnicott's (in Buckley, 1986) "incommunicado core," Loewald (in Mitchell, 2001), who describes primary experience as being "…an experience of a perceptual affective nuclear consciousness that resonates in the quality of being the experience of himself" (Casavecchia, 2016 p; 16), and "A nascent core of self is not a social construct but a natural endowment of the organism" (Ryan 1991 p. 214-215) all suggest a deeper sense of consciousness/being/self. Jantsch (1979) comes directly to the point: "…with existence comes consciousness" (Jantsch, 1979, p. 10), while Maturana and Varela (1972) define consciousness as a biological phenomenon: "If you are living, you have consciousness" (p. 5).

The Cambridge Conference on Consciousness (2012) emphasized that there is subjectivity in the fetus before the development of cortical activity: before cognition, language, and relationship. In the same tone, Solms and Panksepp (2012) identified an embodied, affective core consciousness in the brainstem, and that higher cortical brain functions — cognition, language, representation and object creation — are built on and informed by this earlier emotional, embodied core consciousness. "The brain mechanisms of the internal body function largely automatically, but they also arouse the external body to serve its vital needs in the external world." "[…] in the sense that exteroceptive consciousness and learning reflect and serve interoceptive needs" (Solms & Panksepp, 2012, p. 155, p. 165). A core consciousness exists without cortical consciousness. The reverse is not possible.

Experiences are lived not only below cognition, but without it. For example, it is possible to "traumatize" insects. Scientists selected a type of insect that shows maternal care of its eggs and young. They removed eggs from some of the mothers, and one set of eggs were cared for in laboratory conditions. “The researchers found that nurtured female nymphs matured into devoted mothers assiduously cleaning eggs and feeding and defending their young. In contrast, females raised without mothers did not excel as caregivers. They fed their offspring less frequently and were not as effective at protecting them from predators.” Similar results were found with another set of eggs inserted into a “foster mother’s” egg collection. (Scientific American, 2016, p. 13)

Of particular interest for body-oriented psychotherapists is Solms and Panksepp’s core consciousness. The true internal subjective body is represented not in the cortex as has been assumed, but in the core consciousness of the brainstem — not as an object, but as the subject of perception. On this level of functioning, “…perception happens to a unitary, embodied subject” (Solms & Panksepp, 2012, p. 156), which I am referring to as the endo self state. The interoceptive brainstem generates internal states, not external objects of perception. It gives rise to a background state of being: the endo self, where, as Carl Rogers (in Ryan, 2003, p. 75) commented, “All the facts are friendly.”

There are a "vast variety of selves" to work with in therapy on the conscious, cognitive level — false self, social self, true self, fragmented self. But on the functional level there is but one self, the undamaged endo self. This is the root of my argument for *who* is doing the transforming of past object representations. It is an inherent endo self that is undamaged by the trauma, and therefore still capable of transforming an object with the same history once the experience of the object is altered. Functionally, this is a natural, universal characteristic. The healthy child utilizes its endo self to let go of one representation of the mother object and create another. So too can the traumatized patient call upon this still healthy endo self to transform and reorganize primary objects and the experience of events from the past.

Rewriting History

If we postulate an undamaged, embodied, psycho-emotional core called the endo self, we have answered the question of who is doing the transforming. But the question remains: how is the experience altered with the same data? How do patients now access information that was there but not available to them before? The answer to this question lies in the dynamic of what Guntrip originally called the “dual nature of transference” (in Buckley, 1986, p. 467), just as Reich had already differentiated between false positive transference and genuine transference (Reich, 1976).

Freud observed that transference is not limited to neurotics, but is essential for both healthy functioning and healing. “[…]the tendency to transfer in neurotics is only an exceptional intensification of a universal characteristic” (Davis, 1989, p. 4). For Guntrip, a good object is the basis of mental health. In its absence, the patient finds a good object in the analyst in both the transference relationship and in real life. “In analysis and in real life, all relationships have a subtle dual nature” (in Buckley, 1986, p. 447, [Italics added]).

A Duality: Need and Desire

It is this dual nature of relationships that allows for the possibility to transform objects and historic events. I have framed the dynamic of Guntrip's duality in terms of need and desire — a dual flow of both need and desire within all relationships (Davis, 2015). Desire is the natural impulse towards contact, the "universal characteristic" in all relationships. Need is frustrated desire adding an overlay to this universal characteristic, and creating the neurotic's "intensification" or Winnicott's "rupture of continuity," thus distorting the natural flow towards relationship and resulting in the distorted need states.

Maslow (1968) wrote of a "hierarchy of needs" from safety to social to self to altruistic onto transcendence. with the "lower" needs having to be satisfied before the later ones could be engaged. But to differentiate between desire and need changes the theoretical landscape. Need arises when desire is not met. Need is a state of difficulty, a sense of deprivation with a goal implied –- usually at a distance. In the language of psychotherapy, this distant goal is the other. Desire suggests mutuality, a give-and-take dialogue by placing a "request" to respond upon the other to whom the desire is expressed. It has an impervious quality, a request that must be responded to (Crabb, 1917). Desire is a request. Need is a demand.

Thus, need is unmet, distorted desire. A desire to be in contact is a different state than a need to be in contact; they have a different purpose and outcome (Davis, 2014, p. 14). If the desire is not met, it "sours" and becomes need –- a state. The "pushy," "gluey", shrill quality of the need state is a symptom of the unmet desire. In Reichian terms, needs are emotions from the armor that have lost their pulsatory contact with the core.

Need is other/object oriented. It has lost direct contact with its source, through a rupture, and the result is that it must be satisfied from outside. The other satisfies the need. In contrast, desire is endogenous in its origin and functioning, and in its satisfaction. Because desire is still in direct contact with its source, the self satisfies its own desire because it determines what is desired and what is satisfaction.

Another difference between need and desire is that with desire. there is no tension that has to be discharged, as in drive theory. The "tension" is an energetic excitement, a concentration of internal energy, that acts as a spontaneous, natural, mobilizing force towards object relationships and is well within the tolerance levels of the organism: Freud's "universal characteristic." It is pleasurable (libido means "it pleases").
Surprisingly, Piaget spoke directly to these twin themes of flowing out towards the other and the pleasure found in this movement, describing development as "[t]he very nature of life is to constantly overtake itself" (in Ryan, 1991, p. 208): to extend itself outward even further. And this striving outward, what Piaget called intrinsic motivation, is merely for itself. There is a pleasure in mastery, in efficacy, in experiencing merely for its own sake. This is a "basic fact of psychic life" (in Ryan, 1991, p. 209). Fifty years later, the neurological research of Ramachandran verified that the wiring in our brain ensures that the very act of searching for the solution is pleasurable (in Kandel, 2013).

Immutability

Additionally, it should be noted that satisfying needs only creates the possibility that the desires will be met, which brings up the all-important theme of the immutability of the desire of life to "constantly overtake itself" (Piaget in Ryan, 1991, p. 208), to go beyond itself into contact and relationship. And herein lies the nature of the duality in relationships. This is desire, also known as investment, Freud's universal characteristic, Green's objectivizing process, Guntrip's dual nature, etc.

As Reich's energy concepts postulate, it is possible to interfere with and distort this movement towards completion. The interference pattern, typically inadequate parenting, creates need. But the energetic movement of desire cannot be eliminated. It can never be prevented from trying to move forward towards pleasurable satisfaction. This impervious investment quality is the basis of healthy, loving relationships. And with an understanding of duality in relationships, it is clear that this impervious investing is also what underlies the distorted, deregulated need states of sublimation, transference, projective identification, etc.

These need states are a reflection of a continuing attempt to get what has not been gotten and is still desired: to make happen what has not happened. For example, in transference, the patient is not seeking the original father in the therapist. But rather, as Guntrip pointed out, a "good object;" exactly what he did not get in the original father relationship. As Perls said, transference is "[…] about what did not happen" (Perls, 1972, p. 40). Without this still healthy continuing search, in-depth psychotherapy would not be possible. There would be no healing, only repairing; no reconstruction, only renovation.

What I call desire, Kohut (2001) described as the "narcissistic stream," which remains *unaltered throughout life* —immutable— and is the basis of creativity, love, and all future relationships. Even when met, this innate push towards development and satisfaction will spontaneously continue to transform into the next phase of development. as described in Maslow's hierarchy of needs and object relations theory. It is embedded in health, and disguised in deregulated dysfunction for a lifetime. The patient cited earlier is an example. Despite her traumatic history and her negative emotional states, she continued to desire a loved and loving father, and once this was achieved, she could move past her resentment and enter into an adult, reality-oriented relationship with her father and not remain in a bad father/resentful child relationship.

Schore (1999), like Kohut (2001), emphasized this immutable search for completion, Echoing Guntrip's subtle dual nature, he wrote:

> Embedded within the patient's often vociferous communication of the deregulated state (need in terms of this discussion), is also a definite, seemingly inaudible, urgent appeal for interactive regulation (desire/relationship). This is a lifelong phenomenon. (Schore, 1999, p. 14)

Bowlby reflected this when describing attachment. "While especially evident during early childhood, attachment is held to characterize human beings from the cradle to the grave" (in LaPierre, 2015, p. 86).

In an earlier formulation of this same understanding, Reich (1976) emphasized that analysis could not proceed without reaching a level of "genuine transference" with the patient; "…the glimmerings of rudimentary genuine love;" again, a subtle dual nature

(Reich, 1976 p. 143). Reich understood that the original desire for the object is still intact, but obfuscated by false positive transference. Genuine transference is desire for contact and relationship, rooted intrapsychically in the endo self. False positive transference, Guntrip's transference, Schore's deregulated state, and emotions from the armor are need and lack, rooted in dysfunction and defense, and sought externally in the object.

Diagram I below delineates the dual flow in all relationships.

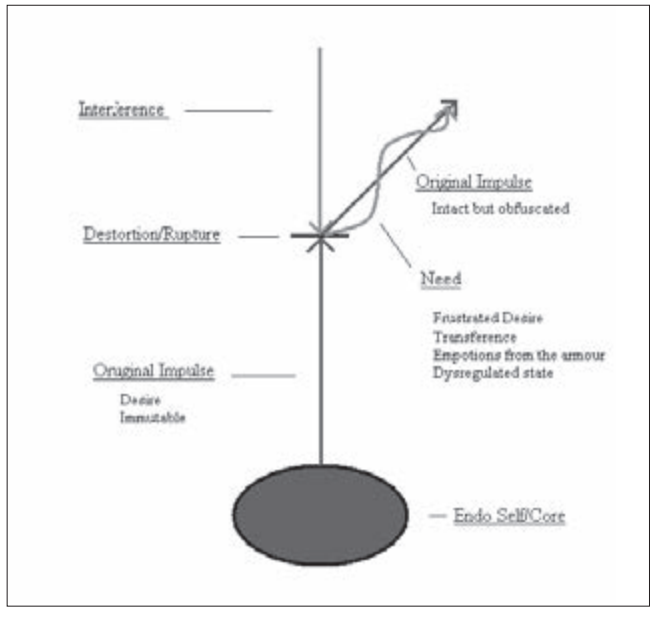

Diagram 1. *The dual flow in all relationships*

The continuation of the straight (blue) arrow past the rupture point represents the original impulse — Freud's universal characteristic — from the self/core towards the other. The continuation of this impulse is embedded within the distorted need state represented by the irregular (red) arrow, revealing the still-alive desire for contact and relationship that underlies all neurotic need states. Because both are there, Guntrip referred to a "duality." And because both are there at the same time in the therapeutic setting, the therapist can decide which to focus on, the need or the desire; the "emergent resource" or the "structural deficits." Fairbairn (in Buckley, 1986) reported that a patient once said to him, "I want a father." From this, he deduced that the goal of the drive is the object. I am arguing that he is correct only when the drive is a need state, a ruptured desire. Differentiating between need and desire, the therapist can choose to work with the need for the "father" object, or the desire of "I want…".

If it is, as Fairbairn suggests, the object that satisfies, why is it that even when the object wants to satisfy, it cannot? We know this as therapists. Any parent knows this feeling. Any lover who has been left knows this experience. It is not about what is offered; it is about what is taken.

The combination of this immutable desire towards mutuality and the innate ability of the patient to create and recreate his or her own objects lies at the source of all in-depth psychotherapy. It lies in the dual nature of relationships, in what did not happen and the simultaneous desire to make it happen. Without these two themes, there is no healing. We are left with compensation, adaptions, compromise, and, too often, resignation.

Green wrote:

> […] what brings a subject to analysis is…a compulsive need [desire] to rebuild his story in order to carry on with his life. (2005, p. 424) …how far does what unfolds in the treatment involve a repetition of the past and how far does it concern not what has been repeated but, on the contrary, what has never been experienced." (2005, p. 71, [italics added])

The clinical implication of this model is evident. Without some model as I am suggesting, as Strecker (2018) has pointed out, we are left with a quite different position whereby the patient is left with compensation and adaptation, and possibly resignation about what still has not happened.

> Stanley Keleman was always very clear that for him there existed no "real self" that could show up after all the distortions and deformations of education and biography had been peeled off. His sober analysis was that there existed no healing in the sense of finding the perfect condition under the surface of alienated existence. So, you have to deal with what you have developed so far, involuntary and voluntary. (p. 54)

A Functional Model for Rewriting History

By mobilizing the instroke it is possible to work safely with trauma patients by going below the cortical level of cognition and emotions, below the defenses and even below the trauma itself, to the undamaged endo self state. Trauma needs objects, others. The endo self seeks itself. As one patient explained, "I love myself beyond the good and the bad."

Neurological research confirmed the position taken in pupillometry; what is happening in the imagination is actually happening, and is not a memory. Cozolino (2002) and others have pointed out that all trauma is stored sub-cortically and in the present moment in the more primitive regions of the brainstem and limbic brain, with little cortical and left-brain involvement, resulting in the absence of localization of the memory in time. "Flashbacks are always in the present and total system experiences" (Cozolino, 2002, p. 272-273), reflecting the position taken in the Cambridge Declaration (2012): "The neural substrates of emotions ...are therefore 'out of time.'"

All of this discussion confirms Reich's earlier insight:

> There is no antithesis between the historical and the contemporaneous. The whole experiential world of the past was alive in the presenting form of the character attitudes. (1967, p. 121)

And,

> The schizophrenic does not "regress to childhood". Regression is merely a psychological term describing the actual, present day effectiveness of certain historical events. The schizophrenic does not "go back to the mother's womb"; what he actually does is to become a victim of exactly the same split in coordination of his organism which he

> suffered when he was in the deadened mother's womb; and he has maintained that split his entire life. *We are dealing here with actual, present day functions of the organism and not with historical events.* (1976, p. 492)

Diagram II shows how on the more superficial, psychosomatic/cognitive level, the patient has organized himself in response to a trauma. Below that is where the trauma is, and how the person is defending against it on the vegetative level. The deepest level is the undamaged endo self, which houses the ability of the patient to transform events and objects, and rewrite history.

The psychosomatic level contains emotions and the central nervous system-based cognitive and neuromuscular system. This level is the location of the body/mind defenses that protect the patient from the underlying trauma. Defenses in the forms of thoughts, emotions, and muscular reactions are evaluative responses by the patient to what he is still afraid of re-experiencing from past event(s). It is an avoidance reaction, preventing it from being experienced again. Defenses are "decisions" made to protect the patient from what s/he experiences as dangerous; the horror of the trauma that lies below these defenses. The patient must protect her/himself from this abomination.

Herein also lie the symptoms and narrative of how the trauma occurred, and how it continues to negatively impact the patient's life. This is what the patient presents in the therapeutic setting. According to Cozolino (2006), the vast majority of memories are unconscious (pre-cortical), but shape our emotional experiences, self-image, decisions, and relationships. The speed of the amygdala in processing information generates a physiological reaction before we are conscious of what is being processed. He calls this the "known and unremembered" (Cozolino, 2016, p. 130)

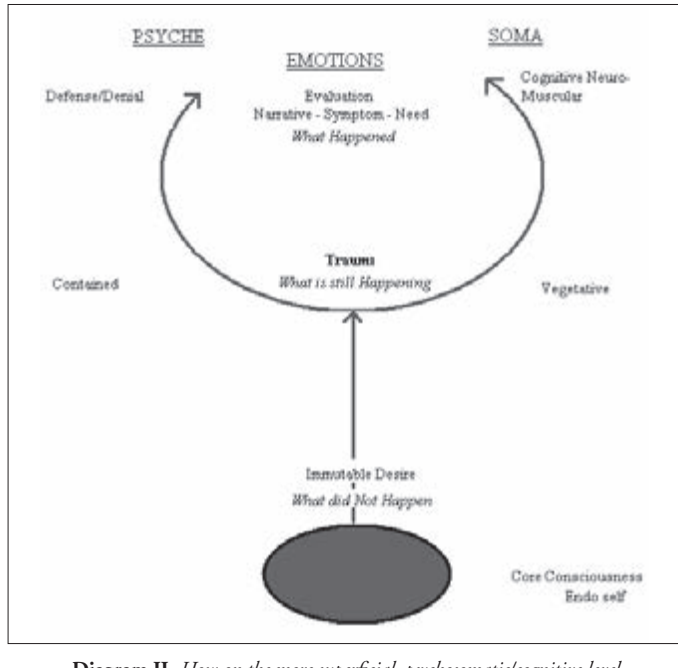

Diagram II. *How on the more superficial, psychosomatic/cognitive level, the patient has organized himself in response to a trauma.*

On the cognitive level, a difficult issue about memory and narrative is whether or not the traumatic event actually occurred. Kohut referred to "telescoping." Looking through the telescope from the other end, experiences are grouped together and condensed to form a narrative; a scenario that may not have happened at all. In this case, it is not a remembered event as the patient believes, but a condensed collection of related sensations, experiences, and mixed memories formed into a coherent narrative. Oliver Sacks (2017) pointed out that it is not possible for external events to be directly recorded in the brain. Our only truth is narrative truth: the truth we tell ourselves and others.

It is very frustrating to both therapist and patient to pin down this "memory." Yet it is imperative to respect and accept the patient's version of what happened. Freud was flummoxed by hysteric descriptions of alleged sexual abuses until he gave up on it altogether. What helped clarify this issue for me was that while a patient was talking about her abuse story, she suddenly interrupted herself, looked at me intently, and said, "I don't care if it happened or not. I feel abused!" And that is the point: the *experience* of a relationship or event that went badly wrong. The emphasis in therapy is not about the story, the past, or the object. The focus of therapy should be on the patient's living experience: about what may or may not have happened. It is too easy for both patient and therapist to get lost in the drama of the narrative.

As we move down the diagram, we come below the cognitive/neuromuscular, to a pre-cortical, yet knowing state on the vegetative level. And here again we have evaluation. Below the cognitive-neuromuscular based defenses, the vegetative state is still out of balance because of the trauma. The organism reacts first to any shocking event on the vegetative level, but not all shock is traumatizing. If the shock is not released, the vegetative system stays out of balance: this is trauma. The cognitive/neuromuscular response is secondary, built upon an evaluation of the more primary response to danger on the vegetative level. The vegetative response is the active, living level. As Reich emphasized, it is not historical. It is not a story of what happened, but what is still happening. This is why it must be defended against continually. If it truly were in the past, there would be no threat to the patient. The problem for the patient is that it could happen again right now, because on this level, there is no time. It is always now. It is always haunting the patient, threatening to happen again. The psychosomatic narrative level is about what happened in the "past," and the patient is desperate to keep it there. In reality, and understandably so, it is simply being avoided. Unfortunately, in the deeper vegetative level, it is still happening. It is, hopefully, contained by the vegetative response, but it has not been eliminated. Further down the diagram, represented in brainstem functioning, is the endo self, the level of what has not happened; the incomplete, immutable desire for satisfactory contact and relationship.

The psychosomatic level is the manifestation of the incompleteness in terms of need-based behavior: over-dependence on the object, isolation from or rejection of the object, transference, false positive transference, projection, projective identification, idealization, etc. On the vegetative level, we encounter the caged "alive" trauma experience, the contracted, imbalanced state of the vegetative response to this non-historic, living event. On the deepest level, we encounter Solms and Panksepp's embodied, subjective core consciousness housed in the brainstem. Or Maslow's being states. Or Reich's core. Or my elaborated synthesis, the undamaged endo self.

One patient reported this state as "I feel an extreme presence in the absence of myself." Another commented: "She is back!" But who is back, and where was she all this time? The answer is the immutable, undamaged endo self, the original source of desire for satisfactory contact and relationship, and the continued hope that what has not happened, will. This is where the self seeks, chooses, creates, and transforms objects and experiences. It is an individual, self-referential, interpretive process that decides and creates one's own reality based on the experience of oneself, not the other.

Often in Functional Analysis, nothing happens in the sessions and the object reorganization happens safely later. In this case, using an older mobilization technique, the partial release of a deep contraction on the vegetative level allowed the patient's whole body to be involved. She began the gentle, gathering, curling movement of the instroke with her head and shoulders rising up gracefully from the mat. But suddenly she interrupted this flowing movement with a strong contraction in the rhomboids pulling her shoulders backward, contracting her throat, and preventing any further gathering, instroke movement. I supported this defensive movement by placing my hand on her rhomboids for a few moments and applying light pressure upward in the direction of the contraction. I then told her to stretch and move on the mat. She then described the interruptive, blocking quality she felt in the rhomboid contraction. Returning to the work on the mat, the same gentle rising up movement came again but this time she did not interrupt it and gathering herself, she came into a curled-up ball where she felt satisfied.

Afterwards, I asked her what happened to the block/contraction? Where did it go? She replied:

> "It joined the party! How beautiful. It tells us how our body and every part of our self are in favor of our self. I feel fluid, a unit. It creates a nostalgia in me. A beauty I want to be more and more of."

I commented that nostalgia implies that there is something known; something you had or know of and want to have again.

> "Exactly." She replied. "To go back to who I used to be — who I am. I am a unit. The contraction in the back of the shoulders was separating me from myself. Then I realized everything was intact. At first, I felt this rigidity here (rhomboids) and when I released it, I became aware of my heart."

Summary

During the physical treatment phase when generally the patient and I do not converse, a patient suddenly opened her eyes and said, to no one in particular, "Abused and still alive." Then she laughed. This was not a recounting or a reliving of the trauma and the sufferings incurred from it. It was a profound self-affirmation. "I made it." She was not stuck in the trauma or the defenses around the trauma. She was below that, declaring herself.

I have argued that despite the fact that the unimaginable has happened, there is still a reserve, a resource that continues to seek unity, wholeness, and satisfying relationships. It lies below the defenses and below the turmoil of the trauma contained by the vegetative system; the endo self. By not getting lost in the drama of the narrative and the historic past, by working below the defenses, by contacting and supporting the ever-present, embedded,

subtle desire for contact within all relationships, we can help patients to not continue to be haunted by their "living past."

> Those who know about ghosts tell us that ghosts long to be released from their ghost life and laid to rest as ancestors. As ancestors, they live forth in the present generation, while as ghosts, they are compelled to haunt the present generation with their shadow life...ghosts of the unconscious, imprisoned by defenses but haunting the patient in the dark of his defenses and symptoms. In the daylight of analysis, the ghosts of the unconscious are laid to rest as ancestors whose power is taken over and transformed into the newer intensity of the present life, of the secondary process and contemporary objects. (Leowald, in Mitchell, 2000, p. 25)

Will Davis *has 45 years of experience practicing and training in America, Japan and Europe. He developed Functional Analysis which focuses on the energetic instroke, plasmatic origins of early disturbance, the energetic qualities of connective tissue and its role in character development, the endo self, the gentle self-oriented release technique of Points & Positions, and a unique synthesis of verbal therapy. He is a member of the editorial boards of two journals, the Italian Society of Psychologists and Psychiatrists, the EABP, AETOS and teaches as a guest trainer. He lives with his wife Lilly Davis in the south of France.*

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Judyth O. Weaver

SOMATIC MEDITATION 2

Have you been sitting for a while?
Do you feel you need to move? To stand up? To walk?
Get a drink? Relieve yourself in other ways?
Did you feel that before you read it here?
How did you respond?

How do you answer your needs?
Do you ignore them at times?
How does that feel to you?

How are you feeling now?
Is your vision different?
Is your breathing different?
Is your posture different now?

How are you NOW?

Toward a Somatically-Informed Paradigm in Embodied Research

Jennifer Frank Tantia

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ABSTRACT

The field of somatics has existed for more than 80 years without the complement of substantial research to accompany it. As it began to evolve into mental health treatment, the experiential orientation of somatic psychotherapy attracted those more interested in the art of the practice than the practice of scientific research that could support treatment outcomes. This has created a weakness in the field, and has arrested the development of somatic psychotherapy as an evidence-based treatment for emotional health. This article will offer an overview of the extant literature on embodied research and make a case for the need for somatically-informed embodied research. It will describe general ways in which somatic psychotherapy and dance/movement therapy clinical practice can be repurposed to create somatically-informed research methods. Finally, it will project how embodied research methods might be useful to studying complex issues in social phenomena, as well as the intricacies of treatment-resistant medical and emotional illness.

Keywords: embodiment, embodied research methods, embodied inquiry, mental health, psychophysiological health

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Over the last 25 years, an extensive collection of work on embodied research has emerged from fields outside somatic psychotherapy. Disciplines such as philosophy (Abrams, 1996; Lakoff and Johnson, 1999; Varela, Thompson & Rosch, 2016), neuroscience (Damasio, 1999; Porges, 2009; Scaer, 2007) anthropology (Csordas, 1993, 2008) nursing (Gavin and Todres, 2009; Mason, 2014), education (Kiefer and Trump, 2014), sociology (Perry & Medina, 2015), social psychology (Meier et al., 2012) and health psychology (MacLachlan, 2004) have explored the murky waters of what is labeled "embodiment." Some have evaluated embodied experience from phenomenological methods (Finlay, 2011; Todres, 2004, 2007; van Manen, 2015; West, 2011), grounded theory (Rennie, 2006), and arts-based research (Levy, 2009, 2017; Spatz, 2015). Still others have explored embodiment more specifically from a feminist perspective (Ellingson, 2012; Vacchelli, 2018), or queer theory (Thanem and Knights, 2019).

These researchers have each laid a conceptual framework for embodiment (according to their respective fields), examining it from decision-making (Bechara, et al, 1994: Hervey, 2007) to identifying the intricacies of personal oppression (Ellingson, 2012;

2017). However, many of them have stopped at a crucial part of the embodiment process. They explain how we think about embodiment, but miss the very essence of the experience itself: the sensorial experience of the present moment that can offer deep insight into personal (and potentially universal) human truths.

The embodied psychotherapy community has long been shy when it comes to producing research studies, and only a handful of therapists have advocated for more research in the field (Caldwell and Johnson, 2012; Cruz and Feder, 2013; Hervey, 2000, 2012; Koch & Fuchs, 2011; Ladas, 2005; Mehling et al., 2012; Payne, et al., 2016; Tantia and Kawano, 2016; Young, 2012). When discussing the difficulty of solidifying a research base for body psychotherapy and dance/movement therapy, Michalak et al. (2019) suggested that there was a "…huge diversity in theories and methods ranging from ideas about the treatment of specific disorders to applying specific methods for a wide range of human problems" (p. 53). The authors concluded that the variety has led to a shortage of randomized controlled trials, which are crucial to the integrity of a field's body of knowledge. Another perceived problem, which this author has heard about firsthand from the body psychotherapy and dance/movement therapy communities, is that clinical research in these fields is inappropriate since it could compromise the sensitivity and individualized process involved in conducting embodied research. Developing a protocol, for example, could possibly "dehumanize" the process that is so unique to somatic psychotherapy healing.

However, there may be a way to collect and analyze data without compromising the integrity of the treatment setting. Without trying, somatic psychotherapists already utilize methods to gather information from their clients that are akin to what researchers do while gathering data for a study (Caldwell & Johnson 2012, 2015; Johnson, 2014). For example, during sessions with clients, they are listening to what clients are saying (collecting data), organizing the information in terms of the clients' patterns (data analysis), and revising their interventions accordingly (revising the research question). In Gestalt therapy, Fritz Perls (Perls, Hefferline & Goodman, 1995) called his interventions "experiments," offering interventions with open curiosity and adapting them in present time to best understand and work with a client's needs.

What is special about somatic psychotherapists, however, is that we not only listen to what the client is saying, but we also listen and look for how they are describing what they are saying; for example, we notice pauses in the narrative, changes in eye gaze, gestures, deepening of the breath, or other indicators that are often missing in traditional "talk therapy," but are crucial from a somatic lens. To the somatic psychotherapist, this may seem like second nature, but it is the uniqueness of noticing and inquiring into the nonverbal that may be the heart of what makes somatic psychotherapy different — and researchable.

In the same way that attention to embodiment makes somatic psychotherapy different from talk styles of therapy, it may also be the missing piece in current embodied research methods. If somatic psychotherapy practice could be translated into research methods, it might not only evoke more interest from practitioners to engage in research, but embodied methods might also have the potential to change the face of traditional research paradigms that do not attend to the actual experience of the body alongside the client/participant narrative.

The Problem With Embodiment In Research

Embodied research methods that stem from embodied epistemology are necessary, not only for the identity of the field, but also for its survival. Young (2012), a somatic psychotherapist and prominent writer and researcher in the field, critiques its lack of research:

> We have got to become a lot more objective – of ourselves – and about ourselves – and that does not necessarily mean de-humanisation [sic]. We have got to find ways (resources with which) to do the research, which probably means the current Somatic Psychology PhD programs and students initially. (p. 79)

Young's conjecture is true; we do have to find ways to do the research, but most of the graduate programs in somatic psychotherapy and dance/movement therapy are strongly focused on practice, and few doctoral programs in the U.S. focus on research: two in dance/movement therapy, and one doctoral program in somatic studies. The disproportion of practitioners to researchers in the field makes the cultivation of research an overwhelming task.

Perhaps an even larger problem facing the development of embodied research in somatic psychology is that current research methods do not fit the elements and nuances that emerge within a somatic psychotherapy process. Traditional psychotherapy treatment ("talk therapy") relies on explicit communication, so it naturally follows that methods for studying clinical research would rely on explicit means to collect and analyze data (i.e., measurements and comparisons, or words from interviews). From an embodied epistemology, however, there is a mismatch when a researcher tries to fit embodied (often implicit) experiential data into a traditional (explicit) way to study it.

Too often, students and researchers in somatic psychotherapy find themselves collecting and analyzing embodied data with traditional research methods. It is not surprising that somatic psychotherapists might feel intimidated, not only by the unintuitive process of conducting research (Caldwell and Johnson, 2012, 2015) but the constant mismatch of applying explicit methods to implicit (embodied) data. Instead of attempting to fit a somatic experience into an explicit paradigm, new methods and approaches are needed to better suit somatic experience.

A Paradigm Shift In Psychotherapy

The awareness and attention to embodied experience in the psychotherapeutic process has been called a paradigm shift in traditional talk psychotherapy (Bruschweiler-Stern, et al., 2010; Schore, 2009, 2011), with the emphasis that traditional focus on explicit, verbal communication in the psychotherapeutic process is not enough. According to Schore, psychotherapists must move from "conscious verbal language to unconscious affective nonverbal communications" (2009, slide 26). Schore also seems to correlate "unconscious communication" with nonverbal communication that, unless attended to, is not otherwise available. He lists factors such as "visual-facial, auditory-prosodic, and tactile-gestural emotional communications" (Schore, 2009, slide 27). The shift to the implicit supports what somatic psychotherapists have known and practiced for decades: embodied experience is a valuable healing element in the psychotherapeutic process (Barratt, 2010; Heller, 2012; Marlock and Weiss, 2015; Payne, 2017; Payne, Koch, Tantia, & Fuchs, 2019; Porges & Dana, 2018; Rothschild, 2000; Tantia, 2016; Young, 2012).

Most psychological research in "implicit relational knowing" (BCPSG, 2010) focuses on developmental interactions between mother and child. In a somatic psychotherapy setting that is largely practiced with adults, there are parallel interpersonal experiences between the adult therapist and adult client. Therefore, there may be implicit data available= that can be collected and analyzed for a study but has yet to be formally explicated in research. Embodied studies between or among adults who have access to memory, verbal description, and interpretation of embodied experience constitute a wealth of knowledge yet untapped in current embodied research.

Embodied Forms of Inquiry

As far back as 50 years ago, a study was conducted on embodied experience in clinical research. Researchers found that patients who brought attention to the felt sense (an amalgam of sensations and emotions in the body) experienced a reduction in psychiatric symptoms that lasted longer than traditional "talk therapy" (Rogers, Gendlin, Keisler, & Truax, 1967). This idea developed into what is known as Focusing today (Gendlin, 1981). Focusing has since emerged as probably the strongest base for exploring embodied experience in psychotherapy.

Embodiment is more than the sum of its parts; in fact, it cannot exist as only physical, mental, or emotional, but is a present-moment experience that is an amalgam of aesthetic experience. As Blackstone (2007) states, "The internal space of the body is not just filled with physical organs; it is filled with the self-existent qualities of being, and with energy and consciousness" (p. 70). Embodiment can be both a state of awareness and a process to be cultivated. Mindfulness, which constitutes a large part of embodied psychotherapy practices (Weiss, 2010) could be thought of as attention *to* the body. However, when one brings attention to the body, there is an enlivened response to that attention (Tantia 2012): attention *with* the body. When one inquires deeper (for example, through Gendlin's Focusing), a feedback loop of *attention to* and *attention with* the body is created in present time, which cultivates a deeper state of embodiment. This process of embodiment can reveal further information than could not be known by simply "talking about" an experience. Finally, embodiment can be developed from the client's awareness of their own experience, or from the therapist's awareness of their client's posture, gesture, prosody, rhythm of breath, or movement, (Tantia, 2016, 2019). Even a client's proximity to the therapist can play a role in developing embodied experience.[1]

In order to respond to the need to study embodied experience through research in a way that recognizes and values the qualia of embodiment as a rich source of information, new ways of inquiry — namely, embodied research methods — are needed. Embodied forms of inquiry bring implicit information to the foreground of awareness, allowing the researcher to recognize and collect data inaccessible through traditional research methods. Similarly to the ways in which somatic psychotherapy elicits embodied experience in the clinical setting, embodied methods can elicit embodied experience in the research setting.

[1] For a more detailed description of the ways in which somatic psychotherapists and dance/movement therapists facilitate embodied awareness, please see Tantia, 2019.

Clinically-Friendly Embodied Methods

Embodied data are points of unconscious information that are revealed through attention to the body. Beginning with the ingenuity of Gendlin's philosophy of the implicit (1981), bringing attention to one's embodied experience can make a significant difference in the ways in which embodied data are collected and analyzed. In lieu of "talking about" one's experience, an example of embodied data is found through ways of observing and sensing inside the body –

a familiar, if not integral to, somatic psychotherapy treatment. Sensations of shapes, weight, texture, color, or movement within the viscera and limbs are some of the ways in which embodied data emerge from embodied inquiry (Tantia, Cruz, and Kawano, 2017). The amalgam of feeling sensations might manifest in words such as "buzzing, twitching, swirly, heavy" or even a combination of such that might not make logical sense at the outset, but eventually creates meaning for the participant. Data like these are often described in trauma treatment (Levine, 2010; Ogden & Fisher, 2015; Porges, 2009; Rothschild, 2000; van der Kolk, 2015).

Another example of clinical practice is a process of embodied elicitation is from Authentic Movement, a form of dance/movement therapy created by Mary Whitehouse, which can also be a source of data collection (Payne, 2017; Tantia, 2012). Akin to a moving meditation, the participant closes their eyes and waits from an impulse from their body to move (Adler, 2007). Often the participant sees visions, feel textures in ways not familiar to them, and finds themselves in the midst of a dream-like experience (Stromsted, 2015). Authentic Movement has been studied in terms of how it affects the embodied experience of the witness (Payne, 2017) or, for the purposes of this article, the researcher/therapist, who sits still with eyes open. Following the movement, the mover and witness report their experiences as if they are happening in the present moment, or immediately write or draw to capture the nature of the experience. These types of embodied data may reveal more closely the direct experience of phenomena, or perhaps information that cannot be revealed by recalling and interpreting an event from the past in a linear fashion. This data, along with the witness's experience, can be collected and analyzed as part of an embodied data research method.

The whole conjecture that is argued here originated out of a need to create a new method of data collection for a doctoral dissertation on clinical intuition (Tantia, 2013). After several failed attempts at asking seasoned somatic psychotherapists by phone how they experience intuition in their bodies, I realized that I needed to interview in person, and use a different way of asking questions. Borrowing from elements of Focusing in conjunction with movement observation, I developed the Body-focused Interview (Tantia, 2014a) out of the need to explicate the kind of language from the body that was necessary to describe the complexities and nonverbal nuances found when observing a person trying to characterize an experience that was difficult to describe. By collecting both verbal descriptions of participant's sensorial experiences and recording their movements, I was able to postulate an original conjecture about how intuition happens, and how it arrives from unconsciousness to consciousness through the body (Tantia, 2014b).

Below are examples from the study with my nonverbal descriptions inserted, noted from viewing the video recordings of the interviews (Tantia, 2014b, p. 220):

> (RK): When I feel into it (looks right, eyes partly closed), right now (head turns to right), it seems (right hand gestures out, palm toward head and up, mid-level) more like something that happened here (right hand raises up to the right side of his head and moves toward and away from head, palm toward head), like in my right temple area (shaking hand next to right side of head, then suspends hand next to head…long pause in words and suspension of movement).
>
> (LM): It kinda came in through my head (both hands raise to right side of her head, palm toward her head), but it wasn't mental. I can't describe it. Like, it was like hearing a thought (right hand waves with palm toward right of right head, then rests on her chest), but then it just landed here (cupping right hand in front of solar plexus) and there was a solidity, and it was like, "Oh!"

This example is offered here as a way to introduce to the reader how it might be possible to collect embodied data. In the original study, I used a descriptive phenomenological analysis (Giorgi, 2009) in order to capture the experience as closely as possible. For a more detailed account of the study, please see Tantia (2014b).

Years later, I became curious about whether others had also found ways to collect and analyze embodied experience in the way that I had: eliciting data that included the aesthetic language of one's internal sense of their body, and/or including posture and gestures around the body. I wanted to know whether others had also created methods for this to meet the needs of their own research. I put out a CFP for an edited book on embodied research methods, hoping to gather studies that have specific ways of collecting and analyzing embodied data. To my astonishment and delight I received fifty proposals from many different disciplines, and many countries who had courageously diverted from the prescribed research route and created their own methods. From systems of analysis, embodied interview styles, and creative research methods, I collected and collated these original methods into two textbooks that are forthcoming (Tantia, in press).

The present-moment embodied experiences are valuable data that can be collected and analyzed in a research study. Body memory, which is alive in the present time (Fuchs, 2012), can also be collected with awareness of its limitations (Changaris, in press). Embodied data, collected through the researcher's reflexivity (Johnson, 2014), observation of the participant's nonverbal descriptions (Tantia, 2014a), or through the participant's self-report (Anderson, 2002, and in press; Freedman & Mehling, in press) are but a few ways in which embodied experience can be collected in a research study. It is my hope that the forthcoming texts will act as scaffolding for clinicians and embodiment researchers to see the many ways in which embodied data can be collected and analyzed for a study.

Discussion

Embodied methods are ways to bring implicit knowledge into conscious awareness so that an experience can be more fully understood. The very process through which somatic psychotherapists encourage present-moment embodied awareness from clients can be ways to create and collect embodied data for empirical research. Felt images in embodied data collection may include body memories that arise in the present-moment, or new sensations that arise from current experience. Specific to somatic psychotherapy, they can manifest in qualia of temperature, tension, shape, weight, texture, color, movement (Tantia, in press), or even interactive images of the participant (Tantia, 2014b).

By using an embodied approach that gathers descriptive data, somatic psychotherapy treatment offers ways to bring implicit knowledge into conscious awareness so that an experience can be translated into a form suitable for research inquiry. A participant might be asked to "sense" their bodies in response to a question, bringing attention to embodied data that include physical, emotional, and cognitive dimensions (Tantia, 2014a, 2014b; Tantia and Kawano, 2016; Westland, 2009).

This article makes a case for a path toward conducting embodied research by articulating the value of somatically-informed psychotherapy practice as a parallel to the process of data collection in an embodied research method. It also introduces the development of forthcoming embodied research methods that appropriately describe and capture the implicit data produced in somatic psychotherapy. Although a discussion about recording analysis was not offered, there are some current somatically-informed systems for recording and analyzing data that are both published (Birklein & Sossin, 2006; Grossman. & Cohen 2017; Mehling, et al., 2012, 2018; Tantia, 2014a, 2014b) and forthcoming (Tantia, in press). There is much to further explore in this topic, and the author hopes that this article sparks inspiration and conversation toward a fuller body of somatic psychotherapy research.

Conclusion

Embodied research methods are imperative for testing and building better theories for how somatic psychotherapy promotes an individual's overall development, while remediating symptoms of specific conditions that include both intrapersonal as well as interpersonal difficulties. Embodied research methods can offer data that are not traditionally accessible through current research methods, and might provide a gateway toward further discovery about human experience that is felt, rather than only thought.

Creating new methods that address embodied data arising during somatic psychotherapy sessions is crucial, not only for the field of embodied psychotherapy, but may also be useful to other fields who have already begun to address the value of embodied research. By developing new embodied research methods, current philosophy and research in embodied phenomena can further develop a new paradigm. Embodied experience of (Zahavi, 2010) oppression (Johnson, 2009, 2015, 2018; Johnson and Caldwell, 2010), gender and sexual diversity (Caldwell and Leighton, 2018; Thanem and Knights, 2019), ability diversity (Ellingson, 2006, 2017), and even more elusive phenomena such as embodied safety (Mair, 2018), clinical intuition (Marks-Tarlow, 2012; Tantia, 2014b), medically unexplained symptoms (Payne, 2019), and addiction (Payne et al., 2017) could

be researched more fully by applying embodied research methods. Finally, embodied research methods may also elucidate difficult to treat conditions such as chronic fatigue, irritable bowel syndrome, vasovagal syncope, pain disorders like fibromyalgia, reflex sympathetic dystrophy syndrome, and rheumatoid arthritis, as well as other symptoms that may be comorbid with other complex traumas or existentially conditioned responses to stress. Attention to these phenomena is needed to meet the new national and international human threats that challenge us today. It is with hope that the newly emerging literature in embodied awareness and research becomes a new standard for collecting and analyzing particular data that cannot be found through current methods alone.

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Jennifer Frank Tantia, PhD, MS, BC-DMT, LCAT *is a somatic psychologist and dance/movement therapist in the Times Square section of Manhattan, specializing in trauma and medically unexplained symptoms. She has introduced somatic psychology to several universities in the U.S., and guest lectures internationally. Dr. Tantia has recently served as a grant adjudicator for the NEA Research Artworks commission, as well as formerly serving as board member and chair of research for the United States Association for Body Psychotherapy. She currently serves on the board of the American Dance Therapy Association as chair of Research and Practice, and is an associate editor of the international journal Body, Movement and Dance in Psychotherapy. She has authored several publications in both dance/movement therapy and somatic psychology, and recently co-edited The Routledge International Handbook of Embodied Perspectives in Psychotherapy. Her two-volume textbooks, Foundations of Embodied Research and Embodied Research Methods Cases, will be published by Routledge in the fall of 2020.*

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Depression and Body Psychotherapy
A Qualitative Study from a Resilience Perspective

Christina Bader Johansson

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ABSTRACT

The aim of this qualitative study is to find out how body psychotherapists describe their approach to promoting health, and their methods of treatment and signs of recovery in depressed clients. Using Grounded Theory, literature studies and analysis of open questions were conducted in parallel. The open questions were sent to the members of the Swiss National Association of the European Association of Body Psychotherapy (CH-EABP). The answers from 18 participants were analyzed using open axial coding with the method of constant comparison until saturation. Four main categories were identified as selective coding emerged from the data: 1) attachment and the therapeutic alliance; 2) body awareness; 3) contact with grief enabling healthy, creative aggression; and 4) self-regulation and rhythm. These categories form a theoretical core for treating depressed clients. Findings indicated that body psychotherapists have therapeutic tools to work with resilience.

Keywords: depression, body psychotherapy, resilience, therapeutic alliance, body awareness, grief, healthy aggression

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According to the World Health Organization (WHO, 2017), depression is the worldwide leading cause of ill health and disability. WHO investigated psychological problems in general health care, and found that depression and anxiety are the most comorbid diagnoses, along with somatic health problems (Sartorius, Üstün et al., 2018).

Body psychotherapists often see clients with minor or major depression. A depressive episode has usually been preceded by the loss of a significant other, the loss of a job, or the risk of losing a job, creating great emotional stress (Bauer, 2013). A depressed person's symptoms are psychological, as well as body-based and vegetative (WHO, 2017). However, research on the description of how treatment is organized is rare in the literature (Röhricht, 2009).

Definitions

Today, resilience is a common theoretical expression, describing how people can better manage life experiences based on previously developed psychosocial abilities (Richardson, 2002). In body psychotherapy, self-regulation is an essential concept (Reich 1945,

Marlock, et al., 2015) that means an organism can regulate itself despite moderate stress and challenges. Etymologically, the word resource means "to recover, to recuperate, to collect power again," and shows a new direction. The word repair, on the other hand, means reset — getting back to something. How does body psychotherapy address creating or restoring resilience? What about repair and supporting the ability to self-regulate and recover? How are body psychotherapists engaging these different directions?

My Research Perspective

I have been working as a therapist for 40 years, and I am interested in the interplay between theory and practice. I treat depressive clients from the perspective of the reflective practitioner who regularly looks at her professional work to improve her clinical practice (Schön, 2013). The potential and willingness of clients to try new strategies to help themselves and harness their inner power by interpreting their reality in a new direction has thrilled me time and again.

I was interested in a qualitative study, because I wanted to better understand how body psychotherapists describe factors promoting health and the use of resources when working with depressed clients. Giorgi (2003) and Corbin & Strauss (2015) state that people's experiences and know-how come from the relevant insights of their lives, and that people strive to describe these phenomena spontaneously, directly, and without bias. I wanted to know what my colleagues directly and spontaneously would say about treating depressed clients. Is it possible to state that body psychotherapists are working towards resilience? I broke the subject of resilience down to operational questions that could be answered from the perspective of clinical practice.

General Open Questions

- Why do you think people stay healthy?
- Which body psychotherapy concepts and methods do you find most valuable to support the recovery of depressed clients?
- By what signs, including bodily expression, do you recognize and confirm clinically that clients are on their way to recovery from depression?

Grounded Theory is used in different professions to explore new areas of phenomena without suggesting a hypothesis (Sbaraini et al 2011). The methodological steps of Grounded Theory are detailed in the Method and Material sections. I began with a literature study, while at the same time sending my colleagues a survey that investigated their professional data and experience working with depressive clients. The results of these open questions are presented later, and put towards existing theory and context of the resource models presented below.

Theoretical Background

The concept of self-regulation has been used in different resource models describing how people get through difficulties, get back on their feet, and learn how to manage their problems in a supported way. These models are called salutogenesis, self-efficacy, and resilience:

- *Salutogenesis (in contrast to pathogenesis).* This term was coined by Antonowsky (1987) who first studied history and economy, and then medical sociology. The Latin word salus means "healthy, being saved, or in safety." Antonowsky's model A Sense of Coherence contains three parts: 1) comprehensibility, 2) manageability, and 3) meaningfulness. Salutogenesis describes a person's ability to develop a certain way of "standing in this world," to see meaning even if so much in life is difficult, to understand one's situation within a larger context, and to be able to manage the situation in small steps. According to Antonowsky, these components contribute to health.

- *Self-efficacy.* The ability to believe in one's own competence to handle important life situations (Bandura 1997), which contributes to health. It is based on learning theory, and contains four sources of information:
    1. Experience handling the same or similar tasks
    2. Modeling examples from significant others
    3. Verbal encouragement from significant others
    4. Perception of one's own state of arousal

- *Resilience.* Managing difficult life experiences in a better way based on previously developed psychosocial abilities. It was first developed to explain how children with difficult upbringings could develop to maturity and become healthy adults (Werner & Smith 1982). Etymologically, it means elasticity, flexibility, with sufficient tension, and thus in a broad sense, it describes what is lacking in a depressed person. The term resilience has been in use since the beginning of the 21st century.

No studies were found in which body psychotherapists were asked about their successful treatment of people with minor and major depression. Search keywords for "body psychotherapy and depression" in PubMed and PsycInfo from 2013-2018 yielded no results, and none were found in the index of the International Body Psychotherapy Journal (2013 -2018).

Method

Today, Grounded Theory (Glaser & Strauss, 2005; Corbin & Strauss, 2015) is the most commonly used method of qualitative research. It is designed to find answers in a field in which there has been little research. Systematically observing and constantly comparing phenomena in texts, in real life, and/or in the analysis of written answers can generate a hypothesis, a suggestion for treatment, or a new theory. In the answers to open questions, patterns of meaning units can be identified that suggest interpretation probabilities.

By studying the literature, in this case the literature on depression and body psychotherapy, and by including health issues, a foundation for formulating open questions was created. General questions about the body psychotherapy profession were formulated and sent out to the members of the Swiss Association of the European Association for Body Psychotherapy, with a request for participation in the study. The study's open questions

were then sent to those who agreed to participate. After seeing the questions, 14 out of 84 full and associate members confirmed their participation. Fourteen therapists called the information group — is considered a small sample, so the questions were also given to the four individuals in one of my body psychotherapy intervision groups called the intervision group making a total of 18 participating therapists who are presented as one group in this article. Using an Excel table, participants were asked how many clients with depressive disorder (F31-43 in the ICD-10) they had treated, and their precise diagnosis. They were also asked which body psychotherapy training they had taken, how many years they had been working as body psychotherapists, how many treatments of more than 25 sessions they had completed, and what percentage of their client list were depressed clients.
The open questions were analyzed and compared in an open coding process of meaning units (Malterud, 1998, 2014) until saturation was reached. Saturation means that no more categories contributing to the understanding of the studied field are discovered. The aim in Grounded Theory is not to find every single description of the qualities in a large sample size, but to distill the central meaning of the phenomena (Glaser and Strauss, 2005).

The answers were analyzed by marking them with different colors (coding) and putting them in different categories. Triangulation (Malterud, 1998, 2014) was used to avoid biased errors in qualitative data. In triangulation, "two extra legs," as in sailing when defining one's own boat's position, support the data. The meaning units from both the information group and the intervision group were identified as open coding. One of the extra legs, called method-triangulation, is axial coding that puts the open coding into key categories. In addition, the index lists in The Handbook of Body Psychotherapy both in German (Marlock & Weiss, 2006) and English (Marlock et al., 2015) were consulted to find out how frequent open and axial coding were listed. This is the second leg called a source-triangulation.

Material

- The 18 therapists participating in the study came from 11 different body psychotherapy schools. The different modalities of body psychotherapy were analyzed as one group.
- 16 of the therapists had worked more than 11 years in their profession.
- All of them (n=18) had completed more than 10 treatments of more than 25 sessions with depressed clients.
- 10 therapists concluded that more than 40% of their clients suffered from depression.
- The most common diagnosis these therapists treated were: F32 (mild depressive episode), F33 (recurrent depressive disorder), F41 (panic disorder, episodic paroxysmal anxiety) and F43 (acute stress reaction).

Summary of the Steps Used in Grounded Theory

- Collecting theoretical knowledge.
- Data collection: sample of body psychotherapists and answers to open questions.
- Analysis of the answers to the open questions through constant comparison until

saturation was reached — until no more codes or categories could be found.
- Triangulation with the answers to the open questions in a second group of body psychotherapists.
- Triangulation with the index list of the Handbuch der Körperpsychotherapie/ The Handbook of Body Psychotherapy /Somatic Psychology to see if the codes of the most frequent answers to the open questions supplied by the body psychotherapists occurred as words in the index lists.
- Forming selective coding or core concepts for treatment.

Results

The results of the study are presented in the following four tables. Quotations from the answers to the open questions are presented after the tables. The number of people who answered is quantified, and presented as "number of people answering this open coding." The survey showed that the participants in this study had many years of experience treating people with depressive disorders. The answers from the information group and the intervision group were extremely similar, and therefore they were put as one result for this article in tables 1-3. The contents of the recovery process are also illustrated in the quotations. Finally, phenomenological types of treatment are presented. These form the selective coding of the results, or core categories for a treatment concept of depressed clients.

Table 1. Why do you think that people stay healthy?

Meaning units	**Content of the open coding**	**Number of persons answering this open coding**	**Key category Axial coding**
Attachment	Healthy first years Close relationship to oneself and own needs to others/family/social network	5 13 12	Relationship
Physiological Rhythms	Stress-recovery rhythm Pulsation in the body Body Awareness Weakness/Depression as a stimulation of the soft sides of life	12 5 4	Self
Basic Needs	Financial security Nutrition/Sleep Movement Respect and appreciation	10 8 8 7	Regulation
Fatalism	Luck/Misfortune/Genes Belief/Spirituality Don't know	5 4 3	Belief

- When asked about how people stayed healthy, most of the respondents mentioned healthy attachment, close relationship, and stress-recovery rhythm. The answers were most often given as nouns, such as relationship to oneself and others, stress-recovery rhythm, movement. The verbs mostly used had to do with relationships, which showed a direction or contained a rhythmical word: to be embedded (3 persons); to Gestalt, to find (2); to build up something, take turns, satisfy, fulfill something, keep something, mobilize, create, look after, seek (1 person).

- Many of the respondents mentioned the basic needs according to World Health Organization to maintain health, to have work, enough financial security, enough to eat, to be able to move around, and to experience emotional respect and appreciation.

Table 2. Which body psychotherapy concepts and methods do you as a body psychotherapist find valuable to support the recovery of depressed clients?

Meaning units	**Content of the open coding**	**Number of persons answering this open coding**	**Key category Axial coding**
Concept of the therapy A holistic idea of human image	Body, emotion, cognition Intuition/spirituality Social behavior as a whole	17	Idea of human image
Therapeutic Diagnosing	Condition – dynamics Minor – major depression	6 5	Diagnostic
Working modality: Therapeutic alliance	Working mindfully Resource orientated: Giving trust and hope Stimulating bodily presence Confronting negative attitudes Contracting – suicide prevention	10 12 8 7 8 4	Trustful attachment and therapeutic alliance
Inward perception Going inside Contact inside	Pulsation in vegetative NS Breathing & grounding, Instroke Fostering emotion: especially sadness Painting inner pictures and ideas	9 14 4 8 1	Body Awareness Fostering sadness and grief

Stimulating and becoming aware of rhythms	Tense up, relax, stretch Movement, rest - leisure Demand, protect oneself Being alone, together with others Discover own needs	11 6 6 5 4	Self- regulation and rhythms
Expression of feelings	Fostering emotion: especially disappointment and anger Fostering healthy aggression, setting limits	8 9	Fostering healthy aggression
Supporting meaningful leisure-time activity	Social network, clubs Bodily activity, sport, jogging Creativity – painting, music	4 9 6	Going outside, Social contacts
Medical treatment	According to doctor's prescription	2	
General	"A lot could be said" (but is not done=author's comment)	4	

- Seventeen of the body psychotherapists expressed a holistic idea of the human condition as a guideline and understanding of their therapy: *"to appreciate body, soul, and spirit as a unity, and treat according to this"*

- Only a third of the therapists mentioned diagnosis:
  "For me, depression is a diagnosis of the situation, but I am mostly interested in the dynamic between the client and his surroundings, between the client and me."

  "Without a clear diagnosis and differentiation between minor and major depression, therapy becomes too general".

- Four of the therapists answered in general terms, such as:
  "A lot could be said."

  "This list could be extended, and would not say anything on the individual level, except that there are individual differences."

  "In my opinion, there is no such thing as 'one kind of depressed-person' so I cannot answer this question."

Summary of the concepts and methods body psychotherapists found most valuable when treating a depressed client

Based on the responses, the most valuable concepts and methods that emerged were: a common holistic idea of the human condition, creating a trusting

relationship, working mindfully in a resource-oriented way, working with breathing and grounding, having deeper contact with different emotions, especially grief, and using self-regulative experiences.

The rest of the quotations in this table will be shown under the recovery process and in the phenomenological types or core concepts for treatment.

Table 3. By what signs, including bodily expressions, do you as a body psychotherapist clinically recognize and confirm that a client is on his/her way to a recovery?

Meaning units	**Content of the open coding**	**Number of persons answering this open coding**	**Key category Axial coding**
Physical liveliness	Breathing is deepened, Voice is more sonorous and melodious, eyes are sparkling Mimic and eye contact possible Posture, muscle tone – body elongates, is more flexible Movement has more flow Energy level/drive/initiative – sense of refueling without collapse Temperature warmer, pulsation Sexual charge is higher Suicidal danger	14 14 11 16 14 4 6 5 4 4	Movement inside
Feelings: in the client	Deepened contact to body and emotions, crying, sobbing Healthy aggression in a non-projective way, sets limits Clear gender self-esteem	14 14 4	Differentiated emotions
Feelings: in the therapist	Client is perceptible (resonance), more differentiated and is showing initiative in the session	9	Resonance in the relationship

Rhythm and body care	Regulated day/night rhythm	9	Being aware of rhythms
	Appetite, healthy eating habits	9	
	Body care, touches themselves in a more friendly way, sexual desire	9 4	

Content of the Recovery Process

What seems obvious from Table 3 is that more therapists had an understanding of the recognizable signs of recovery than they did about how to treat their clients:

- Nearly all participants (n=16) emphasized that they knew the significant signs of recovery on the physical level: *"breathing is deeper", "posture is more aligned", "eyes are sparkling,"* or *"voice is more sonorous and melodious".* Then, more differentiated emotions were pointed out: *"deepening contact to grief, to crying and sobbing"* and *"is eventually making healthy creative aggression possible."*

- Clients first differentiate between sadness and anger: *"Anger and sadness are now differentiated again, also consciously experienced in the body."* In this phase, clients use anger as projection: *"It is his fault that"….*

- When clients show increasing aliveness, recognized as more sparkling eyes, flexibility in body posture, and a more sonorous and melodious voice, suicidal danger increases, and must be addressed. One therapist expressed it like this: *"You are allowed to commit suicide, but not as long as you are here in therapy, let's meet another ten times and discuss why you really don't want to live anymore."*

- Healthy aggression enables clients to set limits by protecting their boundaries and stating their needs; for example, *"says 'no' to her husband and should do so," or "I want this instead."* Healthy aggression is physically experienced through the whole body from the feet, through the pelvis and the straightened back, up to the outstretched arms.

- Clients feel a resonance in the contact with their therapist, and show initiative in sessions: *"the client is perceptive," "I'm sensing more than a need for protection and care during the session."*

- It is possible for clients to show more interest in their own body: *"body care and the management of daily living is now possible," "is touching his body more caringly and respectfully."* They experience different rhythms in their lives: *"client sleeps better and experiences appetite again."* Clients are also able to have perspective on the future, and sense hope in their ability to take part in social activities: *"more spontaneity and humor," "the bearable lightness of being," "more*

positive view of his future," "can arrange social activities on his own again," "has a direction towards and not against something," "is able to take risks even if it would not work out." 16 participants said: *"to activate themselves in movement/ sport and music."*

Phenomenological Themes as Suggestion for Treatment

The following four phenomenological themes are presented as a suggestion for treatment of depressed clients. They are based on the open and axial coding answers in both Tables 2 and 3. The themes seem to have a sequence: the therapist cannot begin to facilitate deep crying if there is insufficient trust in the therapist/client dyad, not enough containment, or contact with deep breathing.

1. **Attachment and the Therapeutic Alliance**
   The strength of the therapeutic relationship is considered an efficacy factor in the therapeutic outcome and for clients to learn to better manage their lives. Therapists emphasize trust in their clients' ability to heal, as well as unconditional respect and acceptance of their current life situation. The client's work is to build a new trusting relationship to self and others, where frustration as well as confrontation of negative attitudes are allowed and contained, verbally and also nonverbally:

   "To create a safe space, to work with respect for limits and boundaries – to the client's body, to pain and physical distance, and offer a respectful dialogue."

   "To stay there with them, also when nearly nothing works."

   "As a therapist - to be able to stand the depression and the long moments of silence."

   "Acknowledging the expression of impulses/movements that correspond to the status of the person/the dimension of the depression."

   "To give a sense of being unconditionally accepted through listening, reflecting, mirroring without pressure."

   "What is, is mirrored, accepted, and is becoming more manageable as time goes by."

   "To mirror the often non-existing 'letting go of illusions' in depressive persons."

   "To seek the psychological mechanisms that maintain the depressive mode (agency, speed limits, escapements, inhibitions)."

2. Body Awareness

Most of the participants mentioned the concept of encouraging the client's internal resources as a vital function throughout the sessions, and the need to acknowledge and accept bodily sensations, thoughts, and emotions without judging them:

"To encourage mindful body sensations, thoughts, emotions, and actions."

"Depressed clients often move around in circles of negative emotions and thoughts. The shift of attention to the somatic level is a very frequently used tool in body psychotherapy to break these vicious cycles. On the somatic level, there are no circles, but rather this level always implies a minimum of movement/pulsation, which can help depressed people to gradually evoke volitional movement."

"That there is aliveness inside; in the vegetative nervous system always a little something is moved; some pulsation is there, although clients can feel dead emotionally."

"Instroke, instroke, instroke: to go inside, stay there in the breathing which is possible, and sense the fine-tuned little movements and feelings there."

"Work with deeper breathing and grounding, verbally and bodily."

"To move out of fragmentation - the loss of contact to oneself; through the defragmentation exercises, clients can get out of freeze and exhaustion."

"To work with grounding, strengthen the legs, the pelvis, and the lower back."

3. Grief and Healthy Aggression

This theme was emphasized by most of the body psychotherapists, and identified as a main factor in experiencing healthy recovery and balance between sorrow and joy. A sequence was identified: a) first contacting the hidden crying, then b) building up the aggression. Healthy aggression and not anger — is the basis for setting boundaries, experiencing limits without intrapsychic splitting, and having the strength to handle future difficulties.

The word aggression comes from "aggredi" (Lat.) meaning to "tackle" or to "attack" and also "approach" or "come closer with firm steps." Crying and healthy aggression are built through mindful contact with feelings in the body:

"The body is a resource in which Life in all its sadness and painful facets can be contained and managed."

"There is one medicine for depression, and that is grief, and there is one medication to cure grief, and that is to cry; deeply sobbing."

The somatic tool to facilitate deep crying is to encourage breathing from the lower chest and diaphragm while keeping a loosened jaw. The body psychotherapist can put her hands on the client's chest and keep them there in order to facilitate a deepened contact with the breath. The therapist can put some fingertips on the jaw, which, after a while, can cause the jaw to shiver. Shivering and vibrating of the diaphragm can emerge, initiating sobbing until a healthy deep in-breath spontaneously emerges.

"Of primary importance is the facilitation of breathing, because depressed people have, without exception, very flat, superficial breathing."

Work with the client's grounding, or conscious contact with the surface from the legs and feet, supports the ability for containment and tolerating strong feelings, instead of going back to a split state where the fear is not felt.

"Work with the legs and back must be emphasized"

"Depressed people lack power in the lower back, which results in fewer possibilities to distance oneself from, to assert oneself towards, and to carry something through to others. The chest is usually weak and hard. Before the chest can open, the legs must be strengthened."

"The body is elongating."

"They become more flexible in the whole body, still more aligned."

This can be summarized as creative, healthy aggression.

4. Self-Regulation and Rhythm

In this category, personal, physiological, and social rhythms are included. Most of the therapists had something to say about this, as self-regulation is a key concept in body psychotherapy:

"Usually, depressed people are very tense inside, and very slack in the outer, upper layers of the muscles. Their feeling is that they 'are worn out.' Interchanging exercises of muscle activation and relaxation can help them differ between these two."

"Can feel a difference between breathing in and breathing out."

"The pulsating movement between inner and outer experience is perceivable."

"To be 'out of breath' at least once a day."

"The desire to meet friends again."

"Emphasis on inner sensation and stimulation of elementary biological rhythms (muscular, vegetative, and emotional, from bodily activity and passivity, from demands and the need to protect oneself, from peace and activity and stress (positive and negative), from being alone and together with people."

"To encourage the client to become physically active, starting with short walks towards jogging and regeneration."

Results of the answers from the text reading and the open and axial coding, compared to the index list in the Handbuch der Körperpsychotherapie/ The Handbook of Body Psychotherapy

Source triangulation was made to the models of Salutogenesis, Self-efficacy and Resilience by studying the index lists in the Handbuch der Körperpsychotherapie (2006) and The Handbook of Body Psychotherapy (2015). The occurrence of the answers in the open and axial coding were researched from the index of these books. The words were Selbstregulation/self-regulation; Selbstwahrnehmung/ self-perception; Atmung, Atem/breathing, breath; Erdung/grounding, Beziehung/ relationship/relating; Therapeutische Bindung/therapeutic attachment; Bindung/ attachment; Achtsamkeit/mindfulness; Präsenz/presence; konfrontierend/ confronting.

Table 4. Source triangulation of text key words and open and axial coding

Theme **German and English books**	**KPT-Buch**	**BPT-book**
Salutogenesis	5 times	6 times
Self-efficacy	2	4
Resilience	1	0
Depression	8	23
Self-regulation	22	17
Self-perception	6	3
Atmung,Atem/breathing,breath	12	7

Atemmuster, -rhythmus, breathing pattern - rhythm	7	29
Erdung/Grounding	9/13	8
also horizontal	2	9
and vertical	1	7
Beziehung/Relationship,relating	11	16
Therapeutic relationship	20	15
(also relational approach, relational modalities)	-	21
Attachment	2	7
Achtsamkeit/mindfulness	8	0
Präsenz/Presence	2	0
Konfrontierend/confronting	1	0
conflict	3	7
conflict resolution	1	1
Klärend psychomotorisch/ psycho-motoric educative	1	2
Differenzierung/differentiation of emotions	2	0

(also breath block, breath education, breath healing, breath techniques, breath therapy, breath work, breathing awareness, breathing patterns, breathing practice, breathing stool, breathing technique, breathing therapy, breathing wave, breathwork)

The most common words, "self-regulation, breathing/breath, grounding, relationship, therapeutic relationship" are found in both the German and the English versions of *The Handbook of Body Psychotherapy*, and correspond to the open and axial coding. Interestingly, no reference to mindfulness is made in the English version. The word resilience does not occur in the English version, and occurs only once in the German one. The method of relational body psychotherapy does not exist in Switzerland.

Discussion

O'Hara (2012) claims that we need a new epistemology in the field of psychotherapy that incorporates both research-based knowledge and practical-based knowledge. She argues that knowledge is what we agree it is from within our shared context of experience. Practical knowledge "…provides the basis for intuiting the possibility of answers to yet unsolved problems" (O'Hara, 2012, p. 68). This study is a contribution toward solving the problems of treating depressed clients.

In this qualitative study, responses from body psychotherapists to their approach to health, and to methods of treatment and signs of recovery in depressed clients were collected. First, a detailed questionnaire was created about the professional experience of body psychotherapists who treated depressed people. This revealed that the therapists in this sample had lots of experience as body psychotherapists who treated people with depression; 16 (n=18) had been in practice more than 11 years, and 18 had completed more than 10 treatments of more than 25 sessions. Since body psychotherapy includes practical methods of bodywork, it might be an advantage to have worked more years, which cannot be stated for psychotherapy in general (Goldberg et al 2016). The sample of therapists, although small, was thus perceived as a group with competency to answer the questions about the treatment of depressed clients and the signs of recovery. Nevertheless, some of the therapists found it difficult to describe their tacit knowledge — intuitive knowing for which it is difficult to find words *("Eventually, I do answer your difficult questions," "Big questions put too easily.").* This type of tacit, embedded knowledge was originally defined by Polanyi (1966), who wrote that it is hard to define knowledge that is largely experience-based: it is simultaneously understood as present and hidden. However, since the 1960s, many methods within the field of qualitative research have been developed that give words to tacit knowledge.

Seventeen of the body psychotherapists expressed a holistic idea of people as a guideline underlying therapy: *"to appreciate body, soul, and spirit as a unity, and treat accordingly."* Body psychotherapy includes body-oriented methods that can stimulate regression, healthier early attachment, an ability to form better relationships, as well as increasing the experience of self-regulation and rhythms. One of the respondents gave this description: *"Depressed clients often move around in circles of negative emotions and thoughts. The shift of attention to the somatic level is a very much used tool in body psychotherapy to break these unproductive circles."*. Stern (2000) described the so-called Representations that have been Integrated and Generalized— RIGs, which are contained within sensorimotor representations, and can be reactivated only through body awareness and movement impulses. McWhinney et al. (1997) emphasized that "the connection between emotions and bodily states must be made at the affective and cognitive levels by the patients themselves … helping patients to make the breakthrough to a new level of understanding, without the requirements of verbalization" (p. 749). This is a strength in body psychotherapy when the bodily connection is made by the client, the client and the therapist (as a good role model and significant other) can find words to confirm the sensation and the emotion. Through this, the more difficult feelings, such as disappointment, passive aggression, and sadness could be recognized and understood in their context by the client. In this way, a better connection to inner resources in stress situations could be discovered. This is one of the four sources of information in the self-efficacy model, which makes it possible for clients to believe in their competency handling important life situations.

When clients reorganize their sensorimotor affect schemes, and when they are met with more respect and trust by the therapist, a new relationship to self and other can be built, which is freer from fear and a diminished self. This gives comprehensibility, manageability, and meaningfulness, the three aspects of the salutogenesis *sense of coherence* model. Some therapists stated that depression could be viewed *"as strengthening the soft side of the personality*

as opposed to persistently being strong and jolly." This is similar to what Scheiber (1996) found women appreciated after depressive episodes: a "redefining of the Self."

An important part of clients' recovery is their increased physical aliveness, which manifests in deeper breathing, livelier responses, increased appetite, and the desire towards movement, sport, and increased sexuality. At the same time, this can become a risk, because as clients feel stronger and more alive, they can make use of this strength, and the risk of suicide increases. At this point, the therapeutic alliance and quality of the relationship are tested. Experienced therapists underscore the importance of talking about suicide, and ask clients to agree on enough sessions to deepen this theme.

In body psychotherapy, research on depression is rare, and the findings from an exploratory randomized controlled study with chronically depressed people during a period of over two years are encouraging (Röhricht, Papadopolos, Priebe, 2013). They suggest that body psychotherapy is a feasible treatment option for clients with chronic depression who have not responded to other treatments. These authors suggest further research to analyze processes that could increase the efficacy of treatment. This study contains the respondents' descriptive data of treatment processes that include the capacity for attachment in relationship, mindful contact with bodily reactions, the ability the set boundaries by learning healthy aggression, and sensing and respecting the body's rhythms in everyday life.

Another study supported the effectiveness of body psychotherapy treatment compared to doing nothing. When clients with chronic depression were treated with body psychotherapy and compared to untreated clients on a waiting list, Winter et al. (2018) found a decrease in negative construing and body dissatisfaction. Resilience means the ability to manage difficult life experiences in a better way, based on previous psychosocial abilities. This study suggests that body psychotherapists have tools to work in such a way with the clients. Certain *life skills* are named by WHO (1997), which the organization suggests should be emphasized to support human health. These include the following abilities: coping with relationships, self-perception, emotional regulation, stress regulation, decision-making and problem-solving, which help clients develop resilience in their lives. Based on the therapists' responses, this study contains suggestions about these issues.

The numbers of colleagues who participated in this study was small. They were therefore put in one group, despite their training in different body psychotherapy modalities. The intention of this study was not to compare different body psychotherapy modalities, but to get a broad description of body psychotherapy methods when treating clients with depression. The answers from the intervision group, as one part of the triangulation, used nearly the exact same wording to the same questions as given by the information group. For that reason, their answers to the open questions were grouped with the information group.

Though the size of the sample was small, the study has descriptive validity (Thomson, 2011), in that the research process is described in detail, and thus gives accurate data independently of the size of the sample. It is not unusual that the percentage of respondents is small. Cook et al., (2010) sent out information to the 22,000 subscribers of *Psychotherapy Networker Magazine,* and got 2,200 answers after two rounds of

publication in the magazine. Dropouts in their study said that they did not have time or enough suitable clients. This problem was recognized a few decades ago: then too, therapists stated insufficient time and considered their clients inappropriate for the research (Vachon et al.,1995). Perhaps the request for their professional experience, for the number of depressed clients treated in a certain time span, and the exact ICD diagnosis could have been too difficult for those therapists who declined participating in the study. One third of the respondents mentioned diagnosis, which could be a confirmation of their difficulties with this theme.

Limitations and Future Recommendation

This study was conducted and evaluated by only one person without a computer program, which could bias the interpretations into categories. However, the answers were easy to code since they were similar in wording or meaning. As the author used the triangulation method as validation and reliability, this limitation was reduced. NVivo, CAQDAS (Computer Assisted/Aided Qualitative Data Analysis) Software to discover "meaning units" was developed after this study was conducted.

Conclusion

This study was designed to investigate the perspective of body psychotherapists on general health, treatment methods, and signs of recovery when working with depressive clients. Body psychotherapy contains treatment tools that include salutogenesis, self-efficacy, and resiliency. No conclusion was reached regarding the phenomenological types suggested as core concepts for the treatment of depressive clients, but it is suggested that further studies be conducted to verify the validity of these core concepts, and confirm or reject them through experimental studies among body psychotherapists.

Note: *This study (118 pages, in German) was conducted as a Master in Psychotherapeutic Psychology, Donau Universität Krems, Austria, 2007. A new literature study of the field was made 2018.*

Christina Bader Johansson, MSc, MSc *is an accredited EABP Body Psychotherapist and a Swiss Chartered Psychotherapist (Eidg. Anerkannte Psychotherapeutin), as well as a chartered physiotherapist and teacher. Originally from Sweden, she worked in a private practice near Zürich, before moving back to Sweden in 2017. She was the President of the Swiss National Association of the EABP (CH-EABP) for six years, and worked with others in Kosovo, teaching body psychotherapy to psychologists. She has written four books (in Swedish and German) on the theme of body psychotherapy and integrated physiotherapy. Currently, she gives supervision in body psychotherapy via Skype.*

Email: cbaderjohansson@gmail.com

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Sexual Pleasure in Light of Intersubjectivity, Neuroscience, Infant Research, Relational Psychoanalysis, and Recognition Theory[1]

Lawrence E. Hedges

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ABSTRACT

Unlike other species, humans can experience sexual pleasure as an intersubjectively achieved sense of interpersonal union, a phenomenon that is distinct from other forms of sexual experience. Infant studies demonstrate that the human capacity for intersubjectivity is present at birth. Right-brain to right-brain affective communication can be achieved between infant and caregiver through the cultivation of complex processes of mutual affect attunement and regulation — thus giving rise to reciprocal psychological and psychophysical experiences of mutual pleasure. The human polyvagal nerves allow genetically-driven neuroception of safety and danger — of potential pleasure and pain — in human relationships. Recognition and attachment theories clarify how these and other primal human response systems can be cultivated toward mutual pleasuring in infancy and early childhood. *Interpersonal pleasuring is foundational to later experiences of reciprocal and mutual sexual pleasure accompanied by a sense of psychological attunement and union.*

Keywords: sexual pleasure, sexual, intersubjectivity, neuroscience, infant for research, recognition theory, relational psychotherapy

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Intersubjective Sciences Offer a Fresh Vantage Point

Objective views of human psychological and neurological development have slowly given way in recent years to an understanding that *human developmental processes can best be understood by reference to culturally-constructed, subjectively-defined interpersonal relational processes* (Berger & Luckmann, 1966; D. B. Stern, 1992; Aron, 1996). The research and theory generated by the intersubjective disciplines has profound implications for the human experience of sexual pleasure.

[1] Presented at the World Congress for Sexual Health, Porto Allege, Brazil, September 24, 2013

The Intersubjective Perspective

While the topics of subjectivity and intersubjectivity have interested philosophers for several centuries, only during the past few decades have the development of subjectivity and the maintenance of intersubjectivity been scrutinized in a wide range of multidisciplinary studies, including neurobiology, infant research, and relational psychotherapy. Philosopher Jürgen Habermas, in *A Theory of Communicative Competence* (1970), speaks about "the intersubjectivity of understanding" to mean both an individual capacity and a social domain. Infant researcher Colin Trevarthen (1980) observes in early infancy a phase of "primary intersubjectivity" characterized by *mutual sharing of intent* as an effective psychological activity. Infant researcher D. N. Stern (1985, 2004) sees intersubjective relatedness as a crucial step in self development as the infant becomes able to share subjective experiences, especially affective ones. Further, Stern has come to consider the capacity and drive for intersubjective communication as innate and present from birth (2004).

Stated simply: "I am a subject, an agent of my desires, thoughts, and actions. You are a subject, an agent of your desires, thoughts, and actions. When we come together for an *intersubjective engagement* over a period of time, something else begins to happen that affects us both." Intersubjective theories provide different ways of thinking about our shared intersubjective experiences, and how the self develops through intersubjective exchanges.

In recent years psychotherapists from divergent schools of thought have begun to formulate various kinds of relational views of self-development. These formulations rest on the belief that the *human mind emerges from and continuously exists within interactional processes,* rather than being simply constructed or conditioned as a separate or isolated mind-self.

One of the clearest formulations holds that the central theoretical construct of intersubjectivity theory is the "intersubjective field," defined as "a system composed of differently organized, interacting subjective worlds" (Stolorow, Brandchaft, & Atwood, 1987, p. ix). Robert Stolorow and his colleagues use intersubjective "to refer to any psychological field formed by interacting worlds of experience, at whatever developmental level these worlds may be organized" (Stolorow & Atwood, 1992, p. 3). "The concept of an intersubjective system brings to focus both the individual's world of [personal] experience and its embeddedness with other such worlds in a continual flow of reciprocal mutual influence" (p. 18). The subjectivity of sexual experience is a critical aspect of the intersubjective field.

Psychoanalyst Jessica Benjamin (1988) formulates a sequence of theoretical stages for the development of intersubjectivity:

1. *Primary recognition* — is "to affirm, validate, acknowledge, know, accept, understand, empathize, take in, tolerate, appreciate, see, identify with, find familiar . . . love [the other]" (pp. 15-16).

2. *Mutual recognition* — includes ". . . emotional attunement, mutual influence, affective mutuality, sharing states of mind . . . . Research reveals infants to be active participants who help shape the responses of their environment, and 'create' their own objects" (p. 16).

3. *Actual interpersonal interaction* — "is the development of the self within relatedness and interpersonal interaction. The accent here is on the self that is affected by the other's recognition or lack of such so that the child feels either confirmed or denied in his/her sense of agency and self-esteem" (p. 18).

4. *Intersubjective mutual recognition* — occurs when "the individual grows in and through the relationship to other subjects . . . . The other whom the self meets is also [recognized as] a self, a subject in his or her own right . . . we are able and need to recognize that other subject as *different and yet alike*, as an other who is capable of sharing similar mental experience" (pp. 19-20).

Some writers see the intersubjective and relational perspectives as replacing the traditional (Freudian) intrapsychic psychological perspective. Others (myself included) view the two perspectives as complementary — one highlighting the psychological dimension that develops *within* individuals, the other highlighting the psychological dimension that develops between individuals. Most relational theorists now view both perspectives as essential to our understanding of ourselves and our relational embeddedness with others.

Intersubjective theory generally distinguishes two subjects in the process of *interacting and recognizing* each other from one subject observing or influencing another. The main experience of intersubjectivity is one of being *with* rather than one of observing and interpreting. Sameness and difference exist simultaneously in the tension of intersubjective mutual recognition (Benjamin 1988, 1995). The goal of psychotherapy in this view is for both participants in the context of a mutually-evolving, co-constructed intersubjectivity to come to recognize each other and know themselves more fully in order to attain more creativity, flexibility, freedom, and passion in living and loving.

The Neuroscience Perspective

UCLA neuropsychologist Alan Schore (1999; 2003a,b; 2013) has skillfully analyzed the results of thousands of brain imaging and other neurological and infant relational studies concluding that the centerpiece of human development is the mutual affect regulation process established through right-brain to right-brain affective channels available to the infant at birth. UCLA developmental neuropsychiatrist Daniel Siegel (1999, 2007) has amassed research evidence demonstrating that *human neurobiological development is guided by interpersonal processes from birth throughout the life cycle. All of these studies make clear that the human brain and neurological systems are actually formed according to relationships that are and are not available in early development.*

I wish to call attention to one small piece of Schore's work on the subject of shame since, as we know, sexual experience is universally imbued with shame. Schore begins his discussion of the neurological substrate of shame with a review of Margaret Mahler's (1968) developmental theory highlighting the "practicing" subphase of separation-individuation that extends from about 10 to 18 months. Schore (2003b) makes a case for the abrupt change that occurs in infant-maternal behavior as the interpersonal focus shifts from the early pleasure principle to the later reality principle:

> In optimal growth-promoting environments, the interactive mechanism for generating positive affect becomes so efficient that by the time the infant begins to toddle he is experiencing very high levels of elation and excitement . . . . At 10 months, 90% of maternal behavior consists of affection, play, and caregiving . . . . In sharp contrast, the mother of the 13- to 17-month-old toddler expresses a prohibition on the average of every nine minutes. In the second year, the mother's role now changes from a caregiver to a socialization agent, as she must now persuade the child to inhibit unrestricted exploration, tantrums, bladder and bowel function (i.e., activities that he enjoys) . . . . In other words, in order to socialize the child, she must now engage in affect regulation to reduce the heightened levels of positive affect associated with the pleasure of these activities. How does she do this? In fact there is one very specific inhibitor of accelerating pleasurable emotional states, one negative emotion that is closely associated, both psychologically and neurologically, with positive affects. Shame, a specific inhibitor of the activated ongoing affects of interest-excitement and enjoyment-joy, uniquely reduces self exposure or exploration powered by these positive affects . . . . The negative affect of shame is thus the infant's immediate physiological-emotional response to an interruption in the flow of an anticipated maternal regulatory function . . . . In other words, shame, which has been called an "attachment emotion" . . . is the reaction to an important other's unexpected refusal to enter into a dyadic system that can recreate the attachment bond . . . . This intense psychophysiological distress state, phenomenologically experienced as a "spiraling downward," reflects a sudden shift from energy-mobilizing sympathetic-dominant to energy-conserving parasympathetic-dominant autonomic nervous system activity . . . . In such a psychobiological state transition, sympathetically powered elation, heightened arousal, and elevated activity level instantly evaporate. This represents a shift into a low-keyed inhibitory state of parasympathetic conservation-withdrawal . . . that occurs in helpless and hopeless stressful situations in which the individual becomes inhibited and strives to avoid attention in order to become "unseen." (pp. 17-18)

Schore thus calls our attention to a developmentally determined physiological process mediated by maternal attunement and misattunement that occurs during Mahler's practicing subphase, so that a toddler alternates between elated states of self-aggrandizement and pride when affirmed, and deflated states of shame and helplessness when disconfirmed. In an essentially normal process of "disruption and repair" the good-enough caregiver induces stress and decreased activity through misattunement, and reinstates increased activity and positive affect through reattunement. But, of course, this process occasionally goes awry even in optimal child-rearing situations, and becomes disastrously shameful in non-optimal situations. Just how and how much each of us was subjected to physiologically disabling shaming experiences in toddlerhood and in later life profoundly affects how we address later interpersonal situations, including potentially pleasurable intersubjective sexual engagements.

Addressing the issue of pleasure and pain from a somewhat different angle, neuropsychologist Stephen Porges (2004) from the University of Illinois introduces the concept of neuroception as a subconscious system for detecting threats and safety:

> By processing information from the environment through the senses, the nervous system continually evaluates risk. I have coined the term neuroception to describe how neural circuits distinguish whether situations or people are safe, dangerous, or life threatening. Because of our heritage as a species, neuroception takes place in primitive parts of the brain without our conscious awareness. The detection of a person as safe or dangerous triggers neurobiologically determined prosocial or defensive behaviors. Even though we may not be aware of danger on a cognitive level, on a neurophysiological level, our body has already started a sequence of neural processes that would facilitate adaptive defense behaviors such as fight, flight, or freeze . . . . A child's (or an adult's) nervous system may detect danger or a threat to life when the child enters a new environment or meets a strange person. Cognitively, there is no reason for them to be frightened. But often, even if they understand this, their body betrays them. Sometimes this betrayal is private; only they are aware that their hearts are beating fast and contracting with such force that they start to sway. For others, the responses are more overt. They may tremble. Their faces may flush, or perspiration may pour from their hands and forehead. Still others may become pale and dizzy, and feel precipitously faint. . . . To create relationships, humans must subdue these defensive reactions to engage, attach, and form lasting social bonds. Humans have adaptive neurobehavioral systems for both prosocial and defensive behaviors . . . . By processing information from the environment through the senses, the nervous system, continually evaluates risk. As evolution has proceeded, new neural systems have developed. These systems use some of the same brain structures that are involved in defense functions to support forms of social engagement . . . . When our nervous system detects safety, our metabolic demands adjust. Stress responses that are associated with fight and flight, such as increases in heart rate and cortisol mediated by the sympathetic nervous system and hypothalamic-pituitary-adrenal axis, are dampened. . . . In the presence of a safe person, then, the active inhibition of the brain areas that control defense strategies provides an opportunity for social behavior to occur spontaneously. . . . In contrast, when situations appear risky, the brain circuits that regulate defense strategies are activated. Social approaches are met with aggressive behavior or withdrawal . . . . (pp. 19-22)

Porges and his research collaborators speak to evolutionary forces in vertebrate nervous systems that have allowed the expansion of affective and behavioral repertoires and that have molded both human physiology and behaviors. "A product of this phylogenetic process is a nervous system that provides humans with the ability to express emotions, communicate, and regulate bodily and behavioral states" (p. 22).

Porges has been especially interested in various kinds of interpersonal situations and how the polyvagal system of nerves that regulate the prosocial and withdrawal states that a person has developed over a lifetime profoundly affects how that person experiences, at a subconscious level, the safety-pleasure or danger-pain of interpersonal opportunities, such as sexual engagements. He asks how any particular person manages to override her or his instinctually triggered danger-pain defensive strategies in order to make use of the safety-pleasure interpersonal opportunities such as those afforded by sexual and other intimate interpersonal engagements. Thinking intersubjectively, we can see that our inner worlds of subjectivity — formed on the basis of a lifetime of interpersonal traumas — are highly likely to trigger our danger-pain defenses in any intimate encounter. How do two individuals work to override their relational fears in order to create mutually rewarding sexual experiences?

The Infant-Caregiver Erotic Interaction Perspective

The past three decades have seen the emergence of a community of baby-watchers, ingeniously researching every possible aspect of infant life they can define and observe. (See Lichtenberg, 1983; D. N. Stern, 1985; Tronick, 1998; Sander, 1995; Beebe et al., 2005; Fonagy, 2001; Beebe & Lachmann, 2003.) Summarizing recent infant research from a dyadic systems point of view with an eye to shedding light on intimate adult interactions and therefore, adult sexuality, Beebe and Lachmann (2003) develop three principles of salience for considering infant-caregiver interactions and lifelong attachment issues: (1) moment-to-moment ongoing self-and-other interactive regulations; (2) disruption and repair of interactive connections; and (3) the special impact of interactive moments of heightened affect.

Beebe and Lachmann propose that *affectively charged expectancies* based on these three principles of self-and-other mutual regulatory interaction are stored in infancy as *prototypical or foundational presymbolic representations* that later evolve into relational interactive possibilities that form the foundation of adult relationships and sexual engagements. This point of view (see Tronick, 1998; Beebe et al., 2005; Fonagy, 2001; Beebe & Lachmann, 2003) is consistent with fifty years of somewhat differently-formulated attachment research (for example, Fonagy, 2001), as well as relational psychotherapy research. (See Benjamin, 1988, 1995, 1998, 2012.)

Infant research has established that human babies at birth are already equipped — through genetically-driven processes of mirroring, synchrony, curiosity, and the capacity for affective resonance — to search out and make creative use of various aspects of the inner (subjective) rhythmic and affective life of their caregivers (Beebe & Lachmann, 2003; Fonagy et al., 2002; D. N. Stern, 1985, 2004; Trevarthen, 1980.) The Boston Change Process Group has been particularly invested in ferreting out exactly how early relational processes promote intersubjective development and the implications of these change processes for lifespan development (see, for example, one of their early papers: Stern et al., 1998).

Attachment research likewise makes clear that the attachment motivational systems in humans are governed by intersubjective processes occurring between infants and caregivers (see Diamond & Marrone, 2003; Fonagy, 2001, 2002).

Of special interest in considering the origins of mutual sexual regulation are the infant studies that involve both mimicry and affect-mirroring — that is, the parent's use of facial and vocal expression to represent to the child the feelings she either mimetically reflects or assumes in her interactions that the infant has. Research indicates that the image of the caregiver mirroring the internal experience of the infant comes to organize the child's emotional experience. Thus, the self is not merely open to environmental influence — *the self is constituted through its interactions with the mirroring social environment.* The caregiver's mirroring display is internalized and comes to represent an internal state, but it can do so only under certain conditions, which include sufficient emotional attunement, together with signaling to the infant that the affect the caregiver is expressing is not her own but the child's. These relational processes are foundational for later experiences of sexual pleasure as intersubjectively generated and reciprocally shared.

Infant researcher Ed Tronick (Beebe & Lachmann, 2003) has suggested that, in the process of mutual regulation, each partner (mother and infant, or therapist and patient) affects the other's "state of consciousness" (state of brain organization). As each affects the other's self-regulation, *each partner's inner organization is expanded into a more coherent, as well as a more complex, state.* In this process, each partner's state of consciousness expands to incorporate elements of consciousness of the other in new and more coherent forms. While these intersubjective processes of mimicry and affect mirroring have been defined and studied in infancy in a variety of ways, they have also been demonstrated to be lifelong processes characteristic of all intimate intersubjective relating including experiences of mutually shared sexual pleasures.

In considering the implications of infant research for understanding the establishment of erotics in adult relationships, Benjamin (1988) says, "These [early] internalized schemas lead to expectations of closeness vs. distance in relating, of matched and met vs. violated and impinged upon experiences, and of an erotic dance, [each schema being] fundamental to mutual attunement and pleasure in adult sexuality as well as to movements and mutual empathy in the analytic relationship" (p. 160). Benjamin views these early sensual experiences of mutual attunement as becoming internalized as interactional or intersubjective schemas. When they reappear in later intimate relationships, including the therapeutic relationship, she refers to them as *erotics of transference.*

Benjamin writes extensively on the importance of mutual recognition in intimate relationships, moments when mutual attunement between separate minds and bodies is achieved. "In erotic union this attunement can be so intense that the separation between self and other feels momentarily suspended [and] *a choreography emerges that is not reducible to the idea of reacting to the outside.* In erotic union the point is to contact and be contacted by the other — apprehended as such" (p. 184). Says Benjamin:

> In erotic union we can experience that form of mutual recognition in which both partners lose themselves in each other without loss of self; they lose self-consciousness without loss of awareness. . . . This description of the intersubjective foundation of *erotic life* offers a different perspective than the Freudian construction of psycho-sexual drive phases, for it emphasizes the tension between interacting individuals rather than that within the individual. (pp. 27-29)

The Perspective of Relational Psychoanalysis and Recognition Theory

Relational psychoanalysis has sought to integrate these various lines of study with massive implications for how we view sexuality. Relational concepts in psychoanalysis can be traced from the early work of the Hungarian psychoanalyst Sandor Ferenczi (1931/1955a, 1933/1955b), through the Interpersonal work of Harry Stack Sullivan (1953) and the foundational studies in self and other relational psychology of Greenberg and Mitchell (1983) and Hedges (1983/2003), to the groundbreaking Stephen Mitchell (1988) text, *Relational Concepts in Psychoanalysis.*

Noting the numerous difficulties encountered over the years with Freud's biologically-based instinct approach to sexuality, Mitchell, in his relational approach, reverses the classical formula — that internalized object relationships transferred into adult relationships memorialize infantile sexual conflicts — to read that *interactive adult sexuality expresses early relational configurations.* Stated differently, Freud's "bottom up" approach to sexuality as *biological drive conflicting with psychological structures* is replaced in intersubjective and relational views with a "top down" understanding that *current intersubjective experiences of sexuality express prior-learned relational possibilities* — for good or for ill. In his 2002 book, *Can Love Last?,* Mitchell further develops the intersubjective and relational aspects of sexuality, sexual inhibition, and sexual pleasure.

Heavily influenced by the feminist accent on the historically destructive male-subject/female-object dominance/submission split, the relationists emphasize that the human mind is not monadic but dyadic in nature. *Vitalizing dynamic human relationships are seen as constituted by co-constructed intersubjective erotics — that is, by interpersonal interactions, dances, or idioms that are formulated as a "third" force or vector mutually created by and influencing both participants.*

Relational psychotherapy encourages — through studying affective transactions in the ongoing therapeutic relationship itself — the establishment, resumption, and/or expansion of reciprocal affect attunement processes that are essential to human sexual pleasure and other forms of relational intimacy (Mitchell, 1988; Benjamin, 2013).[2]

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[2] There are several general features which characterize the relational approach:

1. Symmetry exists between the two separate and equal subjectivities who engage each other toward achieving mutual recognition (and negation) in the intersubjective field of psychotherapy and psychoanalysis. Yet asymmetry also characterizes the therapeutic situation, in that the therapist can be seen as an experienced expert, facilitator, and leader — although at times the asymmetrical roles can also reverse.
2. The co-creation of a mutually-achieved rhythm and harmony of relating and the emergence of a co-constructed set of relational realities evolves in the therapeutic relationship that is rich, complex, and often confusing and contradictory.
3. Mutually-engaged ego and self boundaries are in constant flux between fruitful and dangerous interpenetrations. The emergent sense of the importance and reality of the relationship itself (often referred to as "the third") can be fruitfully studied by the therapeutic dyad.
4. Numerous dialectics of personality formation — for example, oedipal/preoedipal, narcissistic/object love, depressive/manic affective splits, passive/active participation, and masculine/feminine gender attributes — may all be mutually experienced and worked through in the relational context.
5. A full array of developmentally-determined relational patterns becomes mutually engaged and worked through in the transference/countertransference matrix.
6. Internalized personality functions and structures featuring increased flexibility, expanded horizons, and novel possibilities of relating are thought to emerge from the relationally-centered treatment process (Hedges, 1983/2003, pp. xxiii).

Recognition Theory has evolved as a recent integration of contemporary neuroscience, infant research, and relational psychoanalysis that offers a fresh vantage point for considering human sexuality. Recognition Theory suggests that *human sexual pleasure can be progressively harnessed and expanded by a reciprocally relating couple as a special form of intersubjective engagement.* That is, analogous to mother-child and therapist-client intersubjective exchanges, it is possible for the intimately relating couple to co-create a steadily expanding matrix of pleasurable erotic interaction based on mutual recognition and balanced complementarity.

According to Recognition Theory, if any two individuals desire to enhance their mutual pleasuring — sexual or otherwise — a reciprocal commitment to a mutually interactive, intersubjective relating process is paramount. (See Benjamin, 2013.) Benjamin has characterized the age-old "doer/done to" — active and passive, sado-masochistic, gender-tagged — modes of relating (sexual and otherwise) as "the bonds of love," and challenged us in our personal and professional relationships to work toward achieving and enjoying balanced relational complementarities characterized by egalitarian mutual recognition and caring (1988, 1995, 1998, 2005). She advocates that a relating couple strive toward equality and mutuality characterized by alternating and reciprocal sharing of the doer/done-to loads.

Benjamin recognizes that due to long-conditioned doer/done-to modes of relating established during the course of growing up, mutuality in dyadic relatedness is always difficult to achieve, and bound to break down periodically, so that both members of a relating couple must be constantly on the alert to bring up for mutual consideration and processing these moments of split-off or dissociated experiencing that disrupt balanced complementarity and dysregulate the ongoing affective life of the couple. *These expectable cycles of balanced complementarity followed by breakdown and repair—studied extensively by infant researchers (for example, Beebe & Lachman, 2002)—can be said to form the nexus of intersubjective experience in sexual as well as non-sexual intimate relationships.* Benjamin points out that key moments in intersubjective intimate engagement become mutually experienced as interpersonal union, and are not simply analyzable in terms of stimulus and response or cause and effect.

Conclusion: Intersubjectivity in Sexual Pleasure, in Psychotherapy, and in Life

We have always intuited that intersubjectivity is a crucial component to sexual pleasure. However, the recent contributions of the intersubjective sciences — neuroscience, infant research, relational psychoanalysis, attachment research, and recognition theory — have added new clarity and possibilities to our understanding. The emerging findings regarding the crucial importance of mutual interpersonal affect attunement lead to new understandings of the nature of pleasurable sexuality, as well as what makes psychotherapy and other forms of intimate relating rewarding.

We have always understood that one aspect of therapy is a modeling effect. But we have not yet fully grasped how crucially important *the modeling of the intersubjective experience* can be. If, as therapists, we are willing to develop a more intersubjective attitude, then we will be able to help people not only with their sexuality, but with other kinds of intimate engagements as well.

The big news is that we have a new understanding of attunement, attachment, intersubjectivity, and reciprocal recognition. If we therapists want to help our clients in more substantial ways to live more pleasurably in an increasingly complex world, we need to be willing and able to take advantage of the new discoveries of intersubjectivity.

We might even think of therapy as somewhat of a laboratory opportunity to model an intersubjectivity that leads to a greater capacity for enjoyment of intimacy in other relationships, as well as to increased sexual pleasure. Modeling intersubjectivity places more demand and responsibility on the therapist to be willing and able to participate consciously in an emotionally alive and attuned intersubjective engagement. It demands a certain self-awareness and a willingness to engage as a well-bounded participant.

If therapists are too focused on seeing themselves as separate and objective rather than as relational beings, that is, as performing an objective task rather than a subjective one, then the new intersubjectivity discoveries will be lost to them.

Intersubjectivity's Greatest Challenges

1. We resist the complex relating required by intersubjectivity.
2. We are ambivalent and uncertain about the many feelings that intersubjectivity necessarily stirs up.
3. We resent that others aren't perfect objects for us to engage with—that they are not better relating partners. This unconsciously reminds us of all the other times in our lives that our relating partners were unresponsive, unreliable, or disappointing.
4. We resent having to muster up sufficient maturity to open ourselves up to engaging intersubjectively with whomever shows up in our lives — because of our own needs to be nurtured, soothed, or idealized.
5. We fear aggressive feelings. Therapists repeatedly explain to clients that there is a difference *between angry feelings* and *acting on them in an attacking way,* but in intersubjective engagements we may sometimes have a hard time telling the difference.
6. We fear erotic feelings. Therapists work hard to explain the differences between *erotic feelings and boundary-less sexual acting out,* but when engaging in intersubjective experience we sometimes have a hard time keeping to that distinction.
7. In personal as well as professional relationships we somehow want to "just be there" and to be free from the more chaotic, wet, and messy intersubjective feelings especially when the subject is sexuality that tends to be chaotic and messy in the first place.
8. We are reluctant to enter into the subjective personal and sexual worlds of others. Understanding shame as an attachment emotion helps here. Because of our developmental histories, people expect to be shamed for their sexuality and for their personhood. While they hope to be heard and respected, when we receive them with our own subjective agendas rather than meeting them where they are, they necessarily experience shame that puts a damper on anything potentially pleasurable.

Sexual and other intimate pleasure as an intersubjective psychological event requires that two people freely enter into each other's world of subjective experience and then, amidst uncertainty and confusion, co-create their own special erotic paradise together.

Lawrence E. Hedges, PhD, PsyD, ABPP *is director of the Listening Perspectives Study Center, founding director of the Newport Psychoanalytic Institute, and an assistant professor of psychiatry at the University of California, Irvine, School of Medicine. Throughout his career Hedges has provided continuing education courses for psychotherapists throughout the United States and abroad. He has published 21 books, three of which received the Gradiva Award for best psychoanalytic book of the year. In 2009 his Interpreting the Countertransference (1992) was named by the International Psychoanalytic Association as one of the key contributions in the relational track during the first century of psychoanalysis. In 2015 Dr. Hedges was distinguished by being awarded honorary membership in the American Psychoanalytic Association for his many contributions to psychoanalysis.*

Email: lhedges7@gmail.com.
Website: www.listeningperspectives.com

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The Principle of Minimum Stimulus in the Autopoietic Processes of Bioenergetic Self-Regulation, Bonding and Embodiment

Beatrice Casavecchia

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"The Reichian dream of the orgasm as the pulsatory engine of life and the cosmos finds a conceptual foundation in the revolution brought about by quantum physics.

The psyche, the mysterious level where chemical reactions produce energy, interacts directly with the soma, from which it receives directions.

The nature of the ancients has been characterized by the horror vacui, the fear of the void, the emptiness. The nature of quantum physics is characterized by quietis horror, the fear of an absence of movement."

Emilio Del Giudice, a theoretical physicist, Prigogine Award 2009[1]

ABSTRACT

This paper presents the paradigm of quantum field theory applied to living systems, and orgone energy as developed by Wilhelm Reich and also by Eva Reich in her formulation of Gentle Bio-Energetics. Reich developed the hypothesis of an unconscious anchored in the body, which is the root and the driving force of the libido, and created an energetic approach to a pulsating somatic psyche. He discovered a precise process of entanglement between physical and mental wellbeing.

Keywords: : quantum physical dynamics, neg-entropy, minimum stimulus principle, quantum coherent state, orgone energy, connective tissue matrix, autopoietic processes, self-organization dynamics.

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Post-Reichian development increasingly refers to a systemic-evolutionary paradigm of negative entropy. For example, Ferri (Ferri & Cimini, 1999, pp. 154-157) recognizes and decodes in relationship, the energy of "a living form" that responds to the autopoietic and evolutionary laws of living systems. Davis (2014, p. 13) refers to the autopoietic, self-organizing property of the endo-self, which energetically exists in the core of the living. Nevertheless, in current Reichian thinking, as well as in other body psychotherapy

[1] https://www.wessex.ac.uk/prigogine-award

approaches that derive from Reich, orgone physics seems to have been relegated to the background. Because the energetic orgonomic paradigm is incompatible with understandings derived from classical physics, biology, and neurology, it is no longer the subject of discussion within current therapeutic practice.

To confirm the validity of Reich's system, we refer to quantum field theory (QFT) as applied to living systems and find convincing corroboration in orgone theory. The QFT offers principles to explore the conditions and the quality of interactions that allow the "living form" to express its neg-entropic developmental capacity.

Recent articles focus on the physical processes of the emergence of the psyche in the body, and the physical dynamics that govern energy processes. First, Del Giudice (2004a, p. 58, pp. 69-86) proposed that psycho-emotional and physical units of living organisms emerge as a result of the quantum physical dynamics of resonance of the phase. Secondly, *The Principle of Minimal Stimulus in the Dynamics of the Living* Organism (Tosi & Del Giudice, 2013a, pp. 26-29) focuses on the biophysical response of living systems to external stimuli, and how this response regulates the dynamics of self-organization. In both articles, there are rigorous insights and conclusions consistent with both Reich's energy concepts and current QFT understanding.

Quantum physics has shown how microscopic components behave and perform consistently in macroscopic objects and phenomena. In this framework, reality is observed as fields of energetic relationships in which phenomena are not separate localizable entities, but interact with all localizable objects in space and time. This ensures that there is a global holistic behavior of all parties and that there are correlations between the movements of the separate bodies. Thus, the whole is greater than the sum of its parts.

The starting point of this conceptual revolution in classical physics and molecular biology was the transition from the classical theory of Galileo and Newton to the quantum framework. In classical theory, matter is conceived as an inert object, where uniform movement varies only through the application of external force. In addition, matter is conceived as divided into bodies that are mutually isolated from each other. In both of these models, it is possible to accurately determine all the variable dynamics of an object, such as energy, the quantity of movement, and of course its position in space-time.

Molecular biology and neuroscience are based on classical physics, and are unable to explain the dynamics of perception, the creation of life, and the self-movement of living matter.

In this theory, however, there is no place for the appearance of a self-organizing dynamic, which has so far prevented productive dialogue between physicists and those who study life. Molecular biology and neuroscience are based on classical physics, and are unable to explain the dynamics of perception, the creation of life, and the self-movement of living matter. In the quantum framework, however, this is possible: each

physical object, be it a material body or force field, is inherently fluctuating and able to energize a set of spontaneous oscillations. This enables it to join in phase with other objects, and with a set of existing fields in nature, called gauge fields.

An example of such a field is the potential of the electromagnetic field. Because the oscillations join together, all existing bodies in the universe acquire the ability to mutually correlate in fields of relationships—even at great distances, losing the properties of separation, which is one of the cornerstones of classical physics. This joining together, the pairing of resonances, contains information.

The Quantum Paradigm In The Dynamics of Psychic Processes

Recently, the biological basis of psychic processes and their actions—embodiment—have been explored by neuroscience. Research by Rizzolatti et al. (Rizzolatti, Sinigallia, 2006), and Gallese (2007, p. 362, pp. 659-697.) on mirror neurons has attempted to provide a possible answer to the neurobiological basis of bonding. Rizzolatti argues that *"The availability for mirroring, determined at the neurobiological level, is the fundamental basis for the relationship between the baby and the mother."* Echoing this, Joachim Bauer has written a book on the subject: *Why Do I Feel What You Feel?* (Bauer 2006, pp. 7-56).

Modern neurobiology has addressed this problem from many perspectives. But apart from the above approach, which correlates specific brain functions with specific neurons, there is a theory based on the work of Lashley (1948, pp. 302-306) and Freeman on the nerve cells' capacity for collective resonance (Freeman 1975/2004; Freeman & Vitiello, 2008a, pp. 93-117). Vitiello (1997, p. 16, pp. 171-199), quoting Freeman, writes:

> *"The question therefore arises as to what the agent may be and how it manages to bind and lead to a global order within a few thousandths of a second the billions of neurons that make up each human hemisphere (...). The transmissions on which the cooperation is established cover distances that are a thousand times greater than the diameter of the axonic and dendritic extension of the vast majority of neurons (...) and the time necessary to send impulses between the cortical modules is too long to allow a general synchronization of pulse trains."*

They hypothesize the existence of mass action of a large number of neurons in the storage and extraction of brain memories (Vitiello, 2009, pp. 157-158). Lashley writes[2]:

> *"Nerve impulses are transmitted from one cell to another through defined intercellular connections. However, the whole behavior seems to be determined by masses of excitation within the general fields of activity, without regard to particular nerve cells. What kind of nervous organization might be able to respond to an excitation pattern without specialized paths of conduction? The problem is almost universal in the activity of the nervous system".*

Pribram (2004, pp. 224-225) and Vitiello (Freeman & Vitiello, 2008b, 41 30, 304042) proposed an analogy between these neural activity fields distributed in the nervous system

[2] https://escholarship.org/uc/item/5c43n596

and wave patterns in holograms. Rather than the activation of individual masses of neurons, it is precisely this collective resonance ability of nerve cells that produces a collective aspect of neurocerebral and cellular activity (Vitiello, 1997, p. 16, pp. 171-199). This makes possible the dynamics of perception, mirroring, and resonance with external subjects.

Minimal Stimulus

Del Giudice and Tosi (Tosi & Del Giudice, 2013a, pp. 26-29) look specifically at the bonding and embodiment processes. Their study of the scientific model of minimum stimulus is congruous with the same properties both in QFT and in orgonomy. It has also allowed us to focus on the differentiated energetic quality of the biophysical response of the living organism to the physical properties of the stimulus received from the environment.

Around the middle of the nineteenth century, classical physiology was able to establish a universal relationship between stimulus and response for all living species. This is the law of Weber and Fechner (Del Giudice, Stefanini, Tedeschi, Vitiello, 2011, p. 329, quoting Chisholm 1911), which establishes the proportionality of the response not to the stimulus, but to the logarithm of the stimulus (Tosi & Del Giudice, 2013a, pp. 26-29).

From those assumptions emerges the formulation of the principle of minimum stimulus: the lower the stimulus, the greater the potential of the organism to reform and reorganize, which is precisely the goal of therapy. Naturally, the type of reorganization depends on the nature of the stimulus (Tosi & Del Giudice, 2013a, pp. 26-29). Eva Reich was able to recognize that the orgone dynamics discovered by her father were operative only in an environment governed by minimal stimuli, based on the classical principle of Weber and Fechner. The profound consequences of this change of perspective deepen in light of the principles of quantum physics.

These principles made it possible to prove that interaction with minimal stimuli in the body promotes a co-resonance process, which sustains the ability of living matter to form states of biophysical coherence, and develop the emergence of self-organizing processes. Studies highlight the properties of the bioenergetic function of co-resonance in biophysical processes that promote self-organization, embodiment, and the capacity for bonding capacity (Tosi & Del Giudice, 2013a, pp. 26-29). These processes autopoietically emerge in the biophysical energetic resonance of the energy field of the mother-child dyad as the original form of communication in the process of bio-emotional contact. And they re-emerge in psychoanalytic therapy as primary identification and reverie, as well as through the concepts of resonance, somatic transference, and vegetative identification.

A Look At History: The Jung-Pauli Dialogue: The Psyche As The Bond Of Matter

Emilio del Giudice and Margherita Tosi report on the dialogue that took place between C. G. Jung and W. Pauli on the psyche as the glue of matter (Tosi & Del Giudice, 2013a, p. 60, pp. 26-29). They wrote that Freud thought that physicists could not understand how an emotional sphere could emerge from the molecular structure of a body. He warned his followers to ignore physics. Not everyone followed his advice. The theoretical physicist Wolfgang Pauli, one of the founders of quantum physics, entered into an exchange with the world of psychodynamics through a dialogue with Jung (Jung, C. G., 2001), which planted seeds for future developments.

The first is that the psyche, which cannot be embodied in a particular material body, could instead be the set of resonant relations between the different parts of the body established through the quantum vacuum. In this way, the psyche ensures unified behavior of the organism and becomes the mode of being of organic matter.

These resonant relations, as later shown by Prigogine (Prigogine & Glansdorff, 1971), do not require a flow of energy, but rather a concentration of internal energy already present in the subject, which implies a negentropic state. It turns out that the movement of the organism is not just movement that requires a constant supply of outside energy; it is, rather, a movement from within, based on the reorganization of internal energy and triggered by informational stimuli. The rational basis of the principle of minimum stimulus begins to emerge.

A second and more profound suggestion has to do with the timeless nature of the quantum vacuum, which is able to connect, in a quantum field, events localized in different spaces and times. Jung sensed that this finding of quantum physics would permit a completely different phenomenology from that based on localized events in space and time linked together by the principle of causality. In a quantum dynamic, on the other hand, a collective process is established, which involves events localized in different spaces and times, which consequently become synchronous events. This can actually be observed in different ways in the psychic dynamics of people living here and now, with the presence of psychic experiences that occurred at different times.

The emergence of psychic processes in the body was resolved by physicists. In Freud's time, the field of psychodynamic science would not have needed to learn from physics. When physics shifted the focus of its investigation beyond a deterministic paradigm, it could explain the emergence of the emotional sphere from the molecular structure of a body.

Physicists, however, in order to overcome the limitations of the classical deterministic paradigm in understanding reality, found themselves getting closer to the revolution that began with Freud and continued by Reich. This allowed them to overcome what prevented them from seeing how matter allows psyche to emerge, and also how it can self-organize (Del Giudice & Stefanini, 2013, pp. 9-17). Yet, even now, energetic body/mind-based psychotherapy, still rooted in the classical physics paradigm for its theoretical underpinning, has been unable to account for and explain processes inherent in the energetic dynamics of living matter in the therapy setting.

Reich's Energetic Functioning and the Expressive Language of the Living

The physical foundation of the dynamics of the id (instinctual-pulsatory unconscious), was taken up by Reich, whose thinking went through three phases. The first was his character-analytic phase from 1920 to early 1930, following Freud's footsteps. He focused on the dynamics and functional aspects of character structure; how psychic structure gives rise to corresponding somatic structures, whose solidifying is the "armor" that makes the character rigid. The correlation between physical and psychic structures became the center of Reich's research. He suggested an alternative way to intervene in psychic structures through physical interventions in the body.

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In his second phase, vegetotherapy, from 1930 to 1938, Reich (1949, p. 437) discovered that the living organism is characterized by a primary "pulsation" in the breathing rhythm of the whole organism (Tosi & Del Giudice, 2013a, pp. 26-29). This pulsation brings unity and harmony to the organism. The psychic disorder that corresponds to neurosis derives from an alteration of the pulse in which the inhalation phase (corresponding to the energy charging process) plays a dominant role compared to the exhalation phase, which corresponds to the discharge of energy, associated with the possibility of feeling pleasure). According to Freud's theory, neurosis is seen as a consequence of the suppression of pleasure, but Reich goes far beyond this by initiating a thorough biophysical investigation of how and why this process occurs.

This marked the beginning of Reich's third phase of research, which lasted from the late 1930s until his death in 1957. In this phase, Reich studied the organic basis of living pulsation, and traced that process to a particular form of energy, which he called orgone. Reich doesn't clarify whether the orgone is one of various forms of energy, such as gravitational or electromagnetic energy (Tosi & Del Giudice, 2013a, pp. 26-29), or if it is, as we shall see later in the proposal made with QFT by Del Giudice, organ energy's way of being—an electromagnetic interaction between the different parts of an organism when they manage to synchronize their oscillations, their individual pulsations.

Reich saw a special correlation with water, but he could not develop this idea further, given the limitations of physics at the time, although he did study harmful orgone dynamics in organisms. He managed to show how cancer is a representation on the physical level of energy produced by the suppression of pleasure and the blockage of pulsations (Reich, 1960).

In 1949, in collaboration with his daughter Eva, his research on the energetic functioning of living systems led them to the understanding of co-resonant processes in energy fields. In its deepest recesses, nature expresses this "resonance in phase:" co-resonance with configurations and behaviors carrying a biological sense that never ceases to amaze and touch us. Examples are presented below, which support the idea of a circularity and interdependence of relationships based on co-resonance and self-organization of the bioenergetic fields involved.

In orgonomy, we see the energetic process of contact between biosystems; in biology the maternal fetal microchimerism (Boddy, Fortunato, Sayres, Aktipis, 2015, pp. 1106-1118); in ethology, the breast crawl (UNICEF I, 2007); in psychology, Winnicott (1949, p. 221) speaks of internal states of continuity of being; in neuroscience, the mirroring processes; in psycho-neuro-cybernetics the collective processes of nerve cells' co-resonance, observed by Lashley and Freeman; and the holographic patterns of mind and perception by Vitiello and Pribram (as cited in Casavecchia & Wendelstadt,

2015, pp. 79-81); in physics, the fractal structure in nature—the expression of fractal processes at all levels of the organization of matter and morphogenetic fields. From this emerges a vision of living matter as a set of properties and potentials capable of assuming coherence, resonance patterns, and self-organization. In addition, there is a vision of living beings capable of the conscious production of self at a certain degree of evolutionary organization. The living organism has the capacity to express a core psyche with affective consciousness as the product of the resonant relationships of the parts of the organism with the environment that surrounds it. The psyche itself, in accordance with the principles of non-locality and non-causality, resonates in the body in synchrony with energetic affective memories, including those of the bio-genealogical networks. In each adult, in fact, is contained the seed of the child.

The Living Organism In Light Of Quantum Physics

To summarize, we recognize two types of movement: the first, from classical physics, is movement generated by an external cause, which manifests as a force and requires a flow of external energy and/or impulses. The second, from QFT, is movement coming from inside the subject: self-movement or spontaneous movement. All living matter shows self-movement and perception. Chiappini, Tosi and Madl wrote:

> *"Living matter produces biological codes that convey meanings. These codes are modulations of different frequencies and express fractal structures and processes. Human development from conception onwards manifests itself as a fractal structure"* (Chiappini, Madl, Tosi 2016:1)[3].

Even inert matter is subject to this. Think of fractal structures expressed in the journey of water in rivers, in the atomic arrangements of crystals, in clouds, in galaxies. The basic dynamic of biolinguistics and its representations (Piattelli, Palmarini & Vitiello, 2015, pp. 96-115), reveals itself in the properties of its own syntax (Chiappini, Madl, Tosi, 2016, p. 4), coherent with the very same mathematical representation used in the demonstration of the coherent dynamics of living water (Del Giudice, Spinetti, Tedeschi, 2010a. 2, pp. 566-586). This leads us to believe that we are dealing with one reality in various and different degrees of developmental organization and evolution. As Reich realized, this unifies the living with the universal. Everything that exists appears to be an expression of modulations of different frequencies. The role played by spontaneous fluctuations is essential for all physical objects; they cannot avoid fluctuation and the dynamic interaction that occurs. This oscillatory behavior of the physical object is defined as the "ground state", the state of minimum energy of the object, which in quantum physics is called a "vacuum." The vacuum is, in fact, the totality of spontaneous fluctuations of the object.[4]

In the dynamics of living systems, the vacuum, this field of fluctuations of living matter, acts in, through, and around the body. It is both a network of information and a perception

[3] https://www.evareichmilano.it/wp-content/uploads/2019/01/On-this-side-of-the-principle-of-minimal-stimulus-Chiappini-Madl-Tosi.pdf

[4] https://www.sinistrainrete.info/teoria/3108-edel-giudice-gvitiello-quando-il-vuoto-e-pieno.html

system that receives and transmits messages from the environment. These spontaneous fluctuations keep the system "open" so it can communicate with the environment through these fluctuations. The fluctuations in the rhythm of oscillation of objects, known as "phase", spread out in the environment in the form of special fields of potentiality.

The most obvious example is the electromagnetic field, which governs the interactions between atoms and molecules. The phase, considered apart from the energy, can travel faster than light, and carries information. This produces a violation of causality in the way Einstein meant. As a result, *"interactions based on transmission of energy obey the principle of causality (no effect occurs before the arrival of the cause), while those interactions based on the transmission of the phase, that can travel at infinite speed or even go back in time, do not follow the principle of causality and can connect different subjects in different spaces and different times"* (Tosi & Del Giudice, 2013a, pp. 26-29).

Here we can find a rational basis for understanding the origin of synchronic phenomena suggested by Jung (Jung, 2010, p. 115). There are then two possibilities (Tosi & Del Giudice, 2013a, pp. 26-29); the first is that when the fluctuations of bodies and vacuum remain unsynchronized, they lead to a large indeterminacy of the entire oscillation rhythm, which cannot define value and averages. In this case, the bodies retain their individuality, so it is still possible to accurately determine their atomic structure. Spontaneous oscillation does not play an essential role here, and the whole, as in classical physics, is consigned to the dynamics of strength and energy. Self-regulating movement disappears; all that remains is movement from outside bodies that are considered inert. This is the world described by molecular biology, which is the basis of institutionalized medicine, and the scientific model used in psychotherapy.

Fortunately, there is another possibility. Under appropriate conditions, the fluctuations of matter and vacuum can be synchronized, thus beginning a collective dance that embodies the orgastic organismic pulsation sensed and observed by Reich. In physics, this state of matter is called "coherent." In coherence, the number of components remains undetermined, while the oscillation rhythm acquires a more precise definition (Tosi & Del Giudice, 2013a, pp. 26-29). To engage in this collective dance, the oscillatory rhythms of the participants and their frequencies should be the same, but absolute equality does not exist in nature. The probability that two frequencies are exactly equal, or even only slightly different, is equal to zero. Then how can these objects resonate? Del Giudice says:

> *"It could never happen in a state of isolation, because they need a comfortable environment, full of fluctuations at a very low frequency, with a widespread noise that would let the two physical objects resonate, or as Reich would say, enter in a deep orgonotic contact or orgasm, stealing from the environment the small fluctuations that fill the gap, and equalize the oscillation frequencies of the partners* (Tosi & Del Giudice, 2013a, pp. 26-29)."

This is the condition that allows a coherent (or correlated) state of matter to form (Del Giudice, 2004a, pp. 77- 81).

A coherent system is able to decrease its own entropy and increase the capacity to perform external work. The Reichian energetic biophysical model of tension-charge-discharge-release is coherent with this particular quantum phenomenon,

which explains the dissipative, negentropic function, the orgastic discharge process that allows the organism, through the emergence of states of biophysical coherence, to recover expendable energy (Chiappini, Madl, Tosi, 2016, p. 9). In addition, in a physical system, gaining coherence is equivalent to self-regulated movement (Del Giudice, Spinetti, Tedeschi, 2010b 2: 566-586). The role of coherence in the dynamics of life has been highlighted over the years by Mae-Wan Ho (Ho M-W, 2008, pp. 39-50) in her research on the coherent dynamics of liquid water, proving that the onset of coherence in a physical system opens up the possibility of autonomous movement (Ho M-W, 2011, pp. 26-29).

Orgone Energy As A Coherent State Of Matter

We can now put forth our hypothesis that Reich's orgone energy is the form taken by the energetic functioning of the organism in a state of coherence (Del Giudice, 2010, pp. 47-50). The disappearance of the orgone (Reich, 1978, pp. 29-31) is the consequence of the loss of coherence (Tosi & Del Giudice, 2013a, pp. 26-29) of the organism (Vitiello G., 1997, pp. 171-198), with the consequent loss of self-organization, agency, self-movement, and a tendency toward the state of inert matter (Chiappini, Madl, Tosi, 2016, p. 6).

The quantum object is therefore characterized not only by energy and impulse, as is the classical object, but also by the rhythm of oscillation known as phase, a concept expressed by Reich as orgonic pulsation. It can be influenced not only by external forces, but also by the resonance between the phase of its oscillation and the phase of oscillation of other objects and external fields. This resonance does not involve exchange of energy or impulse, but produces the mutual feeling of the bodies involved moving in phase with no expenditure of energy, just as in the organismic pulsation of the orgasm, and in the bioenergetic-emotional body contact of lovers or of mother and baby (Tosi, Del Giudice, 2013b, p. 32). In 1951, Reich called this process cosmic superimposition (Reich, 1951). Wendelstadt and Casavecchia (Wendelstadt & Casavecchia 2015, p. 76) have defined it as *innate configurations of co-resonance, original forms of communication.*

According to QFT, the same biological and energetic dynamics appear as an outcome of coupled co-resonance between networks of functions. The first network (Del Giudice, 2004b, p. 47), (biochemical), which provides the supply of ions circulating in the connective tissue in the cellular and interstitial protoplasm, puts the processes into phase and carries information.

The second network, informed at every moment with no expenditure of energy by the first network, which is in a state of phase coherence, produces currents of awareness throughout the body via the nervous system in its perceptual expression (Del Giudice, 2004b, p. 48). The first network, responsible for biochemical activity as an energetic product, gives rise to the bodily sensations that translate into emotions.

The unconscious informational content of the first network could correspond, as proposed by Solms and Panksepp (2012, pp. 147-175), to the Id theorized by Freud, which Reich identified with the deep vegetative bodily currents. Del Giudice, Popp et al. say this informational content could coincide with the current

of ions traveling in the connective tissue network, also conceivable as the Chinese meridian network. (Brizhik, Del Giudice, Maric-Oehler, Popp, Schlebusch, 2009, pp. 28-40).

The first network contains the foundation of emotional movement and the "affective" mode of consciousness at the level of the id, the biological basis of affectivity. The second network is the basis for the perception of emotions at the subconscious and conscious level. Psycho-emotional and physical unity emerges from the quantum resonance processes in phase through the establishment of states of coherence in the organism, which take place in the energetic communication between the two networks in their energetic interaction with the environment (Del Giudice, 2004a, pp. 81-83).

The question of what promotes this dynamic has initiated investigation into the function of the quality of stimulus on living matter. The rationale of the principle of minimum stimulus was articulated by Prigogine (Tosi & Del Giudice, 2013a, pp. 26-29), who had established that resonant relationships do not require a flow of energy, but rather a concentration of internal energy already present in the subject, which implies a decrease of its entropy resulting in development, structuralization, and order.

As shown earlier, the movement of the organism is not only a movement that requires a constant amount of energy from the outside, it is also a movement from within, based on the reorganization of internal energy and triggered by informational stimuli. Stimuli capable of forming information must be able to make contact with the bio-system without introducing energy exceeding the sustainability of the system, but providing a co-resonance, able to harmonize in phase and promote states of greater holistic integration of its individual functions. This biophysical dynamic is also observed within the living phase[5] (Del Giudice, Spinetti, Tedeschi, 2010a) of liquid water (Ho M-W, 2011, p. 510; pp. 26-29). Resonance phenomena that create coherence states have been observed in nature, and are called solitons. Vatinno (2015) notes that it was John Scott Russell who first observed a solitary wave flowing along a canal for miles without losing energy; then Alfred Richard Osborne discovered solitons by studying ocean waves. The existence of a self-reinforcing wave function resulting from the concomitance of non-linear and dispersive effects, mutually erasing in a propagation medium, was seen in nature; a wave capable of propagation and conservation of the amplitude and frequency function without loss of information and energy, without dissipation. The solitonic wave is indeed capable of changing appearance while undergoing attenuation or amplification, depending on the propagation medium. But it can always resume the aspect of the initial signal, if propagated in a similar medium. The physical mathematical model of solitons finds application in plasma physics, in the biology and neurology of neuronal signal transmission, and in optical guidance systems. Studying the dynamics of self-organization in vivo, Del Giudice, Popp and others hypothesized the possibility of electromagnetic field self-focusing in

[5] https://www.mdpi.com/2073-4441/2/3/566

collagen crystal structures (Brizhik, Del Giudice, Maric-Oehler, Popp, Schlebusch, 2009, p. 37), and they proposed that "*a rational therapy therefore appears to be the stimulation of solitons able to clean the paths and recover the coherence of the system.*" The quantum model showed that it is the interaction with the phase that allows the fluctuations, in a coherent state, consent the emerging of solitons (Brizhik, Del Giudice, Maric-Oehler, Popp, Schlebusch, 2009, p. 2), which, developing chains of impulses at long distance with no thermal dissipation, involve the network of the nervous system and connective tissue in more harmonic dances (Del Giudice, 1997, pp. 479-481). This is the content of the Böhm-Aharonov effect (Bohm, 1959, pp. 485-491), formulated on a theoretical basis in the 50s and confirmed experimentally in the 80's. Interaction with the phase does not carry energy and momentum, it does not exercise forces, it only tunes together the phases of the parts provided they have a specific phase. This is another important step towards the understanding of the principle of minimum stimulus.

In the energetic functioning model proposed by Davis (2014), he describes the property of the endo self, a state reached as a result of the energetic instroke process. The contents of this model present coherent elements with both Eva Reich's Gentle Bio-Energetics and QFT applied to living systems. The theoretical approach of the QFT specifically provides an energetic-physical understanding of the gathering force of the Instroke, understood as an inward movement, a process where the internal condensation energy of the subject is facilitated by a specific co-resonant quality of informational stimuli able to promote self-regulatory reorganization. This reorganization of the internal energy is what happens in the endo self state, which is the result of the instroke gathering force. Moreover, other studies by Del Giudice and his colleagues (Brizhik, Del Giudice, Maric-Oehler, Popp, Schlebusch, 2009, p. 37) highlight the energetic process involved in the connective tissue matrix and the outcome in physiological and psychological states, and in its relation of correlations with the minimal stimulus process.

Furthermore, Preparata (1990) has also shown that a large number of small oscillations are much more useful in facilitating the achievement of the condition of resonance between the components than a single oscillation of equal amplitude. This also consistently emerges in Eva Reich's principle of minimum stimulus.

When the domains of coherence take a greater share of energy from the outside, an alteration of the gradient of the phase occurs to the point of cancelling it. This recognizably stops the flow of ions and is the basis of the dis-embodiment phenomenon, i.e. of the separation and splitting of the psychic, emotional and physical components due to the system's absence of coherence. Reich speaks of this as an "energetic block."

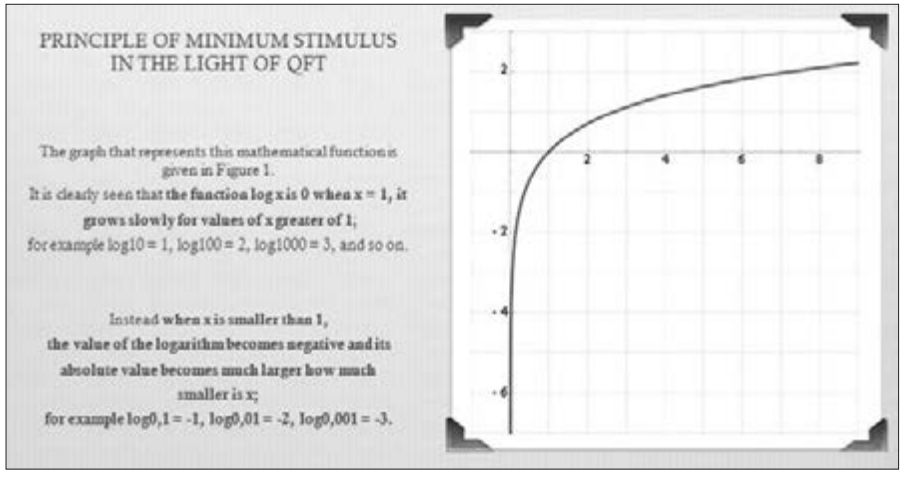
The flow of emotions in this framework can be identified as the organized system of traffic over the distance of the ion's currents guided by the phase, in their expression of the wavelength of the oscillation. Living beings do this because their components interact with a medium, the quantum vacuum, which is not empty, but is the set of all the oscillations. This creates an energetic matrix structure capable of interacting with objects through the phase and the resonance. The living organism is oriented towards a continuous attempt to establish coherence

between the vibrating elements. This helps us understand why phase-centered living organisms have an expansive desire (libido energy) and why they tend to connect with the largest possible number of beings in nature.

For this reason, when in the bio-system the conditions for co-resonance of their constituents are created, the bioenergetic function of self-regulation emerges from an interaction of co-resonance in phase between the individual and the quality of the stimuli provided by the environment.

As previously discussed, the QFT emphasizes the *quality* of the relationship between the intensity of the stimulus and the body's response. It has been shown that minimal stimuli contacting the organism below the stress and alarm threshold, have the capacity to promote an interaction and an intra-action with the phase, which does not carry energy and quantity of movement It simply tunes the phases together—provided they have a particular phase.

If the response of a living organism is proportional to the logarithm of the stimulus, as the physiological law of Weber and Fechner showed us, the lesser the stimulus, the greater will be the response.



Observing this function clinically and mathematically, it is clear that, when the stimulus is small (small resonating oscillations), it is capable of activating processes of self-regulation and organizes the field, allowing the emergence of self-perception, because the body perceives the movement as coming from inside, "**creating an inward condition of *inbound***", of psychosomatic embodiment. (Del Giudice, Tosi, 2013a, p. 28)

The essential element is not therefore the amount of energy involved in pulsation but its quality; this latter is able or not able to trigger an information process of phase coherence. Based on that, the correlations between the quantum model of QFT and the orgonomic energetic model become more evident. In particular, QFT shows us that when there is no synchronization between the quantum vacuum and the fluctuations of bodies, no self-regulated movement results. There are only the dynamics of force and energy coming from the outside. When the fluctuations of bodies and the vacuum

(which is the state of minimal energy of the system) are synchronized, a "coherent state" is established. *The coherent state of matter is only produced if there is a system open to the fluctuations of the environment; in order for this to occur, they must be very small.* In the living system this opens the possibility of autonomous movement, evolutionarily self-organized. The orgonotic pulsation of the organism is expanded.

Good health therefore does not coincide with having a lot of energy, but rather with the ability to donate outside all energy exceeding the level of maintenance of vital pulsation. This concept finds a mature expression in the work of Eva Reich's "Glow & Flow principle" (Reich, Zornanszky, 2006).

It has been well argued by Chiappini, Tosi and Madl (2016, p. 9) that the armoring process, sympathicotonie, is decoded as the result of the failure of a normal logarithmic response of the system to external stimuli.

> *"It is this missing response that ultimately slows down the plasmatic movement, the damage and asphyxia of the tissues. Blocking of vegetative movements is followed by muscular contraction and shock reaction, which produce, in a substantially healthy organism, apoptosis and the recovery of expendable energy. On the other hand, in an armored organism it leads to neurosis, to T-cells disintegration (W. Reich, 1948) and to the production of cancer cells"* (Chiappini, Madl, Tosi, 2016 p. 9).

Of special importance is the quality of the dynamics that informs us about the energetic setup of the environment, because the whole picture explained above depends primarily on the phase, and much less on exchanges of energy. An analogy is how the performance of an orchestra depends on the rhythm given to the orchestra by the conductor, much more than on the energy communicated by the musical instruments. The same in a living organism. Dynamics are governed mainly by the value of the phase, and much less by the energy exchanged.

In this process of co-resonance emerging from the capacity of the bio system, the surrounding environment must be able to provide information capable of resonating, by supplying the minimum amount of energy needed to promote the widest possible organization in phase of the oscillation (state of coherence) and thus create coherence domains.

This quality of experience is cultivated by a nurturing environment that promotes an energetic resonance in and between the cells of the bodies of mother and newborn, mutually perceived in the process of bio-emotional contact and resonating within their energy field. This allows the production of specific and functional biochemical substances, such as the ossitocinocinergic network (Moberg, K. U., & Moberg, K., 2003), which is active in the processes of bonding and empathy. Original forms of communication, delicate instinctual forms of co-resonance, are contained in the treasure chest of life's processes.

The biophysical and emotional pulsation that informs the psychobiological sense of the continuum of existence (Winnicott, 2013), emerging from the configuration of resonance in the field of the mother-child dyad, holographically constitutes the delicate energetic and organismic core of basic trust and the intersubjective skill of empathy, the biological basis of affectivity (Solms & Panksepp, 2012, pp. 147-175).

The ability to love as an adult takes shape from this primary matrix. It is from here that we articulate the primal emotional grammar and the ability to form emotional

and social bonds. Eva Reich wrote: *"The baby comes into the world with a strong energy system, capable of informing the environment of his needs."* The baby is the bearer of the meaning of its own agency, as a psychic manifestation of the organizational properties of all living entities perceived in itself (R. Ryan, 1991).

If the environment allows it, the mother and the baby in utero are strongly "attracted" to each other and have an energetic, biochemical and emotional communication. The new being must "nest" in the energetic field of the mother to develop its vital functions. His life depends on that nesting. If he is in bioenergetic contact with her, if he "pulsates and flows", then he is a very healthy baby. He is centered in his pleasure in "functioning". In his body he lives and feels interoceptively, in the experience of the flow of internal states, the emerging experience of a perceptual affective nuclear consciousness that resonates in the quality of BEING THE EXPERIENCE OF HIMSELF (Davis, 2014, p. 13; pp. 32-41). Grounding and bioenergetic bonding have this common vibration.

Being the experience of himself is the entanglement process. It is psyche in matter. This entanglement is not simply being intertwined and interconnected with the self or with the other, as if it were a meeting of separate entities, without an independent self-contained existence.

From the first moment of existence, every generative life process is a relational and embodied process. According to Barad (2007) existence is not in fact an individual affair. Individuals do not exist prior to their interactions; rather, they emerge through and as part of their implied intra-relative involvement. This informs the setting of each process, biological or therapeutic. It becomes necessary therefore to make the transition from what happens as *"inter (between or in the middle) action"* to what becomes in the *"intra (from inside) action,"* in order to understand the communication and the relationship that takes shape at the confines of the domains of each intra-active and co-resonant individuality.

For this reason, we must pay attention to the whole, to issues of therapeutic methodology and of "interface", both in relation to the external/internal environment of the therapy setting and to the internal state of the therapist, in order to create the possibility of an informed setting of minimum stimulus.

Summary

This paper presents a model of how Reich's orgone energy and quantum field theory (QFT) share common ground in their understanding of the phenomena of life. With an emphasis on the dynamics of resonance of living matter, it has been shown how the further developments of Eva Reich's Gentle Bio-Energetics have developed this model further.

Del Guidice's QFT model, based on the classical principle of Weber and Fechner, offers an element of theoretical physical research proving that interaction with minimal stimuli in the body promotes a co-resonance process, which sustains the ability of living matter to form states of biophysical coherence and to develop the emergence of self-organizing processes, embodiment, and bonding. Using these arguments, it was suggested that the movement of the organism is not only a movement that requires a constant amount of energy from the outside, it is also a movement from within, based on the reorganization of internal energy that does

not involve exchange of energy or impulse, but produces the mutual feeling of the bodies involved moving in phase with no expenditure of energy.

The quantum model showed that it is the interaction with the phase that allows the fluctuations in a coherent state to develop chains of impulses at long distance with no thermal dissipation, involving the nervous system's network and the connective tissue's matrix in more harmonic dances. Highlighting the energetic process involved in the connective tissue matrix in its correlation relationship with the function promoted by the minimal stimulus process, the congruity and coherence with the energetic functioning model described by Davis has been proposed and discussed.

Creating the possibility of an informed setting at minimum stimulus both in relation to the external/internal environment of the therapy setting and to the internal state of the therapist has been propounded as relevant to promote autopoietic processes of self-regulation, bonding and embodiment.

TranslatIon: *Ermanno Bergami / Editing: Elizabeth Marshall*

Beatrice Casavecchia *is a social worker, psychologist, orgonotherapist, and Gentle Bioenergetic analyst. In 1992, she specialized in Vegetotherapy Character Analysis and Orgonotherapy at S.E.Or., the European Orgonomy School of Rome (F. Navarro, G. Ferri). Her thesis was titled Orgone-Plasmatic Memory. She later joined the methodological network of Gentle Bioenergetics and with Silja Wendelstadt formed the Eva Reich Study Center. She completed her training in Gentle Bioenergetics with S. Wendelstadt and T. Harms at the Zentrum fur Primare Prävention und Korper-psychotherapie, Zepp, Bremen (2001-2007). She conducted personal research and further professional training in holistic Reichian and transpersonal analysis with professor R. Sassone and professor SIAR of the Italian School of Reichian Analysis. She furthered her education in Functional Analysis with W. Davis (1999-2019). Beatrice is a professor at the Eva Reich Study Centre and director of the Eva Reich Research Center of Ancona, Italy. She is an expert and professor of Gentle Bio-Energetic Massage, Bio-Energetic Basic Bonding, and expert practitioner of Emotional First Aid.*

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Biofeedback as a Viable Somatic Modality for Trauma and Related Comorbidities

A New Methodology

Cynthia Kerson

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ABSTRACT

Biofeedback is a behavioral modality that focuses on the interconnection between psychological and physiological phenomena in real time. Its main premises are that emotional and cognitive behavior begets physiological behavior, vice versa, and that the conscious connection between the two augments healing. To achieve this learning, the client is coached using operant conditioning learning models while recording heart rate, breath rate, distal temperature, muscle activity, electrodermal activity, and/or brain waves. Each modality relates to the person uniquely, and it is the skill of the practitioner to know which one(s) to train to enhance the psychological process and encourage mental, social, and emotional growth. This paper explores these modalities and their best uses.

Keywords: biofeedback; neurofeedback; applied psychophysiology; learning theory, somatic modality

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As somatic psychologists, we know that the phenomena of cellular memory (Pert, 1997), psycho-somatization, and living our fears (Van der Kolk, 2014) are not new. Talk, massage, somatic movement, felt sense, and the many other modalities that we use to lure the symptoms of physiological remembering up to the surface and out of the person have evolved because we know these phenomena are possible, very real, and trained away. A newer approach to augment these interventions is known as biofeedback. Biofeedback is the tool a practitioner uses to connect the somatic to the often intangible emotional experience at the person's consciousness (Schwartz & Andrasik, 2016). Because it is technologically based, biofeedback is often considered a Western approach to the ancient Eastern understanding of mind and body.

Biofeedback is used in real time to help the person connect the real feeling, whether in the chest (heart and breathing), gut (breathing and electromyograph), muscles (electromyograph), hand (galvanic skin response and temperature), or brain (electroencephalography or neurofeedback) with the conscious, unconscious, and/or emotional content (Sherlin, Arns, Lubar, et al, 2011). This is done by amplifying the actual minute measures of the electrical potential of body systems as they are happening

using sophisticated equipment. These changes in physiology are barely noticed until, in many cases, too late – such as a panic attack or regrettable aggressive reaction. The process of real-time observation teaches the person to know what the earlier symptoms are, and the clinician will use this information to teach the client to break old habits and self-regulate in order to avoid an upcoming unwanted and regrettable reaction.

This author was in clinical practice in Northern California for close to 20 years, specializing in biofeedback and neurofeedback, and helping children and adults with issues such as PTSD, anxiety, depression, ADHD, learning disabilities, stroke, and brain injury. A typical client experience included an assessment of all body systems in which we measured the electrical potential of their behaviors during certain tasks, some of which were meant to stress (Arena & Schwartz, 2016). The trends during stress and recovery are the most important in the assessment, and guide the clinician to the modalities and learning style of the client. For example, an adult with PTSD will understand biofeedback very differently than a child with ADHD.

Coupling the state of relaxation with the noxious element teaches the client that he can experience the stressor while also experiencing relaxation.

The first few sessions include an acclimation to the modalities and to the concept of self-regulation. For example, a hand-held mirror is often used for the client to see what was happening from a new perspective. Once the client became aware of their reactions, and how they actually felt from their earliest stages, we would then practice preventing them. The easiest example is desensitization, when one presents with a phobia. Coupling the state of relaxation with the noxious element teaches the client that he can experience the stressor while also experiencing relaxation.

Almost always, biofeedback clinicians start with breathwork. Clients usually present breathing too shallowly and fast. Or they may be capable of fire- or other yogic-breathing styles that don't always yield calmness. Coupling this with heart rate and heart-rate variability training is usually indicated. (Further in this article, there is an explanation of the modalities.) Usually, the almost immediate change in state is recognizable and informative. But there are times when the feeling of calmness can be upsetting, a phenomenon known as relaxation-induced anxiety, and thus, these steps need to be taken with precaution.

One would normally do about 4 to 6 sessions of biofeedback for the client to feel confident she can self-regulate and apply the newly-learned skills. Each time the client comes in, a mini-assessment is done. Typically, we meet weekly, and the skills learned during each session are practiced at home, once or twice each day. This might include 3-5 minutes of diaphragmatic breathing, temperature regulation, or skin conductance reduction, and could be practiced in conjunction with a cognitive behavioral skill. For example, I worked with a couple who were both OCD, and one of their at-home tasks was to go out for their morning walk without cleaning the breakfast dishes. They

both found it very challenging at first, but when coupled with some diaphragmatic breathing, were able to "let it go." This introduced them to their OCD in a new way, and coupled with biofeedback, helped both of them to have a less compulsive lifestyle.

At each session, this important home-training is discussed in order to assess progress. Over the years I was in practice, I was interested in the reasons (excuses?) for why the 3-minute breathing session was not done. For example. in the case of the couple above, the experiences / body feelings when they could, as well as when they couldn't, leave the dishes, were meaningful. The explanation of the lack of time to complete a 3-minute exercise is quite revealing to the motivation and "stuckness" of the client. Discussing this is an essential part of the process.

Importantly, when doing biofeedback, it is an important skill of the practitioner to get the client "out of their frontal lobes." After a 15-minute breathing session, I ask how the client is feeling; the typical response is "calmer" or "so relaxed" or "grounded." These are meaningful responses and experiences, but with biofeedback, the clinician is not seeking definitions of feelings that come from the frontal lobes; the biofeedback clinician asks about how it feels physiologically. The improved responses, which are often gotten when prodding, are "I don't feel the pang in my chest when I inhale," or "My shoulders are not as tight." The clinician is looking for physiologically-felt sensations. Once these are recognized, at-home training becomes more successful, because the sensations are attended to from a new perspective, and are followed and regulated in real life. This often couples with frontal lobe explanations, and from a biofeedback perspective, the physiological experience is what's important.

Biofeedback Modalities

- **Temperature:** Temperature training involves training temperature up or down from the surface of a finger. This is known as distal temperature because finger location is furthest from the core (Peper, Tylova, Gibney, et al, 2008a). Typical temperatures at presentation are between 70 and 90*. The general goal is to increase distal temperature to the low 90s. The reason for monitoring and training distal temperature is because the temperature at our furthest extremity is indicative of blood flow, which is further indicative of blood vessel diameter, which is influenced by muscle contraction. And finally, muscle contraction occurs when the muscle is activated. This can be due to movement or the stress response, the latter being pathological if chronic. When a set of muscles is chronically constricted, those muscles clamp down on the blood vessels that pass through it, and where there is no blood flow, there is no warmth.

  The instrument used is a thermistor, which is applied to the middle finger of either hand with an elastic band, a Velcro enclosure, or medical tape. It measures temperature with very little time lapse and within a tenth of a degree. Temperature fluctuations represent changes in muscle constriction that reveal one's experience with particular tasks. Temperature changes are slow compared to other measures. For example, one can be monitoring temperature while discussing a very emotional event. The fluctuations in temperature, which can range from a tenth of a degree to 10 degrees, are an indication of the person's reaction to the content of the emotional discussion on a global scale.

Temperature training is indicated in stress reduction and Reynaud's syndrome, as well as migraine. Reynaud's syndrome is caused by a constriction of blood flow to the affected hand(s). If one can learn to open up the constriction, usually by muscle relaxation, the compression of blood flow is eliminated. Since migraine is a vascular issue, regulating blood flow can revive symptoms, severity, and duration of migraine headaches.

- **Muscle Electromyograph:** Electromyograph (EMG) measures the tension/use of muscles. The more constrained a muscle, the higher the value. Typical values at presentation are between 5 and 25μV (microvolts). The goal, generally, is to be below about 3μV during relaxation, but this is dependent on specific muscle groups (Bolek, Rosenthal, & Sherman, 2016; Peper, Tylova, Gibney, et al, 2008b).

  Myograph is the measure of the electrical output of muscles as they are activated. Muscles are activated during common tasks, such as moving, posturing, carrying, etc. If the electromyographic output at the relaxed state is high — meaning if the patient is sitting in a reclining chair and the muscle activity is high — there likely is residual muscle activity that is emotionally driven. The clinician can use modalities such as Jacobson's progressive relaxation, autogenics, and/or mindfulness, along with monitoring the EMG to teach the client how it feels to have relaxed muscles.

  One client reported feeling relaxed, specifically in her forearms, yet the sensor measured quite the opposite. This is a perfect example of cognitive dissonance in that the sensation of activated muscles was considered relaxation. The client needed to learn that her sense of relaxed forearm muscles was, in fact, incorrect. She was shown that every time she thought her muscles were relaxed, they were not. As she learned how to relax those muscles, which was a challenge, she needed to constantly remind herself that she "had it backwards," and, in fact, once accomplished, relaxed forearm muscles felt completely different to her. In this case, the association was of holding on, as with a clenched fist. This metaphor served the therapeutic process well because holding on to past familial experiences was hindering her personal growth.

- **Skin Conductance:** Skin conductance is the measure of the clamminess of one's hands (or feet). The purpose of measuring clamminess is to assess the level of arousal or agitation one is currently experiencing. It is measured by placing two sensors (they could be either on the palmar surfaces of the hand or foot, or on the fingers or toes, separated by a few inches (if on the fingers/toes, on two separate ones on the same side). The sensor sends a very small electrical current, which can be accentuated by clamminess or attenuated by dryness. Typical presenting values are between 2 and 10μSiemens. Optimal levels at rest should be under 1.5μSiemens (Peper, Tylova, Gibney, et al, 2008c).

  For example, when doing a psychophysiological assessment, monitoring the skin conductance as it changes between the typical stress and recovery tasks can be revealing to how one responds to stressors, and, more importantly, how well

one recovers from it. The usual assessment stressors are Stroop and Series 7s.

While skin conductance measure is often confounded by medications, it is an excellent insight to how one relates to stress, and how one can recognize the stressed state when in it. Skin conductance is quite responsive and labile. For example, while doing any body modality, monitoring the skin conductance will inform of a reaction (both positive and negative) to a protocol well before the client or clinician can observe a response to it.

- **Breathing:** Breathing is measured with a sensor known as a strain gauge. It is strapped around the waist with Velcro, just above the belly button. As one inhales and exhales, the gauge expands and contracts and measures in μmeters of mercury (like a thermometer). This informs the length of time of each phase of the breath cycle (inhale, exhale, and hold), and whether the breath has traveled as low as the abdominal muscles.

  When one breathes shallowly, the movement of the breath does not make it to the abdominal area, where the diaphragm sits (just above the kidneys). And the breath itself doesn't satiate the lungs, providing gas exchange (O_2 and CO_2) to the upper areas only. The strain gauge confirms this, because there is little change between the diameter of the abdomen during inhale, when it should be largest, and exhale, when it should be smallest.

  Breathing diaphragmatically, also known as relaxation, or deep breathing, is necessary for optimal gas exchange, as well as helping to regulate heart rate (more on this below). A healthy relationship between breathing and heart rate is vital to well-being and success. When the heart rate increases with inhale and decreases with exhale, we name this coherence. Slowing one's breath, as well as consciously (at least, at first) breathing more deeply so gas exchange can be done at all surface areas of the lungs increases parasympathetic tone. Parasympathetic tone (the opposite of sympathetic tone – or flight/fight) is optimal for both objective and subjective experience and behavior.

  In the literature, a goal of 6 breaths per minute is typical. However, one can also train the person to breathe at what is known as resonance frequency, which could range from 4 to 8 breaths per minute.

- **Heart Rate and Heart Rate Variability:** Heart rate is simply the number of beats per minute (BPM). The average is from 60 to 85 BPM. People who are more athletic and aerobically fit will tend to have a lower rate. Lowering baseline heart rate has been shown to reduce risk of cardiovascular disease and the overall message of stress to the body. One regulates heart rate through the breath. As described above, a smooth and rhythmic breath pattern is optimal. When this is achieved, the heart follows; this is known as coherence of the two values. Since breathing is a very tangible process, it is often used to access less-tangible processes, such as heart rate. The sensation of heart rate and breathing coherence is one of calm, yet fully alert (not drowsy).

  A sensor known as a photoplethmograph is Velcro-strapped onto the left middle finger. This device emits an infrared signal. It then registers when that

signal is returned – in milliseconds. If quickly, then there is blood flow because it bounces off of its density. If less quick, then there is less blood flow, and thus less density. The constant pulse of the flow informs the heart rate as well as oximetric value and the variability of the heart rate (which we will further discuss below). This can also be measured on the ear lobe with a clip, which can be better since there is less chance of movement artifact.

Heart rate variability (HRV) is measured as the distance in the number of beats from the average (and standard deviations) of the BPM during inhale and BPM during exhale (Gevirtz, Schwartz & Lehrer, 2016). There is a natural and healthy need for there to be a difference. The heart pumps faster when, during the inhale, fresh oxygen is delivered and needs to be pumped to the vascular system. And, it naturally slows down during exhale. A healthy difference is about 15 BPM. So, if one has a heart rate of 70, it usually means during inhale it's about 78, and during exhale about 62. When training HRV, the BPM measure is monitored from the photoplethmograph, and the person is taught to slow their breath to a level that brings the HRV into coherence with it, as measured by a power spectrum that tracks electrical output of the cardiac muscles and is a good indicator of the fluctuations in heart rate during the breath cycle.

- **Neurofeedback:** Neurofeedback is by far the most complicated biofeedback modality. One needs to understand brain anatomy and function at least minimally, or be supervised by someone who does. Like all biofeedback, the neurofeedback modality utilizes the operant conditioning learning model. This involves rewarding the physiological behavior when it meets the expectations the clinician designs within the biofeedback equipment. The most common and well-investigated disorders include ADHD (Monastra & Lubar, 2016; Thatcher, 2012), seizure, depression, anxiety, stroke, mild traumatic brain injury, dementia, and PTSD (Martins-Mourao & Kerson, 2017). While each disorder has recognized brain EEG (electroencephalic) profiles, EEG patterns are like fingerprints — extremely unique to the person (Urlich, 2013). Therefore, be wary of systems that have default protocols for dysregulation without performing an assessment. The assessment for neurofeedback is called a multi-channel EEG. This usually entails doing a "brain map" of 19 channels that are universally designated. The clinician will observe the patterns and connection grids of the EEG, and can then compare it to a normative database to discover the standard deviations from normal populations. The individual patterns are as important as the comparison to the normative database.

  Once the brain map is assessed and the client conveys their goals, the clinician develops a training program. Generally, about 30 sessions are needed. Clinicians will train anywhere from 20 to 60 minutes per session. During my years in clinical practice, I trained for 30 minutes, usually using 5-minute rounds and small breaks in between. The training protocol is designed to teach the client to regulate brain waves by programming the software to offer a

reward, which was usually a soothing sound, a puzzle filling in, bars extending above or below the threshold (depending on whether the specific brain wave frequency should be rewarded or inhibited), etc.

The brain is eager to please and learns quite quickly what it needs to do in order to get that reward. Original studies of brain wave operant conditioning were done with cats, rats, pigeons, and monkeys. Because humans have further-developed frontal lobes that incorporate and complicate emotional content very differently than other species, neurofeedback takes much longer than the original animal studies. This is also why neurofeedback can be considered an adjunct to other somatic modalities (or vice versa), and should not stand alone.

A typical neurofeedback session starts with the client getting hooked up. Let's imagine a client with anxiety using a protocol designed to be calming. The clinician hooks up a few sensors to the scalp (active sensors) and ear lobes (references and ground), and settles the client. The environment is a quiet space, with dimmed incandescent lighting and a comfortable reclining chair. The software is programmed to provide the appropriate feedback, and the session begins. The client is instructed to intend for the positive reward to happen. It really is that simple; let the reward happen. The instructions should include removal of thinking and over-strategizing and to allow the process. This first step can be very complicated for the client, but once learned, the process accelerates. (For some, this could take many sessions that are interspersed with other modalities to incorporate the learning of letting go.)

Integrating Biofeedback and Body Psychology

Of importance, the American Psychological Association (APA) has recently granted proficiency for biofeedback (APA, 2019). This is significant because first, it recognizes biofeedback as a reliable adjunct modality for psychologists, and second, with proper training and mentoring, psychologists can practice biofeedback for many of the physiological indications commonly seen by body psychologists (of whom, many are licensed by APA).

The many body psychology modalities that are used to alleviate anxiety, trauma, pain and other real physiological ramifications of emotional imbalance, such as Somatic Experiencing®, healing touch, and neuro-effective modeling, are an excellent match with the practice of biofeedback because biofeedback can illuminate body experiences in a tangible way. In the case of pain, one learns to recognize and regulate differing levels of pain while working through the etiological emotional context. In addition, assessing and regulating brain wave profiles, which become dysregulated as one braces and/or dissociates from pain, can support the energetic work of body modalities. Camfferman and colleagues (2019) found that pain intensity, coupled with sleep issues, which are commonly comorbid to pain issues, dysregulates the alpha bandwidth. The clinician can teach self-regulation of the brain wave profile in conjunction with body therapy, which crafts a dialog between brain and body not previously accessible.

Authentic movement is another modality that could benefit from biofeedback – specifically EMG or skin conductance. Since authentic movement is a process in which the experience of the body is from within, having the muscle patterns recorded could illuminate differences in subjective and objective experiences. For example, when one is moving, one could learn of muscle groups that "hold" when not needed, which could be connected to unhealthy body patterns. As well, the skin conductance can measure changes in perspiration that can determine when certain body postures become more emotionally activating. The former could be useful in determining when there is residual or idiopathic pain when certain movements are made, and the latter could be useful in cases of trauma associated with sexual abuse, for example.

Catastrophizing can derail a somatic treatment because the practitioner is helping work through issues that are emotionally severe, but project to differing systems than the client reports or recognizes. Using most (or all) of the biofeedback modalities explained in this paper during an initial assessment will elucidate actual body system behaviors while asking the client to describe their body experience. Often, body experience and actual level of body strain are incongruent, and the clinician can use this discrepancy to guide the body therapy. One example is when one conducts bioenergetic analyses, in which measuring actual physiological systems can support or challenge observations from an energetic perspective.

Family and couples therapy can be enhanced with biofeedback, which may expose physiological trends that are not otherwise evident during any therapy in which these dynamics are aided. For example, during a couple's talk therapy session, the skin conductance and video recording, can reveal individual reactions to the deliberations of the other participants. The client may not have cognitively recognized how physiologically toxic a comment or event was. During the session, these responses likely will have been noticed by the clinician, yet they are much more implanted in the client's self-understanding by the physiological evidence of, for example, the subtle change in skin conductance, or the review of their body and facial reactions via video.

Pain assessment of cognitively impaired individuals, whether youth or elders, can be complicated as they cannot verbally express their experience of the pain in the same way a cognitively stable person can (Strand, Gundrosen, Lein, Laekeman, Lobbezoo, et at, 2019). Biofeedback can assist with this, because it can support or disprove facial and other responses to testing. These portrayed responses, coupled with the actual objective behaviors, speak to the real need for either physiological or emotional intervention.

In the PTSD population, the levels of depression and suicide are staggering, and our returning warriors are greatly in need of modalities that resolve traumatic stress (US Dep't Veterans Affairs, 2019). The first-line treatment is currently medications, likely SSRIs, which are a class of anti-depressants that focus on altering the chemical properties of between-cell affinities, specifically serotonin, which is the neurotransmitter most associated with pleasure and contentment. Other first-line treatments include cognitive behavioral therapy (CBT) and exposure therapy (Reisman, 2016).

Recent research on trauma-based treatments has reported on many of the biofeedback modalities — in particular, EEG and heart rate modalities (Lake, 2017; Van der Kolk, 2014). Many books and articles focus on these modalities for PTSD, whether for returning veterans, in which case it is event-based, or for developmental PTSD, which is based on long-term trauma during childhood (van der Kolk, Hodgen, Gapen, Musicaro, Suvak, et al, 2016; Gerin, Fichtenholtz, Roy, Walsh, Krystal, et al, 2016)). They discuss the importance of integrating mind (or psychology, emotional balance, and motivational systems) and body (or physiology). The effectiveness of these protocols is currently observed as no larger than 30% (see Reger, Hollloway, Candy, Rothbaum, Difede, et al, 2011; Reisman, 2016). Further investigation would be warranted to validate the use of biofeedback in conjunction with CBT or other body modalities, however, this author can anecdotally report many cases in which the presence of objective physiological feedback improved outcomes.

Case Presentation

A 36-year-old veteran (PS) presents with diagnosed PTSD and self-reported sleep disorder. He describes sleep onset and duration issues; it takes him at least 2 hours to fall asleep, and then he complains that he does not feel rested after a continuous sleep period of about 6 hours. He is highly reactive to daily stressors. He is on a prescribed SSRI (1 year) and reports it has not helped as much as he'd hoped. He recounts conflict with his wife and undue frustration with his 5 (f) and 7 (m) year-old children.

PS reports for a biofeedback assessment in which he is given an EEG (brain wave) recording and a psychophysiological stress profile (PPSP). During the EEG assessment, a spandex cap is placed over his head, and electroconductive gel is inserted into the sensors. He is asked to remain perfectly still for 5 minutes with his eyes open, and then again with his eyes closed. This records how his brain functions during both resting states, as well as how it differs between the eyes open and closed states.

The PPSP is administered in which he cycles through baseline, a stressor (Stroop test), recovery/relax stage, a math stressor (series 7), recovery/relax stage, talk stressor, and final recovery/relax stage.

The EEG recording takes about an hour, and the PPSP about 20 minutes. The total intake session, including interview, is about 2 hours. The EEG reveals typical patterns of "hypervigilance," which is common to PTSD. This means that of the brain wave frequencies recorded, the faster frequencies show the highest power. This presents as a "rev," and an inability to slow the brain down in order to evaluate moments for reaction.

The PPSP shows poor recovery from stress. We are measuring breath rate, heart rate, electrodermal activity, muscle tension (usually in the upper back: trapezius, and frontalis, and the upper facial muscles, which are where stress is mostly held). This means that once the stressor is completed, there is little or no recovery to baseline measures, which in this case were elevated at the outset. So, in the end, the high baseline measure wasn't sustained, and the PPSP left PS in a higher level of arousal. This is not uncommon in the presentation of PTSD The combination of a hypervigilant EEG profile and high physiological baseline in which stressors are difficult to recover from is indicative of PTSD, and PS served as a typical patient.

We started with breathing and heart rate training in which we practiced breathing at a slower pace than the recorded baseline (16 BPM). We started at 12, then 10, and then 7 BPM. This enabled a more functional and healthful heart rate (starting at 90 beats per minute and finally at 72 BPM). Once PS succeeded in breathing at 7 breaths per minute for 5 minutes, and his heart rate slowed to the low 70s, he began to experience what he called "How I felt before my deployment." In addition, his skin temperature raised from 76* to 82* (which is not optimal, but a meaningful start). And finally, his skin conductance (SC) measure shifted from 3.4 to 2.7 uSiemens. A large change in SC was not expected since he was taking an SSRI, which is a regulator of skin conductance.

After 3 sessions of breath work, we proceeded to neurofeedback training, in which we started with a protocol known as SMR, or sensory motor rhythm training (Sterman & Egner, 2006). This training is used to calm the motor cortex. Once PS reported response to daily stressors with much less agitation, we continued to do another neurofeedback protocol known as the alpha theta protocol for 12 sessions (Martins-Mourao, Kerson, 2017). This protocol takes patients to a deeper state, similar to mindfulness meditation, and guides them through suggestion to access memories and thoughts that are normally difficult to process. The combination of relaxation, as learned from the biofeedback protocols, and the SMR neurofeedback protocol (19 sessions) allowed PS to access suppressed experiences while in the calmest state and environment, and allowed him to process these experiences without a reaction of vigilance. Consequently, he learned to process these reactions in his life, and with regular at-home biofeedback training, recalibrated his harsh reactions to everyday stressors to a more healthful level.

In Conclusion

No matter the biofeedback modality (or modalities) used in conjunction with body therapies, once a few sessions have been done, usually the client experiences behavioral changes that act as secondary gain and support further self-regulation. For some, the shifts are life-changing; for others, they are very subtle. Essentially, with the help of physiological information to back up their intuition and expertise, the clinician remains a catalyst for the process, supporting any changes and reminding clients of their specific goals as they advance through the procedure.

The many modalities of biofeedback are diverse, and should be individual to the presentation and goals of the client as described above. Their strategies are symbiotic to the process and specific to their outcome, and should be considered seriously by the clinician. With some training, and possibly certification, the clinician specializing in somatic modalities can add these skills and greatly improve outcomes. Biofeedback can be thought of as an "East meets West" paradigm in which somatic movement (Eastern objectivity) is enhanced by psychophysiological mastery (Western objectivity).

Cynthia Kerson, 2(PhD), QEEGD, BCN, BCB, BCB-HRV *is currently the founder and director of education for Applied Psychophysiology Education (APEd) and professor at Saybrook University, Department of Applied Psychophysiology. She is BCIA certified in biofeedback, neurofeedback, and heart rate variability, and holds certification as a diplomate in QEEG. She mentors candidates for all certifications.*

Her role with APEd is to develop and teach introductory, intermediate, and advanced courses in the specialized areas of brain training and EEG analysis. She teaches the EEG Biofeedback, QEEG, Advanced Neurofeedback, and Neuropsychophysiology courses in Saybrook University's doctoral program, as well as chairs dissertations in applied neuromodulation and assessment. Her research interests are in neuromodulation and the uses of applied psychophysiology for ADHD, anxiety, depression, and PTSD. Dr. Kerson is an awardee and co-investigator of the NIMH grant for the 5-year ICAN study, which is looking at neurofeedback for ADHD, which has completed its final year of collecting data and is now accumulating follow-up.

Cynthia has published many articles and chapters on biofeedback and neurofeedback, and is the co-editor of Alpha-Theta Neurofeedback in the 21st Century. She is the vice president of the Board of Directors for the Behavioral Medicine Foundation (BMRTF,) and has served on the Board of AAPB, as vice president of the Foundation for Neurofeedback and Neuromodulation Research (FNNR), as president of the AAPB Neurofeedback Section, and is two times past president of the Biofeedback Society of California.

Website: www.aped.training

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Ethics and Ethos as Essential Elements of Professionalization of Body Psychotherapy

Ulrich Sollmann

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ABSTRACT

Ethics are essential guidelines in the field of (body) psychotherapy. The implementation of ethical guidelines, and appropriate repercussions to address violations of these guidelines, must be a key component in the psychotherapeutic field, whether it be therapeutic practice, the therapist-patient relationship, or the science of psychotherapy. However, an impartial ethics practice is necessary in relation to the management of a therapeutic organization, especially in smaller organizations. Conflicts in bias can quickly lead to abuses of power. Psychotherapy is, on one hand, a specific form of helping people in personal need. On the other hand, it is a profession, a service. The profession's development includes the development of specific quality criteria, structures, and regulations for training, as well as the social anchoring and visibility of the field, which includes professionalization. This is to be understood as the development of a general ethic and personal ethos. Both are value systems that give orientation to both therapist and patient. Professional and personal (self-) reflection are crucial for this. The development of an ethics code also affects the sustainability and credibility of psychological science.

Keywords: ethics guidelines, morals, body psychotherapy, psychotherapy, professionalization, therapist-patient relationship, power struggle, science, quality criteria, sanctions

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In the last 30 years, "helping work" has not only developed rapidly, but has also become a sociologically and legally regulated profession. It therefore makes sense to take a close look at what is meant by occupation/professionalization. The development of ethical guidelines is a necessary step to take a detailed look at how one operates, and to shed light on the underlying attitude through which a therapist is active.

Occupationalization characteristics are according to Kalkowski (docplayer article: "Beruflichung und Professionalisierung"):

- Particular fields of activity, special qualifications (skills, competences)
- Systematic vocational training with recognized qualification (accreditation, certificates)
- Greater or lesser professional prestige (social position in a company and society)
- Typical mobility paths (ascent ladders, further education, and training)
- The practitioner's inner attachment to the profession (professional socialization and identity, values)

Professionalization

In the beginning, in psychotherapy or counseling, the focus was on qualification and the development of quality standards. In the context of professionalization, this was condensed into generally applicable standards and competence characteristics shared by the majority of the people involved. According to Kalkowski's scientific literature, the profession is rather reserved for academic professions. This leads to quality improvements, standardization, and ultimately to an improvement in the results, and a corresponding comparability of results up to and including scientific research. "In return for the autonomy granted by society, professionals are expected to perform outstandingly and to commit themselves to professional ethics, which reward society with high prestige and income." (Kalkowski)

The better *professionalization* succeeds, the better known it becomes in society, the sooner a profession can develop. It is characterized, among other things, by the fact that a professional career is appropriate, combined with specific access requirements and qualifications, development opportunities, goal formulation, ethics, and others. It is part of the nature of the challenges facing the profession "that knowledge cannot be regarded as "stable" in a given situation, that one must rather "swim" in it, and that the description of a situation includes the professionals" (Buchholz, p. 139). The situations that characterize professional practice are complex, uncertain, unstable, and unique; they require value decisions and cannot be fully described (Buchholz, p. 193ff). They require permanent (self-) reflection.

Finally, professionalization occurs through the development of appropriate organizational structures, which guarantee the training, professional practice, examination of these areas, and the development of professional practice. It includes professional regulations. Such forms of organization in the counseling and therapeutic fields can be professional associations, psychotherapy offices, training institutes, university training courses, and others. In my opinion, professionalization aims at the interplay between occupational and professional development within the framework of specific institutionalization, organization, or structures.

The code of ethics is an essential element of psychotherapy organizations, and is due to social development in general, as well as the development of psychotherapy in particular. "These principles and standards represent a cumulative lived wisdom in the field of body psychotherapy. They are not meant to be all-inclusive. The principles in this ethics code are intended to be aspirational, while the standards are directive. Members of the USABP seek consultation with health care and other professionals and consider cultural and contextual factors, other certification and licensure regulations for their professions, state and federal laws, and the dictates of their consciences when determining ethical conduct." (USABP, Code of Ethics)

If one compares the ethical guidelines of individual institutes, there is a general agreement regarding central aspects, such as no sexual relationships with patients. Many ethics codes define their guidelines more normatively by defining concrete boundaries of relationship, behavior, and influence. Others emphasize the definition of ethical guidelines, and the practice of implementation based on it. Others, such as the USABP, understand its ethical guidelines and implementation as a continuous process that is culturally and contextually conditioned. It embodies a fundamental ground of cultural professionalism in Europe, a space where many different cultures meet (EABP, Code of Ethics).

Ethical Ambiguity in the Field of Psychological Science

Body psychotherapy is based on the science of psychology, insofar as its relation to science is an essential dimension. The German Psychological Association puts the responsibility that derives from this into the following policy (this can be regarded as typical of other psychological associations):

1. The professional actions of psychologists are based on the findings of psychology as a scientific discipline.
2. Psychology:
   a) Provides insights into psychological, psychophysical and biological processes in humans and animals;
   ...
   d) Promotes knowledge of social processes between people in relationships, communities, and organizations;
   e) Develops strategies to support people in their development towards self-confident, self-determined and self-responsible living in freedom and in respectful and responsible coexistence.
3. Psychology as a science generates its findings based on humanities, social, and natural science models with scientifically recognized methods and controlled research strategies.
4. Theories and knowledge in psychology are based on different basic understandings of human beings. It must be taken into account in the interpretation and professional adaptation of individual approaches from different backgrounds." (https://www.dgps.de/index.php?id=85)

In ethics, there are three perspectives:

1. *Normative ethics* that deal with the basic norms of human behavior
2. *Meta-ethics* that correspond to the theory of science
3. *Descriptive ethics* that explain or describe moral phenomena in the concrete social space

The interaction of these three perspectives makes it clear that ethical responsibility cannot and must not only be relegated to science. This implies an important distinction for the field of the science of psychotherapy. Do we understand each other more scientifically or more humanistically? What implications does this have for the concrete ethical choices of the psychotherapist? In any case, it becomes clear that there is no such thing as "science." Instead, there is scientific localization. If psychotherapy/psychotherapeutic action wishes to understand and define itself as ethical, it refers meaningfully and necessarily also to science. To refer to this is always a personal/subjective decision and positioning; one relies, for example, on the scientific or spiritual-scientific perspective. Therapists always reveal themselves through this and reveal their values, ethical points of view, and attitudes to essential things. This aspect correlates with the basics of humanistic ethics.

In his book *Psychoanalysis and Ethics,* Erich Fromm distinguished between humanistic ethics and authoritarian ethics. In authoritarian ethics, an authority determines what is good for a person, while in humanistic ethics individuals determine what is good for them. If humanistic ethics focus on what is "good for a person," it can be concluded that humanistic ethics is the applied science of the art of living. Meta-science-wise, this touches on the need to deal with the theoretical science of humans.

Ethical Relevance of Touch in Body Psychotherapy

The following is a relevant example, especially in the field of body psychotherapy. It is about touch in a therapeutic context. In the 1970s, the German psychoanalyst Tilmann Moser described the space of psychoanalytic teaching analysis as a "contactless space" in which the teaching analyst suffers from lonely lack of contact. Moser, therefore, pleads for touch that is offered in a disciplined way and oriented towards the training of intuition, the therapist's self-awareness, and the model scenes of interaction between mother and child that have been highlighted in infant research.

Another essential feature of the EABP ethical guidelines is their specific reference to the meaning and relevance of touch in body psychotherapy (Young, eabp.org). Young, an expert in the mental health field, co-writer of the EABP ethical code, and member of various professional associations, is convinced that explaining the role and function of touch in psychotherapy is not influenced by a specific ethical or political agenda. His primary interest is to promote better considerations of professional, ethical touch in psychotherapy. His paper on professional touch suggests that it is important to ensure "that (i) we know what appropriate or ethical touch is, that (ii) we have a very clear idea what inappropriate or unethical touch is, and also that (iii) we be very clear and open with those we work with, those we train, and with our professional colleagues, about the times and the ways that we, or they, might transgress these boundaries. It is important to note that working in the field of body psychotherapy does not necessarily require physical contact or touching a client. This increased clarity need not constrain us as professionals from research or experimentation in the field of touch. It behooves us to carefully examine whatever boundaries we happen across and see whether the 'rules' in existence are still valid as blanket rules can be inappropriate in changing times and circumstances. In general, we do not truly learn significant things unless we make mistakes, and if we do have the urge to wander or experiment, then we must be sure that we can correct our transgressions quickly, with proper controls, like adequate training, clear awareness and self-awareness, and regular supervision or professional direction." (Young, www.eabp.org)

Young states that specific clarity is needed to avoid being like a sailor without a map or compass, sailing blindly into unknown seas in search of continents that may not even exist. He refers to the history of body psychotherapy in the last 50 years, calling to mind that for a long time, there was no clear common ground, at least in Europe, for what is appropriate: touch or ethical touch within the profession.

I personally cherish his openness and honesty, especially when he refers to the development of body psychotherapy over the last 50 years. It reminds me of the history and development of touch in psychoanalysis. Initially, there was touch, and nowadays touch is strictly no longer allowed.

In order to deal honestly with the topic of ethics in psychotherapy, it is necessary to have a clear view of the development of psychotherapy, body psychotherapy, and touch in psychotherapy and the surrounding context. This is also essential in order to develop an ethical understanding, which is not (only) based on normative rules. After all, it is precisely the development-related, always historically conditioned approach to the subject that is necessary.

The body-psychotherapeutic space, therefore, is a space of the possible, the allowed, and even the requisite touch. To fill this space carefully, sensitively enough and respectfully, i.e., ethically with life, could be a characteristic of the body-psychotherapeutic relationship with the patient.

Role and Function of Professional Ethics and Ethos

The better the acceptance in society of this occupationalization professionalization succeeds, the more likely it is that the professional ethics developed in each case will have an effect. Professional ethics can be understood to mean personal values that are important in the exercise of the activity. There is also the totality of the values and norms of the respective occupation, the profession, which are to be absolutely observed in its practice. Professional-professional behavior, goal-oriented behavior, but also the basic personal attitude of the active agents, the service providers, are oriented towards these professional ethical principles. Compliance with this behavior is checked by organizations, associations, institutions, educational establishments, and others in question and, if necessary, warned or even punished. In 1997, Cierpka postulated four additional criteria that characterize the psychotherapeutic profession:

- *Self-observation of the therapist*
  This includes the demand for a better understanding of one's self in order to achieve personal maturity, professional success, and adequate self-control. The psychotherapist can only help others heal if they are also concerned about their own health, in the sense of personal care.
- *Training and practice*
  Training and consecutive experience in practice change the treatment technique and, thus, the therapist's tools of the trade. However, these changes do not remain part of the "external nature." The experiences made in dealing with people also affect the therapists and lead to personal development. This is a lifelong process.
- *Person / personal needs of the therapist*
  This refers to self-reflection, integration, and corrective self-understanding. The means to ensure this are teaching therapy, supervision, the climate of ethical culture in one's professional organizations, and others.
- *Self-reflection*
  This refers to an examination of the various aspects of the profession. The psychotherapist refers to empirical research, the acquisition of professional and practical knowledge, and lifelong learning. Self-reflection is and always will be an active part of the discourse of professional ethics and personal ethos. According to Willutzki (1997), however, corresponding competence development is a constructive, not an instructive process that does not function like a Nuremberg funnel.

Behavior that is based on professional ethics is an essential aspect of the quality of the respective service, as well as a relevant factor in the social acceptance of it. Ethics is in a constant, discursive process and can never be conclusively defined. Many people who work in the field of "human work," therefore, experience ethics as the heart of the profession. On the one hand, such an impression results from the intensive and engaged arguments on the topic of ethics. If psychotherapy can be understood "as the art of understanding in a caring, helpful, interpersonal encounter" (Tibone, 2017), ethical guidelines act to protect the therapeutic relationship. In this respect, they create identity. Tibone, therefore, points out that the ethical guidelines of the DGPT[1] "usually do not list the prohibition of certain attitudes and behaviors, but rather create the positive picture of the desirable. ... Such ethical guidelines try to answer the question: "How can I treat well?' They appeal to the power of the ego ideal (a realistic ego ideal) and allow –- if they are really read –- a strengthening, positive identification, while the notion of prohibition awakens unconscious, very widespread fantasies of punishment, which can easily be followed by corresponding internal resistance measures" (Tibone, 2017). In my opinion, such an attitude reflects something that could be described as the "heart" of one's own "helping work." Ethics and self-commitment are to be distinguished from pure professional (service) action based on orders and carried out. After all, the basic ethical attitude "in and towards" one's activity is always implicitly an action designed for ethics. One can, therefore, also speak of a permanent ethical discourse, in which both the person, the service provider, and the organization as a whole must be included.

Foucault, on the other hand, finds more drastic words when he calls ethics a "battlefield." Thus, ethics is also something fluid and dynamic, i.e., behind every moral, there is an enormous conflict between different forms of arguing for the binding. (Foucault, 2018) Ottomeyer also sees this event as a territorial struggle in the background of the practical and economic perspective of the profession. "People who have completed a psychotherapy training want to secure their livelihood..., it has to be marketed; therefore, you compete on the psychotherapy market, and of course you have to raise your own school to support the aura of the special" (Ottomeyer, S 172).

In distinction to this, but also in personal expansion, the personal ethos can be seen and evaluated. In educational terms, ethos refers to the moral attitude of a person, a community, or a special social group (e.g., a service provider) in the context of one's professional activity. The Duden[2] defines ethos as "an attitude shaped by the consciousness of moral values or an overall attitude as ethical consciousness." Ethos can (must?) also be seen in contrast to professional ethics. While professional ethics, one could almost say, shows the ethical guidelines and regulates the handling of these guidelines, ethos is more in the "synonym field of morality, personal sense of duty, sense of duty, loyalty to duty, morality, sense of responsibility, morality." It thus also expresses itself as a professional "habit of living" as a basic personal attitude within the framework of professional activity.

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[1] (Deutsche Gesellschaft für Psychoanalyse, Psychotherapie, Psychosomatik und Tiefenpsychologie e. V.) German Association of Psychoanalysis, Psychotherapy, Psychosomatics and Depth Psychology

[2] Duden= Spelling Dictionary

The ethical guidelines of the European Association of Body Psychotherapy (EABP) are exemplary insofar as they were developed many years ago and have a clear and differentiated structure. The preamble defines the fundamental perspective, followed by different principles distinguished into general principles and specifications. The advantage of the EABP guidelines is the developmental background and intercultural communication. (EABP, Ethics Guidelines)

EABP represents many different psychotherapeutic schools in Europe and North America. In this respect, the differentiation of the ethical guidelines not only does justice to the topic in principle, but also offers a well-founded tool that reflects the fundamental orientation of an ethical procedure, as the result of years of communication and coordination, and implicitly encourages or requires the continuation of a clarification and coordination process.

Instrumentalization of Ethics in Power Discourse

Christof Stock (2019) offers, in his present guide for professionals in counseling and therapy, a kind of toolbox for the "practice of one's own occupation." After all, the relationship with clients is always a professional-personal one and therefore, also a legal one. Stock wants to describe, explain, and make useful the legal framework, which is to be pointed out. The development of occupations in the "field of helping work" leads above all to occupational associations, scientific societies, and occupational organizations, which, last but not least ,also serve to represent the interests of the profession. The more these occupational organizations, such as higher education institutes and occupational associations, develop in the therapeutic and advisory field, the more they are characterized by their dynamics, and the further the organization can distance itself "from the object of its work," the client/patient. Professional ethics, oriented towards the interests of the professionals as a professional group and those of the target groups, can act in the sense of a structural corrective, and prevent possible dangers. It includes, among other things, a discursive process of enhancing scientific rigor with a stronger inclusion of social science traditions concerning "helping work."

Hockel (1998) makes it clear, even before the Psychotherapists' Act[3] was adopted, that both medical treatment and the psychological psychotherapist are (rather medical) constructs. Humans and occupational groups create such constructs that are not primarily shaped by the target of work, i.e., the patient and his symptoms of illness. In this context, he explains that only doctors define what a sick person is. It remains open how the terms illness, medical, psychotherapeutic treatment, and "what needs treatment?" are developed in the sense of psychotherapy guidelines. The extent to which the specific interests of patients are taken into account as independent issues within the framework of psychotherapy guidelines has been the subject of constant discussion since the Psychotherapists' Act came into existence, and the construct

[3] The Psychotherapists' Act was adopted in Germany in 1999, and it regulates the role of psychotherapists, the legal frame of occupation as well as the role and function of the professional (self-) organization. This Psychotherapists' Act doesn't regulate psychotherapy, but the role and function of the psychotherapist.

mentioned above has conditionally been questioned. Such discourse represents an essential corrective to the implicit power dynamics in the field of psychotherapeutic activity, training, and development.

In this context, Hockel refers to the difference between psychological and medical expertise. This difference certainly exists, and logically should also lead to a different professional ethical viewpoint. At this point, I will refrain from going into this positively useful discussion about who is entitled to practice medicine and how. If such a discourse reflects factual and ethical aspects on the one hand, it is, on the other hand, a means/instrument in a power discourse as well.

Therapeutic institutions and organizations such as training institutes are discursive places of power. Therapeutic training institutes are like a system that "contains such high oedipal gratuities, as soon as one has penetrated to the –- as Kernberg (2007, p. 186) calls it – power elite ... that it is equal to a direct satisfaction of the oedipal phantasm. It is very difficult to question the system itself from the position of this gratification." (Zagermann, p. 12) Kernberg even speaks of a "self-engendering," "self-proclaimed," and "self-preserving power elite" (Kernberg, 2006, p. 161; 2007, p. 186, cf. also Sollmann, 2008).

Thinking of multiple explorative relations that one has, he or she has to refer to the dimension of "power; duration of the relationship; and clarity of termination. Power can vary considerably across different persons and contexts and refers to the discrepancy between the status, influence, and control of a psychologist and his/her clients, students, and supervisees. Assuming that power increases over time and throughout the course of a relationship, the duration of the relationship in question is an important factor in assessing the potential for exploitation. Clarity of termination refers to the specifics of the agreed-upon termination, and prospect of whether there will be further professional contact at a later time." (Gottlieb, 1993)

There is another specific aspect that is connected primarily to the field of counseling and supervision. Often the counselor or supervisor works in a multiple-relationship-system. This requires a special responsibility of care, because the network of relationships in the respective organization and the system as a whole must also be kept in view or addressed by the advisor/supervisor. It also includes the different roles someone is responsible for and the variety of role-relations.

"Multiple relationships in counseling supervision is a complex issue that involve role conflicts, power differentials, and various ethical considerations. These relationships, however, are not always controversial and can prove beneficial if a counseling supervisor is aware of the power differential in the relationship with a supervisee. This is a dynamic topic that asks counselors to consider how this relationship may ultimately impact clients." (Heuer)

Possible role problems related to such relations occur in group therapy, marital and family therapy supervision, academia, and if a therapist has outside relationships with clients. The relationship between therapist and client is quite difficult to assess, as it contains professional elements, transferential elements, and perspective-oriented aspects. Or, simply aspects of meeting the client by chance in the street.

Considering this complexity of possible problems, it becomes clear how difficult it will be to deal with such a potentially ethical incident. It also shows how vital joint analysis, clarification, and opinion-forming are in addressing an ethical case. It is critical, as emphasized by the above, for the elements of power to be involved. This can manifest itself in the immediate therapeutic relationship. It can express itself simultaneously in particular, possibly unethical, shaping of different role relationships, but also in the way in which a therapeutic (training) organization is set up either in a transparent, open, and (self-)critical matter, or not.

The necessity of addressing such power relations within the framework of professional ethics is reflected in the logic of professional ethics itself, but also makes systemically clear the paradox that exists in such an organization. Can and should this be applied not only to the therapist-patient relationship, but also to how the respective professional organization applies professional ethics to itself? Therefore, an important yardstick for the implementation of professional ethics is, one might say, the ethical climate or culture within the organization itself. It makes the application of professional ethics possible or more complicated, and is on a permanent discursive test bench due to professional ethical incidents. "Because of the real existing power gap between teacher and student, the education system in all psychotherapeutic schools is a gateway for the establishment and permanent establishment of abuse of power. ... It only becomes problematic if the training methods force infantilization and regression, and the abuse of power is institutionally anchored." (Wirth, 2007)

Zagermann, therefore, believes that it is an illusion to think "that the individual could evade this unconscious dynamic of the institution in which he finds himself." (Zagermann, S, 16) Whether an organization/institute/association has abused or anchored its power is reflected, on the one hand, in the statutes and structure of the organs in the association. Even if nowadays ethics committees are an integral part of the organizational structure as a rule, they often embody to the greatest possible extent the basic orientation of professional ethics. On the other hand, in rarer cases, there are rather only basic remarks on the process of dealing with ethical guidelines, and hardly any arbitration or mediation committees. Democratic structures in society and politics make a clear distinction between the legislative and executive branches. If this does not happen in a training institution or a professional association, abuses of power are potentially structurally anchored. At this point, I do not want to go further into specific dynamics of the abuse of power.

From a psychoanalytical and organizational point of view, one can also understand what happens in a psychotherapeutic organization in terms of the self-idealization of the functionaries. One of the roots for this is "... the ambivalence of the idealization, of the person ... (of the school founder, the author) who consequently withdraws this idealization through a collective identification with ... (the school founder, the author), which leads to the self-idealization of ... (the person responsible for training, the author) as the guardian of the true teaching and the pure gold of ... (the respective psychotherapeutic method, the author). This is about the longing for the appropriation of the creative capacity of the founder of the ... (own psychotherapeutic school, the author) and the appropriation of the father's phallus with all the aggression

contained therein directed against the father." (Zagermann, p. 28) Unfortunately, it is not possible for me at this point, although this is appropriate, to respond to specific dynamics of the abuse of power.

"Helpful Work" in the Field of Tension between Service, Successful Occupationalization, and Reflexivity

"Helping work" with people is counseling, therapy, psychotherapy, coaching, supervision, or mediation. In the meantime, a promising, successful, but also lucrative service sector has developed, which is used by more and more people. If the work, and by this I mean the "helping work" with people, was initially based on a specific, often personally supported motivation, it has differentiated, become more specific, and technically substantially developed over the last 30 years. In the beginning, it was personal initiative, individual commitment or the work of educational institutions to professionalize "helping work," to justify it scientifically, and test it or make it verifiable, but the way was paved for what could be called occupationalization.

As I said before, occupationalization is characterized by, among other things, scientific validation, institutionalization, and expertise. Especially in the field of "helping work," positive professionalization has developed to the extent that in many cases a social scientific orientation and an increase in reflexivity have become visible, or a leading paradigm. The sociology of professionalization therefore says, and this applies in particular to "helping work," that the fact that psychology can no longer claim to offer an objective and reliable truth, but at most a plurality of transient truths, can compel one to reflexivity, which is guaranteed precisely by the social sciences. One can regard the development process of qualification, occupationalization, professionalization, and the development of professional ethics as successful, even if in individual cases there are quite different approaches that have developed in the fields of counseling, coaching, psychotherapy, and supervision. They can only be compared to a limited extent. Structurally or sociologically, however, they are subject to a similar dynamic.

This is also mirrored in the field of psychological science. One can again take the policy of the German Association of Psychology as a basic guideline:

> Freedom of science and social responsibility
>
> 1) The fundamental right to freedom of science (Article 5, para. 3 of the Basic Law) imposes on psychologists engaged in research and teaching responsibility for the form and content of their scientific work. The fundamental right of scientific freedom is formally unrestricted.
> However, it finds its limits where other fundamental rights are violated.
>
> 2) The freedom of research from heteronomy guaranteed by the Basic Law shall at the same time be understood as an appeal to the moral responsibility of psychologists working in research and teaching to promote democratic forms of work within the scientific community. New questions, approaches, and methods must be examined impartially, regardless of their origin.

> Psychologists who are working in research and teaching endeavor to take appropriate account of all available information and counterarguments already in the research process. They are open to criticism and willing to question their findings consistently.
>
> If research projects are subject to formal ethical approval, psychologists provide precise information about their research project.
>
> Psychologists inform the participants in their research as soon as possible of its aim, results, and conclusions. They take appropriate steps to correct any misunderstanding that the participants may have and are aware of.
>
> Where scientific or ethical considerations justify delaying or withholding such information, psychologists shall take appropriate measures to prevent or minimize any harm or risk.
>
> …..
>
> Psychologists do not present work or data other than their own, even if this source is quoted." (https://www.dgps.de/index.php?id=85)

Determination and Implementation of Ethical Guidelines

The need to develop and define professional ethical guidelines arises from the special need to protect the people being helped, be they clients or patients. "Comparable to the situation between parents and children, patients are entrusted with their care and are therefore also largely unprotected against abuse of psychotherapeutic power." (Schleu, 2018) However, it also emerges from the potential and/or structurally conditioned danger of the abuse of power in organizations. Finally, the need also arises from the fact that the persons involved are in some cases in complex dependency relationships. It is how one meets as a colleague, as a trainer, as a certifier, as an ethics officer, etc. The possible danger of narcissistic abuse of power, as well as role diffusion or overlapping, can, in principle, be counteracted by professional ethics. However, this can also be seen as an expression of the general defense against ethical discourse. (cf. Tibone, 2017)

One is the opinion that it would be sufficient to have ethical guidelines. If the ethical body of rules then lacks information on implementation, application of the guidelines, or on the structure of the procedure, there is concern that the ethical guidelines thus formulated will seem more like an announcement. A specific form of concrete defense in individual cases can be the behavior of members, namely "preferring not to learn anything about the cases and to have to vote on them at all, but to leave the decision to the board or the arbitration commission (the author: insofar as there is an arbitration commission) itself." (Tibone, 2017) In principle, one can understand such a pattern of behavior as arising from the unconscious imagination "ethical principles and legal norms would ... be superego norms to be rigidly combated." (Tibone, 2019) It also seems to be part of a great narcissistic fantasy that can be understood as an expression of one's own powerlessness in the occurrence of severe boundary violations.

The reflections of Richter (1963), Schmidbauer (1977) and Willi (1975) on the specific role relationships, diffusions, and collusions point to two typical (helper) role types. "Either the therapist seeks a substitute in the patient for an aspect of his own self (narcissistic projection), or he wants to urge the patient into a role of being a substitute for another partner (transference)." (Wirth)

In principle, it seems as if these role types could also be transferred to organizational relationship patterns. If such a role dynamic serves to stabilize the therapist's fragile self-esteem through admiring dependency, one could fear that many dependency relationships, especially in educational institutions, embody a special form of organizational dependency.

Possible differences in the formulation and design of these ethical guidelines are due to the particularities of the respective occupational group, the respective professional association, or the specific training organization or the respective level of professionalization. On closer examination of the established ethical guidelines, however, two aspects stand out, as already mentioned. On the one hand, there is often no detailed definition of implementation rules, namely a procedure for dealing with violations of the ethical guidelines. On the other hand, quite a number of professional groups, associations, and institutes find it difficult to apply and implement the ethical guidelines in practice when they are applied to individual cases. There are various reasons for this. I would like to briefly mention a few of them at this point:

- The circle of relevant, interrelated persons within the scope of the established ethical guidelines of an institute is so small (one is so familiar) that there are no representatives who would have sufficient distance, neutrality, and objectivity for the professional application of the ethical guidelines.
- The drafting of ethical guidelines, but also their implementation and handling, can often collide with internal (power) dynamics in the respective association/institute/profession. The procedure for dealing with ethical guidelines then rather reflects power interests that are expressed in the respective procedure/handling of the ethical guidelines.
- Even if there are ethical guidelines, perhaps even references to the procedure or effects/consequences, the respective ethics committees have no arbitration function. Ethics committees then tend to have a subordinate function, or fulfill orders from the superordinate (power) committees in the respective organization. It is an explosive dilemma at the latest when the higher-level body itself is part of the ethics case.
- Even if at best the ethics committee and the mediation committee are anchored in the organization's infrastructure, specific difficulties may still arise in individual cases. If no relevant solution/arbitration can be found in addressing specific ethics case, there are no regulations as to how to proceed. Which instance is then addressed, which next higher function can then help? In my opinion, the corresponding responsibility to deal with such exceptional cases must be structurally pre-defined.

"Helping Work" and Dealing with Legal Provisions

Occupationalization and professionalization, or legal regulation of professional activities, absolutely requires a legal orientation. It is reflected in the basic orientation, in a specified guideline, but also in concrete tools, in application-related toolboxes.

Christof Stock's book, Rechtlicher Leitfaden für Beratung, Therapie, Psychotherapie in humanistischen Verfahren,[4] is a concrete, pragmatic, meaningful and relevant guide. Whereas in the past, according to Stock, when there was "sand in the gearbox," one could perhaps get everything running again with a "screwdriver" or a little common sense, today it is more appropriate to go to a specialized workshop. So, why, one might ask, should one concern oneself with legal questions, even if the law seems to have become so complicated that it would perhaps be better to consult an attorney?

Stock addresses those "human-workers," as I would like to call people who are active in helping, namely those who are active in the field of counseling, therapy, and others. This activity presupposes knowledge of where one stands as a service provider.

The relationship with clients is a professional-personal and thus also a legal relationship. In the background, there is always a legal framework to be pointed out and explained. Taking this into account is not a voluntary service, but an obligatory, binding and, if necessary, legally enforceable service.

In the first part of his book, Stock describes the legal bases on which consultants, therapists, or other professionals operate. In the second and third sections, he deals with the legal position that can be taken by an employed person in general, or in a specific occupational field. Understandably, there are apparent differences in the consulting field, in the therapeutic field, or in the psychotherapeutic field.

In the fourth section, Stock deals with the relationship between the "human worker" and the client/patient. It is, of course, characterized by trust, good chemistry, and personal circumstances, but also by certain obligations. Stock explains in detail what it means and, above all, how one takes into account how to satisfy the information requirement, how to observe confidentiality, how to guarantee digital communication, how to comply with the abstinence requirement, and other issues.

The fifth section refers to the surrounding context, the health and social system, where one learns about triangular and quadrangular relationships "which can make their contribution to the financial security of employment." Finally, in the appendix, Stock offers sample texts that can be used as a legal toolbox.

In a nutshell:

[4] This legal guideline for counseling, therapy, and psychotherapy in humanistic processes refers only to the German situation, and yet most of Stock's proposals can be helpful to colleagues in other countries. The structure of Stock's book can be transferred to other areas. The concrete legal provisions of each country would then need to be added.

The book fills a clear gap in the context of the professionalization of psychotherapy, coaching, and supervision. It is a careful, detailed, clearly understandable, and experience-based book on a topic that is usually only neglected in training and practice. Stock is a proven connoisseur of the subject, having been involved for more than 25 years with the legal questions of the profession, including ethical questions in particular. His experience before all German courts, up to the Federal Constitutional Court, is reflected in the thoroughness and comprehensibility of his remarks. I highly recommend this book; it is a must for the practice of every colleague.

General and Discursive Ethical Guidelines

Stock also quotes the ethical guidelines of the German Association for Gestalt Therapy. He emphasizes how important it is to develop ethical guidelines, but also to give the ethics committee an arbitration function. It becomes complicated when role conflicts arise. In order to maintain the necessary objectivity and distance, members of the ethics committee should not have any further function in the association. Furthermore, they should have no further role relationship with the persons concerned, be it through (previous) training or specific project work; if necessary, external experts would have to be called in.

On the other hand, professional regulations, laws, and ethical guidelines of a professional organization may collide. It is particularly the case if, for example, a training institute operates on a national level, but at the same time also as an affiliated or accredited institute on an international level. The latter would be expressed in the fact that there is, for example, a European or international company that develops and controls the training curricula and awards accreditation for local or regional institutes after qualified examination of a corresponding application. What should be done in such a case? How could possible collisions be addressed between ethical guidelines and their possible impact on the accreditation/licensing process?

Finally, professional ethical guidelines, in the sense of ethical goals, can have a concrete effect only if concrete criteria for achieving these ethical goals have been formulated. These can be of a general nature (e.g., prohibition of sexual relations with patients/clients). However, these should always be formulated concretely enough. They must make sense in relation to the corresponding professional context, and must also be achievable or feasible. If one understands the role and function of professional ethics in this sense, then constant review, redefinition, and change are required in order to be able to adjust to the changing social and professional realities in a process-oriented manner. What was frowned upon or even prohibited some time ago, or earlier within the framework of professional ethics, can change over time into a reorientation in line with social development. For example, in the past, the therapist may have given the patient a hand to greet him during the first conversation, only to say goodbye a second time with a handshake in the last therapy session. So today there are quite different forms of greeting. Some do it like the therapists used to do it, and others perhaps greet each other with a hug. Some say "you" to each other, and others stay with the "you" in the mutual address.

Ethics in the field of "helping work" therefore consists of indispensable, unchangeable, fixed policies (e.g., no sexual relationships), and others that have grown out of the concrete social and cultural development in each case. Finally, some codices have a processual effect in individual cases.

Beauchamp and Childress formulate six ethical principles for the permanent, fundamental ethical guidelines. They serve as a basic orientation. In addition to the "principles of respect for autonomy, care, equality and justice, truthfulness, confidentiality, this also includes the principle of non-harm." (Schleu, p. 16) In this respect, the requirements of professional law and professional ethics go beyond the rules of the Penal Code.

The principles formulated by Beauchamp and Childress must be concretized and weighed against each other in each individual case. Thus, for example, the principle of damage avoidance in the sense of refraining from harmful interventions may conflict with the principle of social welfare. Interventions could play a role as harmful interventions, which should, of course, be avoided, especially in the case of "intervening therapies." However, damage can also be caused in economic terms by the fact that psychotherapy can last longer than professionally indicated. Such relationships are tantamount to dependency relationships, which are not only malpractice but also a violation of ethical principles.

When we think about an unethical sexual relationship in psychotherapy, one has to refer to:

- Unethical sexual relationship in psychotherapy or supervision;
- Sexual harassment in psychotherapy or supervision;
- And/or erotic or sexual attention or intimacy (Bartell, 1990) or sexual boundary violations. (Koenig, 2004)

It is part of the topic because psychotherapy and supervision can implicitly touch unwelcome and offensive erotic feelings. Sexual harassment refers to unwelcome sexual attention in the workplace, including offensive comments about one's sexuality or women or men in general. Legally, harassment is defined as occurring when unwelcome sexual attention is "so frequent or severe that it creates a hostile or offensive work environment or when it results in an adverse relationship." Further on, sexual harassment can also be defined as "sexual solicitations, physical advances or verbal and nonverbal conduct that is sexual in nature that occurs in connection with the psychologist's or psychotherapist's activities or roles and that it is either unwelcome, offensive or creates a hostile situation." (EEOC, 2015)

Referring to this ethical topic is essential to point to this clearly enough in the ethical guidelines. Handling an ethics case under this perspective is very difficult and needs a clear procedure in the therapeutic organization. It should specify how to deal with ethical cases and how to communicate so that this is based on trust, transparency clear and well-grounded role acting and the commitment to mutual communication and mediation as a possible means of choice.

The accusation of erotic and sexual harassment must be sensitive enough, personally respectful, but also meaningful in relation to the social and cultural view of gender and the corresponding cultural handling of it. Like many other ethical issues, it poses an exceptional challenge.

Hierarchy of Ethic Codes

Ethics codes in the (body) psychotherapeutic field are an expression of professional self-commitment. Ethical rules reflect fundamental values that play a role in work. They regulate the therapist-patient relationship, but also collegial relationships within a psychotherapeutic (training) organization. At the same time, ethical guidelines reflect social development that is shaped and controlled by law and jurisprudence. This social development is at the same time based on universal, humanistic values, the observance of which is not, or not sufficiently, guaranteed by law. It can thus lead to overlaps between ethical guidelines and law and order. However, there are also apparent differences, or differences in treatment, concerning violations of law and order on the one hand and ethical guidelines on the other.

Democratic societies make a meaningful distinction between the legislative, executive, and judiciary. Such a structure ensures the development and decision-making of legal norms, and their enforcement or sanctioning when disregard or abuse occurs.

Sociologically speaking, social organizations such as body psychotherapeutic organizations should also have such a separation of powers. It might include a functional unit that takes care of the development and further refinement of ethical guidelines, a functional unit that guarantees a professional process in case of violations, and finally, a functional unit that ensures the implementation of (possible) consequences/sanctions. The last two functional units can be governed by the same body. In any case, the first must be separate from the other two. (Body) psychotherapeutic organizations usually have an ethics code. This code is differently weighted, specified, and updated. Not every therapeutic organization has an ethics committee, i.e., a functional body, which can be addressed in case of suspicion of non-compliance with the ethics guidelines to examine the matter. Finally, in most organizations, there is no written explanation about possible consequences, sanctions, etc.

Body psychotherapeutic organizations, at least in Germany, which are organized in the German Society for Body Psychotherapy (DGK), have internal institute ethics guidelines, as well as through the DGK, Germany-wide valid ethics guidelines: https://koerperpsychotherapie-dgk.de/ethikrichtlinien/

They may overlap or differ. The DGK has no ethics commission. However, because it is the opinion that one is structurally and historically in such a way connected in the body-psychotherapeutic field in Germany that representatives of the DGK could not ensure impartial treatment of ethics cases. The DGK therefore forwards possible ethical violations to the Ethics Commission of the European Association of Body-Psychotherapy (EABP): https://www.eabp.org/ethics.php. This committee deals with the cases presented.

The Ethics Committee of the EABP is independent. The members have no other function within the EABP. It is independent of the EABP. There are also some possible consequences and sanctions that can be applied. In America, there is a similar structure with the US Association of Body Psychotherapy (USABP https://usabp.org/USABP-Code-of-Ethics) with a significant addition. If there are substantial differences in the ethics guidelines in a member organization compared to the ethics guidelines of the USABP, the higher-level ethics guidelines of the American Psychological Association

(APA) would be consulted. These are very differentiated and practical. (https://www.apa.org/ethics/code/) There is an independent ethics committee, and there are concrete, possible consequences, sanctions listed that can be used.

The ethics guidelines of the EABP and the USABP also clearly refer to the collegial, professional relationship of colleagues within the organization. It could be understood as an effort to apply the ethics guidelines to the organization as an organization. "Organization" then means the structure and relationship processes of people within the organization.

If I have understood the ethics guidelines correctly, this also includes the ethically responsible behavior that must be guaranteed by the teaching trainers and teaching therapists within the framework of the training. It also implicitly means that there is already an ethical violation at the organizational level if there is an irresponsible (non-transparent) mixing/collusion of roles. For example, a teaching therapist cannot be involved in the certification process at the same time. If this were the case, it would be an unethical mixing of roles. DGK and EABP also seem to have this in mind and include this in the treatment of possible ethical cases. So, there is the ethics code of a particular therapeutic organization. Then, there is a hierarchy of ethics codes (e.g., a single organization related to DGK and DGK related to EABP). The treatment of possible violations will necessarily also have to be carried out from the perspective of the hierarchization of ethics codes.

One aspect seems to me to be missing from the ethics guidelines. It refers to the structure and application of the training curricula. Such curricula are developed individually by the institutes. Within the framework of the umbrella organization of DGK, however, they are also reviewed and modified so that a cross-institute curriculum is created. Above all, the application/implementation of the curricula in the respective institutes is, of course, implicitly also based on the ethical guidelines.

In conclusion, the structure and procedure/process of implementing the curricula must be monitored at regular intervals or subjected to an auditing process. It would amount to an ethical duty of care. In Switzerland, for example, there is such an auditing process that takes both the general criteria and values into account, but which also keeps an eye on respective developments and applications, especially with regard to any new social conditions that may arise.

However, such auditing/controlling cannot and must not be carried out by the functional units responsible for the course. The functional unit responsible for controlling and auditing must be independent, similar to the Ethics Committee.

Epilog

Becoming a psychotherapist is a personal career choice. The activity relates to the concrete needs/problems of the client and takes place within the framework of professional diagnostics and indication. This activity is also embedded in a legal as well as organizational-institutional framework.

Professional ethics shapes the character of the respective ""helping work" in the therapist-client or client-consultant-relationship or the relationship of colleagues within the organization. Also, ethics determines the role, function, and meaning of the activity carried out in the organizations/institutions developed within the framework of the profession.

Finally, ethos characterizes the personal attitude/conviction of the people working in the field of "helping work."

The current debate about professional ethics and the concrete implementation/application, therefore, currently represents a central, significant challenge for each individual. To face this challenge is a permanent characteristic of one's professional activity. It accompanies one concretely, every day in the therapy/consultation process. It also corresponds to an implicit demand within the field of "helping work" to live this together with others in discourse.

Only if it is possible to develop a consistent theory independently of the founder of the school, which then triggers its own dynamic of development according to its implicit logic, can the school expand further on the subject level.

That is why psychotherapeutic organizations are considered to be the best in the relationship with the founder. Only if it is possible to "kill" the founder will the former students become adults and capable of learning. (Simon, 2008, p. 193) Psychotherapists should not lose sight of this dynamic. To face it processually seems to be both a categorical imperative (Kant, 2011) and an ethical one (von Förster, 1993).

Ulrich Sollmann, *Dipl. rer. soc., is a Gestalt-und Körperpsychotherapeut (Bioenergetic Analysis), coach and consultant for executives in business and politics, publicist, author, lecturer, and blogger. He is guest professor at Shanghai University of Political Science and Law. He has been working and publishing internationally for many years, including in China (ethnological research approach). His work currently focuses on infant observation and the development of body competence and on questions of ethics and professionalism.*

Contact:
Dipl. rer. soc. Ulrich Sollmann
Guest Professor at Shanghai University of Political Science and Law
Praxis für Körperpsychotherapie und Coaching
Höfestr. 87
D-44801 Bochum
E-mail: info@sollmann-online.de
www.sollmann-online.de

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Judyth O. Weaver

SOMATIC MEDITATION 3

As you hold this object and look at the material, of what are you aware?

How are your eyes now?
Have you been using them a lot?
Do they feel tired?
Can you allow your eyes to close, to rest, to be soft?
Can you give up the action of looking now,
and just allow yourself to see?

Staying with this as long as you want, how does it feel?

How is your breathing?
Does closing your eyes change your breathing?
Does it change your posture?
Do you notice it changes anything else in you?

How do you sense yourself now?

BODY PSYCHOTHERAPY SCIENCE AND RESEARCH

Trauma Research and Body Psychotherapy

Herbert Grassmann

New study conducted by Stephen W. Porges, PhD of the Kinsey Institute Traumatic Stress Research Consortium in cooperation with the EABP Science and Research Committee

The EABP Science and Research Committee (SRC) is partnering with researchers from Indiana University on a study of body psychotherapy practitioners, their personal histories, current stressors, and health.

In Europe, the study is being conducted by Jacek Kolacz, PhD and Stephen W. Porges, PhD of the Kinsey Institute Traumatic Stress Research Consortium (TSRC) in collaboration with Herbert Grassmann, PhD and Biljana Joki , PhD of the EABP SRC. In the United States, USABP collaboration is under the direction of Dr. Christopher Walling and the TSRC Advisory Board. The research is financially supported by the EABP; the Traumatic Stress Research Consortium is funded by gifts from the USABP and its donors.

All body-oriented psychotherapists/practitioners are invited to take part in the survey.

The study will help better understand how body psychotherapy is applied. It will include research among psychotherapists from other modalities in order to develop a clearer understanding of body psychotherapy practices and their application. By examining body-oriented approaches and comparing them to other approaches, the study will promote body psychotherapy and increase its visisibility to broader audiences.

The aim is to broaden the knowledge of embodied approaches to trauma therapy by connecting clinical practice and research communities. Together we will explore how a collaborative practice research network can transform perceptions of trauma research, strengthen connections among members, and encourage ongoing development and co-creation among participants.

This important initiative is an opportunity to make a significant difference within our profession and to develop—together—the foundations of scientific and clinical research.

The results of this survey will be presented at the next EABP Congress in Bologna in 2020. To reach a wider audience, the publication of a paper in a scientific journal is also planned.

To participate in this exciting **Collaborative Practice Research Network,** please contact us: **EABP:** *info@dr-grassmann.de,* **USABP:** *drchris@somapsychology.com*

Herbert Grassmann, PhD
is Chair of the EABP Science and Research Committee.

BODY PSYCHOTHERAPY AROUND THE WORLD

Body Psychotherapy in Australia

Ernst Meyer

ABSTRACT

Somatic psychotherapies emerged in Australia in the late 1970s, and training programs and professional associations were established from the 1980s onward. Although the field was well established, no umbrella association was formed to bring the different approaches together. The role of somatic psychotherapy in Australia diminished as disputes eroded the field from within, while external financial pressures made training delivery and private practice less viable. To give the field a platform to regroup and remind itself and others of its value, establishing an association dedicated to somatic psychotherapies is currently being considered.

Keywords: somatic psychotherapy, Jeff Barlow, Australia, the tyranny of distance

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Background

Somatic approaches to psychotherapy have a long history in Australia that, to my knowledge, is yet to be told. This article is an attempt to do just that in a condensed format.

I entered the field only a decade ago, and did not witness most of the events and developments. I have therefore relied on first- and second-hand accounts, for better or worse. Not all the major players were approached to contribute to this article; nonetheless, I hope it is sufficiently accurate and concise. I also hope the article highlights the contributions various individuals and organizations have made to the field of somatic psychotherapy in Australia.

Geography

To fully appreciate the challenges of somatic psychotherapy in Australia, one has to understand its geography. In his book *The Tyranny of Distance: How Distance Shaped Australia's History,* Geoffrey Blainey (1966) discusses the impact geographical distance and remoteness had on Australia as a nation. More than 50 years later, this distance from the outside world is still felt in many aspects of everyday life.

The tyranny also applies when traveling from one part of the island continent to another. The distances and travel times are still quite astonishing from a European perspective; flying from Sydney on the East coast to Perth in the far west takes five and a half hours, while traveling from the very south (Hobart in Tasmania) to the very north (Darwin in the Northern Territory) takes five hours.

Furthermore, those who live in Sydney and its outskirts also feel the tyranny of distance. About the same size as London or New York, and more than twice that of Berlin, it is a city that is difficult and time-consuming to navigate, and a two-hour one-way commute to work is not unusual.

Regardless, if a practitioner travels overseas to a conference, interstate to a workshop, or within Sydney to a supervision session or practice room, getting there is often not straightforward. It means that somatic psychotherapists in Australia do not often get to see their friends and colleagues, and tend to go about their professional lives in isolation.

The Arrival of American Traditions

Despite the geographical remoteness from the U.S. and Europe, somatic approaches to psychotherapy arrived in Australia from the late 1970s onward. This was due to the resolve, passion, and sacrifice people made to establish the various modalities.

Core Energetics

Robert Kirby brought Core Energetics in the late 1990s. The first Core Energetics training under the umbrella of his Australian Institute of Core Energetics opened in 2000. The logistical challenges were considerable for teachers and students alike. The trainers came from the U.S. (one being John Pierrakos, the founder of Core Energetics), while the students alternated between Western Australia and New South Wales throughout the training; one can only marvel at their dedication and passion.

After the institute shut down, the Core Energetics tradition moved to Queensland, where, since 2011, Andrea Alexander's Institute of Body Psychotherapy has carried it forward. The next three-year training starts in February 2020.

Hakomi

Hakomi arrived in the late 1980s when a few workshops were presented, followed by the first three-year training in Melbourne in 1997. Since then, trainings have been offered regularly in Perth and Sydney.

The training staff was initially from the U.S., with the intention of training Australians and becoming independent. Today, workshops and trainings are presented by senior U.S. trainers, as well as by teachers and trainers from Australia and New Zealand. The Hakomi community organizes all events locally.

At the moment, Sydney and Perth are the training centers for Hakomi in Australia, but there are also workshops offered throughout the year in Melbourne, Brisbane, and Adelaide. Until recently, the Hakomi Professional Training in Australia was offered as a three-year program, and it was mainly suitable for people in allied health professions. However, to make Hakomi principles and techniques more widely available, the Australian training is now offered as a three-level course, the first level being a stand-alone course suited to a wider population.

Radix

The Radix tradition goes back even further. Between 1977 and 1979, Lara Amber and Roger Andes led workshops in Adelaide, South Australia. This prompted Jacqui

Showell and Narelle McKenzie to move to the U.S. in late 1980 to train in Radix. They completed the first year of training but found it difficult to get a work visa, so they returned to Australia and brought trainers to Adelaide and Melbourne to continue their training in 1982. They completed their training at the end of 1982, established a joint private practice in Kensington, South Australia, and began offering regular individual work and weekend workshops.

In 1984, Charles Kelley, the founder of Radix, invited Narelle and Jacqui to become trainers. Under the supervision of Bill Thrash, then Director of Training for the U.S. Radix Institute, Radix training in Australia commenced in 1987, and was offered as a national program with workshops and trainings in Adelaide, Melbourne, and Sydney. The Australian Radix Body Centered Psychotherapy Association was established in 1988 so that the first trainees could belong to an association.

Initially, the Radix training was two years long. It then expanded to three years as the content and focus of the program developed. Recently, the decision was made to make the training available in modules, which can be taken by themselves or can lead to certification as a Radix practitioner.

The Sydney and Melbourne (Dis)Unity

In the 1980s, Gerda Boyesen's biodynamic psychology method arrived in Australia. Jeff Barlow, originally from Victoria, had been working as a psychotherapist since 1977 when he opened his private practice at the Gerda Boyesen Centre in London. Jeff was actively involved in the first training programs in body-inclusive psychotherapy in the late 1970s in London, Germany, and Austria. He returned to Australia in 1981 and established a private practice in Melbourne, where he continues to work.

In 1983, Jeff started the first workshops and training programs in what was initially called biodynamic therapy with Robyn Lee Speyer, another Australian who trained through the Gerda Boyesen network, and joined Jeff's training program.

At about the same time, in Sydney, Tony Richardson, Daniel Weber, and Julie Henderson offered somatic workshops and trainings. There were probably other individuals the author is not aware of. A Neo-Reichian tradition emerged, and in the 1980s, a training institute was established, which later became known as the College for Experiential Psychotherapy.

Around that time, both colleges offered training in Sydney and Melbourne. When the Australian Association of Somatic Psychotherapists (AASP) was formed in 1986, practitioners had a professional home, and from 1987 onward, the AASP offered training in somatic psychotherapy under the directorship of Jeff Barlow. All seemed to be developing well, but trouble was just around the corner.

Four Significant Splits

The first split occurred at the association level when the AASP was "confronted with ethical complaints against some foundation members by patients. [...] Some practitioners, at the more extreme body-work/humanistic end of the spectrum, left or were expelled from the association when they could not comply with the developing ethical requirements." This "baptism by fire" (Ball, 2002, p. 94) had far-reaching

consequences for the association. AASP members left to form a second association, the Australian Somatic Integration Association (ASIA), founded mainly for Sydney-based practitioners who no longer felt at home at the AASP. Other somatic practitioners sought out a more a psychoanalytic professional environment.

The second split impacted the delivery of training when the marriage between the AASP and Jeff Barlow came to an end. In the early 1990s, after a dispute between the executive and training committees, the AASP stopped offering training. In response, Jeff Barlow, Marianne Kennedy, and Timothea Goddard formed the Somatic Psychotherapy Institute of Australia (SPIA), and from the early 1990s onward offered training in both Melbourne and Sydney for several years.

The third split occurred when the SPIA became interested in new developments such as Kohutian self psychology, neuroscience, trauma theory, and infant research. These developments added an empathic and scientific interpretation to their training, particularly in Melbourne and Sydney, while it can be argued that the original Sydney training continued to be more body-focused.

The fourth split occurred when SPIA broke into two halves. While SPIA stopped training a few years later, from 1997 onward, Jeff Barlow established the Australian College for Contemporary Somatic Psychotherapy, which offered training in both Melbourne and Sydney. and, for a short time, Canberra.

Nails in the Coffin

These splits kept students, practitioners, training institutes, and associations apart personally, theoretically, practically, logistically, and geographically. In 2011, when the AASP and ASIA finally merged to become the Australian Somatic Psychotherapy Association (ASPA), the damage had already been done, and the union was short-lived. The ASPA disbanded in 2016. In 2017, members transferred to the somatic psychotherapy branch of the Psychotherapy and Counselling Federation of Australia (PACFA).

In addition, in 2011, when the Australian accreditation process for diploma-level courses was changed, it became too costly for Jeff Barlow's training institute to continue. The last training group graduated in 2015, and with it, a 30-year tradition came to an end.

Finally, in 2018, PACFA changed the training requirements for the profession. It meant that practitioners who hold only a diploma-grade qualification, without a relevant degree, no longer meet the requirements for full membership in the association. As a consequence, the experiential multi-year diploma courses are no longer sufficient as a foundation for clinical practice. Psychotherapy officially went academic.

Existential Crisis

The current state of affairs in 2019 is that only Radix, Hakomi, and Core Energetics offer long-term training programs, and only Radix and Hakomi practitioners can register as members of somatic psychotherapy associations. However, those who see themselves as psychotherapists in the now-defunct Sydney/Melbourne traditions find themselves without an association dedicated to somatic psychotherapy, a fate they share with Core Energetics practitioners.

The outlook for practitioners informed by humanistic philosophy, such as the somatic psychotherapies, is grim. Referrals from the medical profession are rare, and there is little or no financial support available for those who want to see a practitioner in private practice. When Medicare rebates were introduced in 2006, only psychologists and some social workers qualified. Psychotherapists without degrees in psychology or social work are not eligible for these rebates. Effectively, those who are most in need of somatic psychotherapy are the ones who can least afford it, and they stay away.

Rumblings

In contemporary Australia, trauma treatment is informed by an at times hard-line interpretation of the medical model (for example, involuntary mental health patients have been forced to undergo electroshock treatment). Politicians, insurance companies, and the medical profession have brought in short-term, cost-effective, scripted, pharmaceutical treatments with a focus on symptom reduction.

This is a dilemma for trauma survivors, as embodied and trauma-informed approaches to psychotherapy in the mainstream are still the exception. Yet practitioners who are looking for ways to work with trauma more effectively are forced to engage with the body, and they seek out the voices of Bessel van der Kolk, Janina Fisher, and Babette Rothschild when they come to Australia for speaking tours and workshops. When it comes to training, what has been available for several years is Pat Ogden's Sensorimotor Psychotherapy and Peter Levine's Somatic Experiencing® approaches, which take us to the domain of touch.

Touch

Is touch acceptable in Australia? It depends on who is consulted. Australia, with its diversity and sharp contrasts, defies generalizations. The majority of Australians live in crowded and fast-paced capital cities along the coastline, and are an expression of contemporary multicultural life. In contrast, those who live in remote and isolated rural Australia tend to be Aboriginal Australians and the descendants of the first European settlers. One can argue that these people occupy and embody very different cultural and geographic spaces, and their views about therapeutic touch differs accordingly.

However, a few general trends can be observed in Sydney, at least. While men have become more comfortable hugging each other, in contrast, some women are asserting themselves and push back against being kissed on the cheek by men, or even shaking hands. The #MeToo movement precipitated a debate about the sexual harassment and abuse women face, and much of it has to do with touch. Moreover, importantly, a Royal Commission into Institutional Responses to Child Sexual Abuse has unearthed the widespread misuse of power, and how organizations mismanage that misuse.

It is unclear what this might mean for the field of somatic psychotherapy. However, there can be no doubt that there is a general heightened awareness about inappropriate touch, and it is bound to affect how practitioners who use touch are perceived. In 2019 it is difficult, if not impossible, to envisage a mainstream psychotherapeutic method that includes touch.

Where To From Here?

What the pioneers of somatic psychotherapy in Australia built appears vastly diminished, lost, or pushed aside. As the elders recede to the background, retire, or focus on other interests, a new generation is grappling with the question of what to do with what is left.

The easy way would be to accept the status quo and watch as the various somatic traditions linger on in relative isolation from each other. However, the author believes that a harder road must be taken to preserve what can be salvaged, After all, the various approaches of somatic psychotherapy did not arrive in Australia because it was easy.

The hard road involves rekindling what is left, attracting a new generation to training programs, and ultimately building a community that cherishes what unites us and accepts where we differ.

Such a community cannot be expected to speak with a single voice. It must perform as a chorus if it wants to be heard. What might be the nature of such a community? Should it be an informal one, or a formal one under the already existing umbrella of PACFA? Or perhaps a formal one with membership requirements similar to USABP? Or an even more formal one, with more stringent membership requirements, under the umbrella of EABP?

The issues we are facing, individually and collectively, are manifold. How do we demonstrate to the public that our clinical work is effective? How should we do research? How do we enter the public debate not individually, but collectively? How do we provide training to a new generation that is meaningful in the 21st century?

It is here that Australia-based practitioners would benefit from the expertise and resources of a larger organization. At the same time, those located "down under" have a contribution to make. It seems that our voice has yet to be heard, and our colleagues in Europe and the U.S. might enjoy what we have to say.

In a nutshell, then, the author hopes that with the support of a larger organization, the somatic community in Australia can overcome the tyranny of distance.

Acknowledgement

This article would not have been possible without the input of Andrea Alexander and Leslee Hughes (Core Energetics), Pernilla Siebenfreund (Hakomi), Narelle L McKenzie (Radix), and Allison Ball and Gena Fawns (history of the Melbourne and Sydney training and associations). Many thanks for your generous contributions.

Ernst Meyer *is a somatic psychotherapist in private practice in Sydney, Australia. After graduating in his native Bavaria, Germany, he joined the police force, and over the next 15 years performed a variety of police duties. After migrating to Australia, he changed careers, joined the IT industry, and worked in system and network administration as well as project management. After a personal crisis, he participated in Neo-Reichian workshops, which raised his interest in somatics. In 2009 he enrolled in a training program with the Australian College of Contemporary Somatic Psychotherapy, and graduated in 2012. He joined the Australian Somatic Psychotherapy Association (ASPA) in 2013 and went into private practice. He continued his studies with the Jansen Newman Institute (JNI), and in 2015 graduated with a Masters in Applied Psychotherapy and Counseling. Since 2017, he has been part of the Somatic Psychotherapy Leadership Group within the Psychotherapy & Counselling Federation of Australia (PACFA) and a member of EABP. Since 2018 he has specialized in trauma work with retired police officers and their families.*

E-mail: ernst@ernstmeyer.com.au
Website: http://ernstmeyer.com.au/

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BOOK REVIEW

The Routledge International Handbook of Embodied Perspectives in Psychotherapy

Edited by Helen Payne, Sabine Koch and Jennifer Tantia, with Thomas Fuchs
Routledge 2019

By Adam Bambury

"In contrast to other languages there exist two different German words for body: while 'Körper' means the 'objectively' measurable body ('the body I have'), the older word 'Leib', nowadays rarely used in everyday German language, but still common in metaphors, defines the 'subjective' entity of the body ('the body I am')." (p. 266)

The above distinction seems an appropriate way to introduce this comprehensive new volume, which connects interdisciplinary scientific research into embodiment with embodied perspectives from a wide range of international practitioners in body psychotherapy (BP) and dance movement psychotherapy (DMP).

It arrives at a good time. Embodiment is a buzzword in diverse fields of enquiry. BP and DMP have long traditions of exploring its therapeutic implications, and their insights could usefully cross-fertilize with those of researchers who may not even be aware of the specialized expertise that has evolved in these fields.

Additionally, although aspects of BP have gained more respectability in recent years, it still suffers from somewhat of an image problem when interfacing with the mainstream.

This book's introduction mentions "the difficulty that body psychotherapists/somatic psychotherapists have in gaining lawful recognition as a profession" (p 9), while Wikipedia still categorises BP as "alternative and pseudo-medicine," which it defines as "a practice that aims to achieve the healing effects of medicine, but which lacks biological plausibility and is untested or untestable."

This book can in one sense be seen as a riposte to this view, highlighting the rich tradition of research and practice in the embodied therapies and joining them with the wider field of embodiment, which is described in the introduction as "a genuinely interdisciplinary theoretical and empirical approach that provides a new perspective on the person as a bodily, living, feeling, thinking organism" (p. 3). In short, subjective accounts of the bodies we are meet with objective descriptions of the bodies we have.

Can this meeting be achieved to the mutual benefit, and not diminishment, of all? The editors have made this a real possibility through the wide variety of perspectives and approaches they have included. Their envisioned audience of "theoreticians, health practitioners, academics, clinicians, students and all others with an interest in psychotherapy and the embodied mind" will, if they have the time to delve into its nearly 450 pages, get a well-rounded view of this field of inquiry in theory and practice.

The book is split into three sections, with 2 and 3 focusing on aspects of DMP and BP respectively. Section 1, "Overview of Concepts," takes a different approach, aiming to present "an overview on embodied therapies and place them in present

phenomenological and clinical discourses" (p. 15). This grappling with the essential aspects underpinning both BP and DMP and relating them to a wider research context makes for some interesting, if at times hard to connect with, chapters that represent steps in an ongoing and useful dialogue.

One chapter, by Johannes Michalak, Naomi Lyons, and Thomas Heidenreich, looks at whether embodiment research provides evidence for basic assumptions from DMP and BP. Taking depression as its focus, it includes some striking studies that seem to support three statements: body and mind are intertwined in depression, there is reduced body awareness in depression, and negative feelings towards one's own body are present in depression.

To take one example, a person's manner of walking has been shown to correlate with, and indicate, whether or not they are depressed. Not only that, but adopting what has been discerned to be a depressed walk ("reduced gait velocity, stride length, increased standing phase and gait cycle duration") was shown to change the memory characteristics of participants in a study to being more like those of depressed individuals (i.e. recalling less positive material about themselves) (p. 55).

It is also of note that this book brings together BP and DMP in one volume, eliciting further dialogue between these fields as well as embodiment more widely. Jennifer Tantia offers a clear and engaging chapter outlining the basic premises of BP and DMP, sharing their similarities (such as them both being part of "the emerging paradigm shift toward inclusion of nonverbal awareness as part of psychotherapeutic healing" (p. 69), but also their differences. A distinction is drawn between BP being about "having a body", with DMP focusing more on "moving your body."

This is a useful distinction, so long as it isn't taken too rigidly. While there is often an emphasis on the reporting of inner awareness in BP—Tantia mentions attending to this awareness, as typified by Focusing creator Eugene Gendlin's "felt sense," as a "bedrock" of BP practice (p. 70)—and DMP obviously has an emphasis on expression through movement, in practice this division can be more blurred.

Tantia acknowledges that the different trainings and focuses of BP and DMP practitioners can yield specialties in different areas of clinical practice (such as the sophisticated DMP system of Laban movement analysis). Yet she ultimately suggests we might see them both as two aspects of a single "continuum of healing" that moves from awareness of what is happening in the body, to desire for expression, to the action of expression.

The section on BP contains chapters from a number of names in the field and includes everything from the use of touch, to working with micromovements, to the embodiment of dreams. The first chapter is by Gill Westland. In it she offers an elegant overview of a strand of BP that emphasises the practice of awareness and centers around bringing forth the client's latent potential and organic impulse to heal (p. 259).

It is both a useful introduction to BP for someone new to the field and a reminder, for this practitioner at least, of the different aspects of, and ways of speaking about, BP and what it can do. With its brief sections on training and its aftermath, this chapter emphasizes the importance of experiential learning that becomes "embedded in the psychotherapist and is often not known explicitly, but emerges [...] spontaneously, when the need arises" (p 260). This is something that Westland argues "cannot be acquired through textbooks and interactive technology." Considering the wide audience

the editors of this textbook aspire to, and the growing inclusion of aspects of embodiment into various disciplines, it seems a valuable thing to underline this important aspect of much BP training and the skills developed by BP practitioners.

Westland emphasises the importance of awareness being brought to bear on the relational dynamic occurring between therapist and client, as does Michael Soth in an intriguing chapter about his continuing research into "the relational turn in body psychotherapy."

For Soth, "any habitual therapeutic stance, whether unconsciously taken for granted or deliberately chosen and ideologically rationalized, ends up either avoiding or exacerbating the experience of the client's wounding in therapy" (p. 304). In a useful diagram he outlines eight different stances and habitual positions in the field of body psychotherapy that can be listed along a spectrum between two poles.

At one end is the "functionalist quasi-medical expert," emphasising the therapist's position as someone with authority providing some kind of treatment. At the other is the "phenomenological co-explorer" who strives for a therapeutic encounter of two equals authentically exploring a co-created space. Soth contends that each of the eight stances has "entirely valid and necessary dimensions" as well as "its respective shadow aspects and counter-therapeutic dangers" (p. 304). The point is to identify that we have a habitual stance in the first place, recognize these dimensions and aspects, and open to the possibility of actively shifting stance in response to the client's ongoing process.

Readers may be familiar with both Westland's and Soth's work. Perhaps less familiar to readers outside of Germany is Functional Relaxation (FR), a "psychodynamic body psychotherapy method" founded by the German gymnastics teacher Marianne Fuchs (1908–2010) at the University Hospital of Heidelberg in the years after the Second World War (p. 266). As the name suggests, it emphasises relaxation as well as deep awareness of proprioceptive body states. There is a focus on breathing, with the emphasis on letting go via the outbreath, best accompanied by "a soft sound." The method works to release "unconscious tension and blockades and find one's own rhythm and a flexible inner balance" (p. 269).

As well as providing the statement used at the start of this book review, chapter authors Ursula Bartholomew and Ingrid Herholz describe the history of the approach, its relatively simple practical application, and the results of evidence-based research into its effects. Interestingly, FR has apparently evolved an accompanying language to describe body experience, one that includes "a wide range of pictorial terms and metaphors to make somatic experience accessible to conscious analysis" (p. 267).

I was pleased to see Rae Johnson as a chapter author. A "scholar/practitioner working at the intersection of somatics and social justice," Johnson is concerned with highlighting the embodied experience of oppression, and the role of the body in reproducing and transforming oppressive social norms. She outlines three steps that body psychotherapists can take to bring themselves into fuller contact with the somatic experience of oppression, including engaging with their own privilege and examining unconscious biases with regard to diversity. These are things Johnson argues are not adequately engaged with, or indeed engaged with at all, in most body psychotherapy trainings: "In nearly all of the training I received it was assumed that simply being present in my own body and attentive to the body of my client would somehow transcend the differences in our social identities" (p. 353).

The inevitability of these themes being present in the therapeutic encounter to some degree is mentioned by Nick Totton, who states that "the social world and its power relations directly enter the therapy room, instantiated in the embodiment of both client and therapist" (p 285). Totton's chapter outlines Embodied-Relational Therapy, created with the aim of integrating body-centered and verbal psychotherapeutic approaches in a way that accesses the fundamental connections between them. In what is a very body-oriented book, he cautions against therapists privileging the body, or the relationship, as the main or only channels of enquiry that they pay attention to, arguing that in a therapy session "fixation on specific aspects of experience risks missing what is most important" (p. 284).

Fixation or not, what strikes me most about reading this excellent book, apart from a feeling of excitement, is all the different ways of describing embodiment and practicing embodied therapies it contains. Like the proverbial blind men and the elephant, there is a sense the authors are discussing different parts of the same hidden thing, or the same part in different ways. Taken as a whole, it brings the elephant—a wondrous beast indeed—more fully into view.

Adam Bambury *is a body psychotherapist, writer, editor, and occasional performer of improvised psychedelic rock music. He lives and works in London, UK.*

E-mail: adambtherapy@gmail.com
Web: www.adambambury.com

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