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The Art and Science of Somatic Praxis

SOCIAL JUSTICE

Volume 22 ▪ Number 1 ▪ Summer 2023

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From Our Readers

Dear Courtenay Young,

I received a notice about the special war issue from *The International Body Psychotherapy Journal*, which perked my interest because I am often preoccupied and anguished by occurring wars, especially since the imperialist war on Ukraine by Russia.

Let me say first that I am not a therapist, but simply a person who has been personally interested in neo-Freudian therapy for about fifty years, especially Reich, Lowen, Arthur Janov... and others, not necessarily explicitly body-oriented. I am always concerned about how their findings could be applied at social and political levels.

With regard to your article, I was disappointed you did not point out some of the relevant findings of nearly all neo-Freudians. Your only allusion was to the fact that there is necessarily a deep pathology (true!). Does it not come down to the fact that people are either inherently sadistic to a certain degree, as Freud thought, or, as is probably the case, that they are neurotic on a mass scale for some reason. This neuroticism manifests not only in personal symptoms, but as greed, brutality, cruelty, etc.

What are the sources of this brutality? Are they, for instance, perhaps rationalized by militaristic ideologies? On the extreme case of the Nazis, Reich wrote: "the natural sexual strivings towards the other sex, which seeks gratification from childhood on, were replaced in the main by distorted and diverted homosexual and sadistic feelings, also in part by ascetism. *The hidden motive was to unleash brutality, and make it ready for the use in imperialistic wars.* Sadism originated from ungratified orgastic yearning." (Reich, The Mass Psychology of Fascism)

Whether one agrees or not that sex has as much of an importance as Reich argues, certainly some powerful distorted emotions can lead to irrational brutality. The italicized sentence above has much explanatory power as far as some of the sources of irrational wars (as distinguished from the rare defensive wars against sadistic psychopaths, such as Putin and his clique of murderers).

Another work similar to Reich's is Erich Fromm's *The Anatomy of Human Destructiveness* – a book full of insight on the sources of brutality, cruelty, and war.

Thanks again for your article.

Marco Ermacora
Montreal, Québec, Canada

Dear Marco Ermacora,

Thank you very much for your response to my article *Why War?* in the *IBPJ*, Vol. 21, No. 2, 2023. You make some good points, and I am delighted that you – as a non-therapist – show an interest in "neo-Freudian therapy," although that is not how I would describe the intensive work done in many different fields of the psychotherapies, body-oriented and otherwise. It gives Freud far too much prominence as, in my view, he stole many of his ideas from Charcot's pupil Pierre Janet, when Janet was in Paris for four months during the winter of 1885-86. As Charcot was purely a neurologist, it was probably Janet who inspired Freud, and who was perhaps the first proper psychotherapist (he also happened to be a body-oriented one: see Boadella, (1997), *Awakening sensibility, recovering motility. Psycho-physical synthesis at the foundations of body-psychotherapy: the 100-year legacy of Pierre Janet* (1859-1947). International Journal of Psychotherapy, Vol. 2, No. 1, pp. 45-56).

I am not quite sure what you mean by "relevant findings of almost all neo-Freudians." You suggest either that people are, to a degree, inherently sadistic. I cannot buy that, especially given the extended need of human infants for familial care – much longer than that of any other mammal or primate. I don't think there are any grounds for that assumption – if so, we would probably have exterminated ourselves long ago.

Your second – more likely – possibility is that people are, for some reason, neurotic on a mass scale. This is closer to what I alluded to in the article *Why War?* I hypothesized that we (*homo sapiens*) were sufficiently ruthless (nature is, of course, red in tooth and claw) to have eliminated one of our predecessors (*homo neanderthalenis*), which had been extremely successful in establishing itself in Europe for over 200,000 years. There is no doubt there were significant differences between our species and theirs that had evolved since the Neanderthals emerged from the humanoid gene pool (see my internet article on *A Physiological Theory of Evolution*, written from a body psychotherapy perspective: www.courtenay-young.co.uk/courtenay/articles/A_Theory_of_Evolution_1.2.pdf).

It has already been reasonably well-established that *homo sapiens*' brains were more flexible and innovative than that of Neandertals (see the Pearce, Stringer, & Dunbar reference in my IBPJ article). But this fact alone would not necessarily have resulted in their extinction. Theoretically, we could have co-inhabited prehistoric Europe and would probably have interbred. Therefore, the "greed, brutality and cruelty" you ascribe to our ancestors was probably a result of some genetic traumatization that still exists.

This is not a pretty thought, but since we have been concerned with psychological healing for only about 130 years, the idea of trying to heal such a built-in level of traumatization (over 100,000 years or more) is relatively recent. We are also only just now able to put together a picture of what might have happened to that early gene pool. If we (*homo sapiens*) were traumatized, rather than wise, this could explain why a) we attacked and exterminated a rival species for shelter and food, and b) the trauma has persisted over the generations such that we are wired to fear the Other – be they another genus, a different tribe, or imagined aliens.

I did not choose to go further into this theory as the article focused on war, and I wanted to define and track something of its early history. To posit that war descends from an early form of genocide, and, since we have no Others (as a close species), we extended this trait into warfare with members of our own species, and to the destruction of many other species of plants and animals as well as our own environment, is perhaps a step too far for the scope of this article. I therefore thank you – deeply – for giving me the opportunity to share my thinking a bit more widely.

Finally, you mention Reich's fascism theory. If you suppose that we have a traumatized component in our psyche, then the development of fascism is a social manifestation of this trauma. Yes, of course, it involves sexual repression; I think that Reich was right – and Freud was wrong – in identifying sexuality as a prime mover in our psyche. A distorted psyche will therefore manifest in many different variations: aggression, brutality, sadism, rape, misogyny, violence, self-harm, war, oppression, slavery, etc.

Thank you also for referencing Fromm's *The Anatomy of Human Destructiveness*. I had overlooked that work in writing my article. Yes, it is very insightful. So are some of these:

- Morgan Phillip's *A Humanistic Approach to Warfare*, which uses examples of human skeletons that resulted from war, in a bio-archeological manner to try to reconstruct these individual's experience in order to provide a perspective that could help uncover the motivations and functions of various aspects of warfare. I wanted to go back earlier than the examples used in this article, and also explore more broadly, as the author presumes that "warfare is always going to persist in society …" Though this may well be true, my theory presumes at least a possibility of finding ways to heal transgenerational trauma.
- Sam Keen's *Faces of the Enemy: Reflections of the Hostile Imagination* introduces the concept of a "*homo hostilis*: the enemy maker," which is a very well-illustrated collection of how we often portray the other. This was also slightly too far from the theme of my article.
- There is also a nice article, *Homo Hostilis*, or how the worship of cows prevents genocide, by Miruna Ruxandra Rolea, which looks at the "otherness" of religious affiliation, and how we create social differences and project subhuman images onto the other so as to justify our hostility. Rolea writes: "The process of hate-creation is so subtle that we cannot even sense it – at one time it is there – and we lack the much necessary introspection for discovering how it got there in the first place. …Answer me, if you can: If we didn't have enemies whom would we blame for our problems? Define peace for me if you can. Can we love our country, our traditions and our values without falling into blind patriotism and ethnocentrism? Without making foreigners our enemies? What are the words you use to define those you fear and hate? If you claim that "God is on your side," and they claim that God is on their side, who's right? You talk about what Others are doing to you – How about what you are doing to yourselves?"

I have been attempting to understand how this hate-creating, paranoid, genocidal tendency can have originated, and the creation of a severe traumatization of our species is the only answer that I come up with.

If there really were a mitochondrial Eve (living in Africa, about 200,000 years ago), she was almost certainly part of a quite small population. If she were living in a relatively peaceful environment that would have allowed the evolution of the various hominid

species and that might have – much earlier – spawned several other hominid types, then something happened to that environment that caused her to move out – possibly the destruction of that environment. My hypothesis (mentioned above) is that the "Sea of Eden" was actually located in the Afar Depression in northern Ethiopia, which is on the conjunction of three geological plates, and which would easily have been destroyed in a violent tectonic upheaval.

All someone now needs to do is go there and try to excavate. However, in that particular extremely salty basin, it is quite likely that any fossil remains would have been destroyed. There are several human remains from that era nearby (such as Lucy), but, as yet, no anthropological evidence of five million years of evolution. So, all we can do, as I am doing, is speculate.

Again, I thank you for your letter.

Yours,
Courtenay Young

Note: Please see the *Personal Viewpoint* section for additional material on the ***Why War?*** article.

Racialized Socialization and Trauma from a Somatic Perspective

Aline LaPierre
Editor-in-Chief

This is a time for listening and learning. It is also a time for the conversations that will build a safer, kinder, more compassionate humanity.

Overcoming the effects of trauma includes addressing the seeds of oppression and indignities embedded in our bodies as well as in our identities. When caring connection is violated, relational shocks ensue, leading, at their worst, to irretrievably deep cuts in the fabric of the heart and psyche.

Kenneth Hardy, in *Racial Trauma: Clinical Strategies and Techniques for Healing Invisible Wounds*, writes:

> *"It is hard to imagine how the process of therapy, the efficacy of which is predicated on the cultivation of a trusting and intimate relationship based on a mutual bond of respect, could ever be executed without overtly attending to issues of race... Therapists working with Clients of Color, must be professionally trained and racially prepared to deliver racially sensitive, trauma-informed therapy."*

Discrimination and oppression lodge in our flesh and bones, whether we are Black, Brown, women, queer, transgender, incarcerated, adopted, disabled, etc... – it lives in all who are "othered" through the internalized message that one's very being is wrong, dangerous, ugly, or sinful.

In this issue, our guest editor Karen Roller has collaborated with practitioner-scholars who look at the world through the lens of inclusion and whose work is dedicated to helping us distance from inherited biases. With wise and loving guidance, she has brought together colleagues who, through their clinical understanding, can help us better fulfill our ethical responsibilities, manage power and privilege, emphasize shared decision-making and participatory assessment, treatment, and research. With engaged caring, their offerings speak out against prejudice while nurturing a sense of belonging that celebrates diversity.

There is no one right conversation to have in relation to the global human challenge of social justice. If we want our humanity to be kind, compassionate, and courageous, we must actively claim our part in creating it. The conversations in this issue reflect the

views of colleagues who are dedicated to speaking up when the values that underpin a compassionate humanity are assaulted.

It is our wish that the message of attunement and collaborative reciprocity arising from our somatic community continues to positively contribute to our global healing.

In This Issue…

This issue on **Social Justice in Somatics** reflects our guest editor **Karen Roller**'s fierce and loving vision for change. The title of her editorial, ***Microconnections: Healing our Macrodisconnection and Macrodissociation***, speaks to the courage we need to turn toward each other in acknowledgement of the deep wounding we humans have, and are still, consciously and unconsciously, inflicting on each other.

In ***Black Girls are Taught to Survive: Historical Trauma and the Strong Woman's Embodiment***, **Donya** Wallace, **Chanta Presley Moore**, and **Karen Roller** explore the origins of the Strong Black Woman persona through a trauma-informed archetypal lens. Honoring wisdom traditions, **Florie St. Aime** invites readers to unlearn the violent paradigms that claim our bodyminds under the guise of fixing them. Her article, ***An Anti-Oppressive Quest to Hold a Body***, seeks to breathe new life into our clinical practice. In ***Oppression and Addiction Break Families***, **Rachel Jacoby** and **Karen Roller** address the disproportionate representation of Black, Indigenous, and other People of Culture children who are raised in the American foster care system. They expose the bias of traumatic oppression that shape the perspective of referring professional, a bias that systematically wears down families who are pressed to the margins of society.

Susan F. Branco, **JaeRan Kim**, **Grace Newton**, **Stephanie Kripa Cooper-Lewter**, and **Paula O'Loughlin**, authors of ***Out of the Fog and into Consciousness: A Model of Adoptee Awareness***, describe the social activism adoptees may encounter, and the intersecting racial, ethnic, and cultural awareness that must inform body-inclusive therapists working with the somatic needs of adoptees. ***Disappearing Act: Disabled Embodiment*** by **anna s. kunin** offers a perspective on chronic pain from the disability justice lens. They explore the potential and limitations of somatic therapies to support a client's sense of agency within their chronic pain experience. In ***Somatic Practices in Disaster-Based Global Supervision: Tending to Shared Trauma and Recovery***, **Juanita Barnett**, **Elizabeth Farrah Louis**, and **Karen Roller** present the trauma models and somatic practices employed by their team in post-disaster supervision to prevent vicarious traumatization and compassion fatigue.

Our **Interdisciplinary Section** looks at unlearning voicelessness and reclaiming our voice. ***Voicework and Sound Healing: Overcoming the Silencing Response and Unlearning Voicelessness*** by **Nicole Cowans** and **Karen Roller** highlights the trauma processing and empowerment value of voicework to reclaim one's voice from systematic silencing by oppressive individuals and structures. The authors propose voicework as relevant to somatic psychotherapy to support resolving systematic silencing and self-assertion.

In the **Research Section**, **Letizia Sturiale**, **Roberta Rosin**, and **Irene Leo**'s ***Neo-Functionalism Applied to the Lived Experience of a Transgender Person During Affirmation*** sensitizes us to the transgender embodiment and identity process, and how it transcends the sociocultural expectations linked to binary biological sexes. They offer a reading of a transgender person's lived experience according to the psychological model of Modern Functionalism.

Our **Clinical Practice** section offers two powerful articles. ***Somatic Experience of Microaggressions in Therapeutic Space: Understanding Rupture and Pathways to Repair*** by **Shreya Vaishnav** and **Dareen Basma** explores somatic experiences of microaggressions in the therapeutic setting. They investigate somatization in relation to microaggressions through a detailed case study, emphasizing the manifestations of somatization, and proposing somatic interventions that aim to restore harmony in relational embodied encounters.

A must read, ***Fanon's Vision of Embodied Racism for Psychoanalytic Theory and Practice*** by **Kenyona Young** is a self-exploration of subconscious and preconscious appeasement and enactments as a body defense. Scholars such as Fanon, Hardy, and Knoblauch explored how hierarchal structures of race and racism live in our interstitium. Building on this, Young leads us into an examination of personal complicity in systems of oppression and white ideology.

In **Body Psychotherapy Around The World**, **Maurizio Stupiggia** reviews the history of body psychotherapy in Italy.

Personal Viewpoint offers inspiration and a model for determination and commitment. **Ann Bradney**, in ***A Report from the Trenches***, describes herself as a process person, an experimenter who engages the world as a laboratory to develop, invite, collaborate, research, and learn. She recounts how her journey led her to create Radical Aliveness, a working space where all perspectives, all ways of expression, and all voices would be welcome. ***Why War? Apologies*** by **Courtenay Young** gives us an update on his quest to understand the origins of violence in human beings.

In **Book Reviews**, **Herbert Grassmann**, **Maurizio Stupiggia**, and **Stephen Porges** give us a preview of the contents of their upcoming edited book, ***The Science of Embodiment: Trauma, Body, and Relationship***. To be released by Norton in 2024, this seminal volume aims to update the theory and principles of our field of somatic psychology, supporting a paradigm shift in which the introduction of the body transforms psychotherapy into somatic psychotherapy.

Equally exciting for our field is Courtenay Young's edited volume ***The New Collected Papers of Biodynamic Psychology, Massage, and Psychotherapy: 2022*** reviewed by **Mark Ludwig**. To quote Ludwig: "We are presented a uniquely valuable, large, and accessible archive of writings from the beginning of the modern body psychotherapy movement. I believe it is safe to say that not many readers of this review, outside the Biodynamic communities, have ever seen or read any of these 150 articles, which were written and published between 1970 and 2022." This publication, available in e-book format, is a treasury of 150 articles by 50 authors, the majority being European women.

Lisa Monagle writes about the book ***Together Beyond Words; Women on a Quest for Peace in the Middle East***: "Nitsan Joy Gordon shares her life's work not as an expert in conflict reso-

lution, but as a mother sitting in a bomb shelter with her children. She envisioned creating peace and a better world for all the children. There and then she made the decision to trust her skills, feel all her feelings, and to try to know the 'enemy.' It was a conscious choice, a courageous one, and one to which she invites each of us to bring our skills and souls." Nitsan Joy Gordon describes a world of courage, of heart, of a life-and-death commitment to peace, and to never giving up.

In a statement worthy of closing this issue on social justice, she writes: "When this transformation occurs, and it shall one day, we will truly be a holy spot on earth where an ancient hatred has become a present love. May it be so."

Special Section

GUEST EDITORIAL

Microconnections

Healing Our Macrodisconnection and Macrodissociation

Karen Roller

Microconnections are small moments of intentional attunement to demonstrate respectful empathy and strengthen an emotional bond. Microconnections have been found to improve neurological functioning, boost immunity, support people in acute grief, and improve relational functioning (Fredrickson, 2013; Martino et al., 2015; Murphy, 2019). Oxytocin generation plays a pivotal role in the perception of connection and responsiveness, as well as bonding behaviors, and appears to be a byproduct of microconnections (Algoe et al., 2017; Ellis et al., 2021; Scatliffe et al., 2019). Secure attachment is rooted in successful facilitation of microconnections specific to the relationship.

Clinicians trained in systems theory may consider that the research base of couples, family, and group therapy is rooted in the study of microconnections framed in modality-specific terminology. Socioculturally-attuned systems-trained clinicians also name and intervene where possible on the nested systems whose oppressive patterns (e.g., patriarchy/misogyny, racism, classism, nationalism) play out in personal relationships, and aim to heal those patterns of discord through facilitative microconnections that attend to the oppressive habits relationships must break to be healthy (McDowell et al., 2022).

Whether a partner, parent, teacher, boss, beloved friend, or coworker really beholds you, really steps into your visceral frame of reference and stays with you there, that sensory experience of sharing honest intimacy can wash over and feel empowering, nourishing, uplifting, encouraging, liberating. For a moment, existential isolation and the busyness

of the evaluative mind are suspended; perception can expand to take in a greater portion of the Whole through the co-regulating nervous systems. Satir and Hardy have been lauded for their masterful facilitation of socioculturally-attuned microconnections in families; both are fearless about palpating the deep wound, and turning relationship members toward each other to connect fully through it, rather than turn away (Hardy, 2016; Wretman, 2016).

In our relatively recent evolutionary history, the viruses of racist colonialism and capitalism have fomented what I will call *macrodisconnection*. The seed of this global trauma sprouted in the medieval European abuse of feudal power, and radiated out through colonizers' traumatized bodyminds, perpetrating what they escaped; what white people do to Brown and Black people, they did to themselves first (Menakem, 2017). In that white domination disorder (Hardy, 2016), we see white people striving to reach the summit in the "pigmentocracy of a white body supremacist structure" (Menakem, 2022) to minimize one's own oppression. We see the widespread messaging and behavior of the most privileged people feeling entitled to take up more space, be more heard, have their narrative define discourse. At the slightest challenge to this destructive entitlement, we see reactive white fragility (DiAngelo, 2018); this defensive reactivity is also evident in cis and heteronormativity, male privilege, and able-bodiedness. Collectively, we have traumatized ourselves as a species, and we must collectively re-associate. This is white people's responsibility to heal, because white people continue to benefit from the trauma history the most (Hardy, n.d.; Menakem, 2022). Such a statement matters here because the mental health industrial complex is a predominantly white institution (Roller et al., 2023).

This trauma history is not taught accurately through the public education system, so that white children grow up to be adults who can see it explicitly and make reparations. For instance, the attempted genocide of First Nation members of the Americas and the brutality of white feral chattel slavery (Menakem, 2022) are not honestly acknowledged in history textbooks (Zinn, 1980-2003). This *macrodissociation*, in its implicitness, allows the insidious tendrils of white body supremacy to grab hold again and again. This implicitness is pregnant with rules about how to behave when white domination and other patriarchal behavior asserts itself, when microaggressions occur, when somebody with more protection takes what somebody with less protection has. While many feel righteous rage at the indignity and injustice of these macrodisconnections, we do not have a shared understanding of how this trauma passes down transgenerationally in our DNA, of stories of loss, and of rigid structures that uphold power for the palest, malest few over the many.

Somatically, the lack of a shared understanding of our collective trauma history leads to macrodissociation from our collective human body. This makes it possible to not act from

our feeling hearts to ensure that those who have always had more (freedom, power, access, protection, choice, wealth) "take a step down and back" (Menakem, 2022), while making sure those who have systematically had their human embodied rights constrained and abused instead get to breathe freely and take up space, be seen, felt, and heard, and lead with communal best interest at heart. There is actually room enough for everybody.

■ ■ ■

In this special Social Justice issue, we hope you will resonate with practitioner-scholars who are facilitating socio-culturally attuned microconnections for the underserved and multiple marginalized in structured individual sessions; domestic and transnational advocacy for family cohesion, identity, and wellness; and via global mental health outreach in post-disaster settings. You will read of various approaches that center culturally-affirming microconnections to heal macrodisconnections rooted in historical, persistent, and recent shared trauma, including disproportionate exposure to the climate disaster that is a byproduct of our macrodisconnection from Nature. You will read of the emotional labor necessary when macrodisconnections are left untended, how much effort is required to flush out the survival neurochemistry of patriarchal dominance, stay associated with oneself, and how necessary microconnections are to have moments of safety in relationship. We hope this moves you to become Somatic Abolitionists (Menakem, 2022), committed to anti-racist post-trauma growth.

Many groups of marginalized people are not represented here. We must increasingly make space for them in our practice and scholarship. May this be the only time Social Justice is a "special issue" for the *IBPJ*. For us to heal the macrodisconnections caused by colonialism and the extractive industry of capitalism, and all the many ways their ills have broken hearts, bodies, families, and communal ways of life, we must collectively awaken from our shared macrodissociation that interrupts our connections with each other and our planet. Breath by breath, we do this through microconnections to ourselves, each other, and the Earth.

■ ■ ■

Karen Roller, **PhD**, **MFT**, is an Associate Professor of Counseling at Palo Alto University and Clinical Coordinator of Family Connections, a parent-involvement preschool system serving predominantly Spanish-speaking migrant families in the San Francisco Bay Area. Her doctorate from Santa Barbara Graduate Institute in Clinical Psychology with a specialization in Somatic Psychology included experiential coursework in Pre-and-Perinatal Psychology. Karen has spent her clinical career in family therapy through community mental health for the marginalized and underserved including fostered youth, adjudicated youth, and the Latinx migrant community, as well as international trauma training outreach in Haiti.

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Black Girls are Taught to Survive

Historical Trauma and the Strong Black Woman's Embodiment

Donya Wallace, Chanta Pressley Moore, Karen Roller

ABSTRACT

The authors explore the origins of the Strong Black Woman persona through a historical trauma-informed lens to articulate the archetype as a predictable and necessary trauma response, analyzing the necessity of strength and its generation-to-generation transmission as evidence of ancestral trauma response. We address both post-trauma growth exhibited by the embodiment of the Strong Black Woman, and deleterious effects it engenders. We call all somatic practitioners to seek ongoing training in anti-racist approaches to ensure skilled therapeutic service for clients exhibiting the Strong Black Woman archetype, and for somatic researchers to develop best practice assessments and interventions.

Keywords: Historical trauma, transgenerational transmission, Strong Black Woman, ancestral trauma response

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A growing body of research demonstrates the paradoxical experience of embodying the characteristic traits of the Strong Black Woman (SBW) archetype (Davis, 2015). First defined in the literature in 2000, the archetype exists as a collection of culturally normed behaviors and schemas that scholars believe were originally enacted by enslaved African women in protection of their children and communities, and to survive the horrors of enslavement (Harris-Lacewell, 2001, Romero, 2000; Wood-Giscombé, 2010). Defining characteristics of the archetype include suppression and self-silencing of personal need and emotion, self-reliance, and obsessive caretaking, driven by schemas that discourage self-care and help-seeking behaviors (Romero, 2000). As culturally expected responses to stress, these traits are passed down generationally via implicit and explicit messaging that dictate survival skills for African American women and girls navigating oppressive environments, but with adverse consequences for mental and physical health (Davis, 2015).

> ***Brave Heart conceptualized historical trauma as a collective and cumulative experience of loss and unresolved grief following intentional genocide.***

Donovan and West (2014) found that moderate to high embrace of the archetype among college students predicted depression and poorer mental health outcomes. Moreover, a study on African American trauma survivors revealed that high embrace of the archetype resulted in self-silencing behaviors and difficulties regulating emotion (Harrington et al., 2010). Liao and colleagues (2020) found among SBW "perfectionism, which was associated with low self-compassion and low use of collective coping" (p. 84) led to higher rates of depression and anxiety. Higher rates of cardiovascular disease and other chronic illnesses, increased secondary illnesses, higher mortality rates, anemia, and increased maternal deaths have all been associated with the SBW archetype (Abrams, 2010; Chinn et al., 2021). Yet despite awareness of these negative impacts on both physical and mental health, Wood-Giscombé (2010) found that African American women feel compelled to embrace the persona.

Traits of the archetype are often used to combat and navigate oppressive spaces (Wallace et al., *in-press*) and are often used in protection of the family unit and community (Hannah-Jones, 2019; Romero, 2000). Access to quality healthcare, nutritious foods, safe and affordable housing, quality education, and economic stability are basic needs for most Americans. However, African American women have historically found themselves as the target of discriminatory policies that limit or deny them access to these basic resources. African American women earn approximately $5,500 per year less than white women, and are often the head of their households, requiring them to do more with less and without the benefit of income from partners. Redlining laws inhibit African American women's abilities to purchase homes in desirable neighborhoods where they might have access to better schools, outdoor spaces, or grocery stores for healthy foods. Further impacted at the intersection of race and gender, African American women are more likely to face discrimination in the form of racism and sexism because of their identities at numbers greater than white women and African American men. Laws that protect whiteness and white access (e.g., resource extraction industries, higher educational and employment opportunities) over human rights continue to sanction historical racialized trauma, cloaked by government-led disinformation campaigns, and protect the perpetrators of it today (Mitchell & Schoeffel, 2002; Williams, 1987; Zinn, 1980-2003).

The Substance Abuse and Mental Health Services Administration's (SAMHSA) Trauma-Informed Care Fact Sheet (TICFS) identifies four forms of trauma that may be embodied – cultural, historical, intergenerational, and current (2014). Menakem (2017, 2022 a&b), a social worker and Somatic Experiencing Practitioner who developed Somatic Abolitionism as an antidote to racialized trauma, further elucidates how cultural, historical, intergenerational, persistent institutional, and current personal trauma become embodied, or stored in the muscle memory, fascia, breath patterns, core beliefs, and biobehavioral responses to ongoing environmental threats. DeGruy (2005, 2017) artfully describes how these biobehavioral responses are transmitted through parenting and caregiving practices in anticipatory protection from imminent and ongoing threats in a racially stratified society. Subsequent researchers have further teased apart how these necessary biobehavioral responses impact parenting, caregiving, and attachment styles (Alexander, 2018; Graff, 2014; Hampton, 2021).

The American Medical Association recognizes that inequities in social determinants of health are rooted in historical and transgenerational trauma, requiring updated training for skillful intervention in both medical and mental health, in addition to systemic overhaul of how racialized stress is considered in treatment and research (AMA, 2021). The American Psychological Association is also acknowledging the embodied impact of chronic traumatic stress (2018) and transgenerational impacts of historical trauma (DeAngelis, 2019), which can often result in living in survival mode (Bezo & Maggi, 2015). Williams-Washington and Mills (2018) emphasized the African American culture's multi-generational enslavement, exposure to racism, and the emotional and physiological stresses associated with prejudice, discrimination, and race-based segregation, and its resulting disparities as evidence of *historical trauma* within the culture.

The term historical trauma was first introduced in 1999 by Lakota social work scholar Maria Yellow Horse Brave Heart to bring attention to the experience of members of the Lakota Nation. Brave Heart conceptualized historical trauma as a collective and cumulative experience of loss and un-

resolved grief following intentional genocide and disruption of a culture's historical course, with resulting disparities that span generations (Brave Heart, 1999). Drawing on psychodynamic theory, indigenous cultural healing practices and research on survivors of the Jewish Holocaust, Brave Heart examined how contemporary health inequities are informed by historical trauma. In acknowledging the historical origins of the SBW archetype and its generational effects, this article offers specificity to the expansion of historical trauma literature on African Americans to include that of the SBW archetype as a historical trauma response.

Oppressive and systemic racism and discrimination faced by African American women maintains the SBW archetype as a salient and persistent character within African American culture (Watson & Hunter, 2015). A growing body of work continues to conceptualize the role of the archetype in the functioning of African American women, and the implications for treatment. However, there is a dearth of literature in the mental health field that explores the "historical, intergenerational, persistent institutional" (Menakem, 2022a) origins of the persona, and its survival link to dehumanizing racist practices attacking the body of African American womanhood that span generations in a white body supremacist structure. Examining the SBW through a historical trauma lens demands understanding its historical origins as a product of the intentional subjugation of African women by a dominant colonizer, resulting in disparities that span for generations. In acknowledging the archetype's psychological and physical health impacts, we argue that the implicit and explicit ideologies of strength passed down through generations of African American women serves as evidence of generation-to-generation transmission of a collective trauma response, and propose a SBW historical trauma (SBW/HT) framework for conceptualizing the mental health disparities impacting African American women embodying the persona. Applying critical race theory to our understanding of post-traumatic responses counters the deficit view of trauma (Ault, 2021), and is therefore an ethical duty of mental health professionals.

The theory of historical trauma

The theory of historical trauma is based upon four assumptions of the trauma's origin (Sotero, 2006).

- First, it is an intentional mass trauma occurring at the hands of a dominant population intent upon subjugation of a less protected population.
- Second, the trauma extends over a period of time, and is not limited to one incident.
- Third, the impact of the trauma is such that its effects span for generations.
- Last, the natural progression of the population is derailed by the severity of the trauma, resulting in generational physiological, psychological, economic, and social disparities.

Central to the theory of historical trauma are three basic constructs: *a trauma experience*, *a trauma response*, and *transgenerational transmission*. According to Sotero, the effects of historical trauma are cumulative, with later generations becoming most impacted by the disease and distress of preceding generations. As a *disease of time*, historical trauma presents as culture-specific disparities in physical, social, and psychological outcomes that disadvantage generations of descendants of the primary generation.

The lingering impacts of the kidnapping, torturing, murder, and enslavement of millions of Africans on the psyche of the African American community is well documented in the literature (Akbar, 1996; DeGury, 2005, 2017; Barden, 2013). Akbar (1996) in his seminal work on the residual effects of slavery, maintained that the impact of the enslavement of African Americans' ancestors extends for generations with social and psychological impacts. Post-Traumatic Slave Syndrome (PTSS), a term coined by DeGruy (2005), later defined the concept as a collection of self-disparaging thought patterns and behaviors, which the author attributed to the enslavement of one's ancestors. The syndrome is characterized by vacant esteem, ever-present anger, and internalized racism. Halloran (2019) offered a Terror Management Theory account of PTSS with a focus on despair and helplessness, loss of identity, and lack of meaning and value, which are passed down to successive generations. Moreover, epigenetics demonstrates that traumatic experiences can alter DNA in offspring, with negative implications for both medical and mental health (Jawaid et al., 2018; Krippner & Barrett, 2019; Youssef et al., 2018). Systemic chronic inflammation from stress (including traumatic stress) is the leading etiology of all terminal illnesses worldwide,

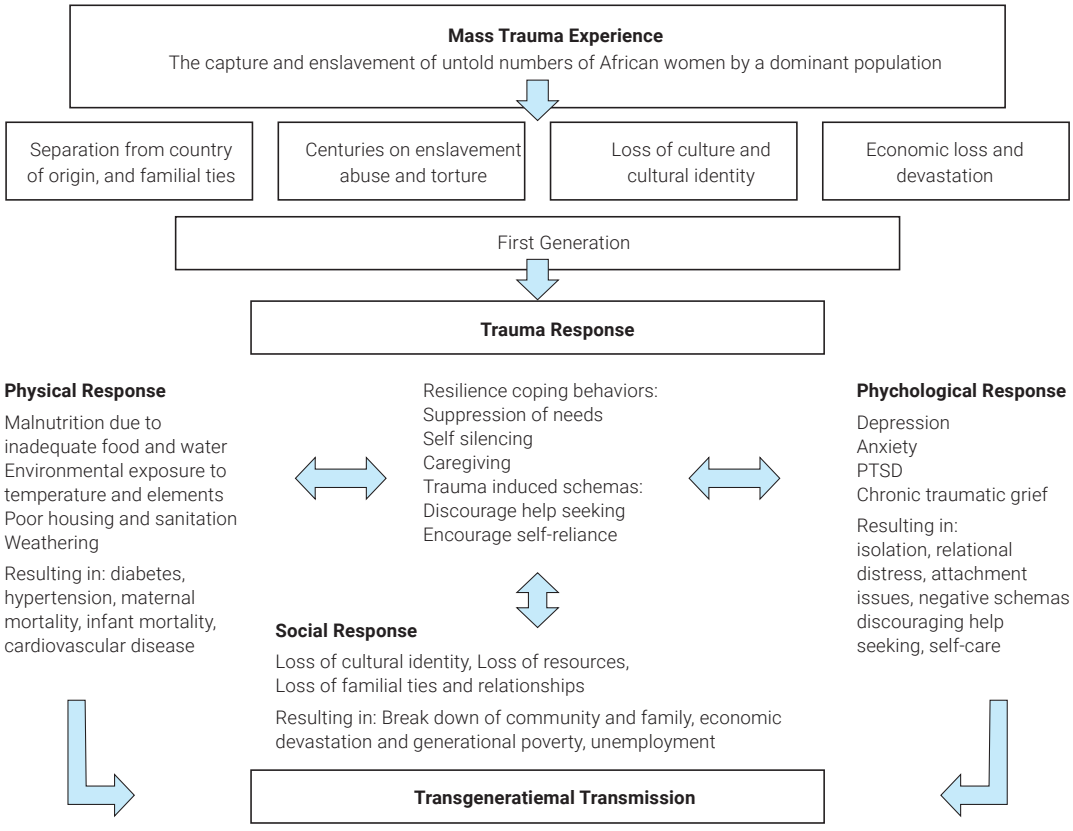

Figure 1. *Conceptual Model of the SBW/HT Framework*

the effects of which further increase for women after menopause (Furman et al., 2019).

Scholars have conceptualized the enslavement of the African American population using historical trauma as a framework. Hampton et al. (2010) offered a definition of the historical trauma of African Americans: "the collective spiritual, psychological, emotional and cognitive distress perpetrated intergenerationally deriving from multiple denigrative experience originating from slavery and continuing with pattern forms of racism and discrimination to the present day" (p. 32). The enslavement of millions and centuries of oppression – which is obviously still underway – resulted in derailment of the natural course of development of African culture, with impacts that span two continents, and continue to be experienced through economic, social, psychological, and physical health disparities. These social determinants of health result in atrocious maternal morality rates, infant mortality rates, pregnancy-related mortality, and acquired chronic illness. In spite of these disparities, Black women have among the lowest rates of suicide (Chinn et al., 2021; Curtin & Hedegaard, 2019), which is yet another measure of how strength and resilience are the only options considered. According to Williams-Washington and Mills (2018), race is the primary factor contributing to historical trauma. Citing the familial, social, biological, and individual consequences of historical trauma, the authors demonstrate the African American culture's history of race-based enslavement, and resulting disparities as evidence of historical trauma.

SBW/HT Framework

The conceptual model of the SBW-HT framework (Figure 1) demonstrates the SBW archetype as a collection of trauma-induced behaviors and thinking patterns that developed in response to the trau-

ma associated with generations of enslavement and ongoing oppression. Central to this framework is the ideology of strength, which serves as the vehicle of intergenerational transmission of the past trauma of enslavement, and demonstrates the archetype as a historical trauma.

A trauma experience

From 1619, when the surviving 21 enslaved Africans arrived as cargo on the *White Lion* in Jamestown, Virginia (Hannah-Jones, 2021), African American women have been subjected to the uncertainty of tomorrow through daily acts of violence, oppression, racial harassment, and microaggressions, with few opportunities for respite. Recent state legislation has sought to remove the accurate history of enslavement from modern textbooks; however, the literature and lived experiences of its descendants give voice to its existence. Respected no more than mules (Beaufoeuf-Lafontant, 2007; Harris-Lacewell, 2001), and subjected to the same labor expectations as men (Jones, 1982; Leary, 2005), enslaved African women worked from dawn to dusk, with added expectations of nursing and raising the offspring of their captors (Ball, 1999). Frequently subjected to the brutality of rape and forced mating, enslaved African women also suffered the same severe consequences as men in response to acts of defiance and insurrection (Jones, 1982). Whippings, hangings, mutilations, and sexual assaults were common and legalized forms of punishment, in addition to daily exposures to sexual harassment, and bearing witness to the torture, abuse, and murder of others (Ball, 1999). Dehumanization was a feature unique to American chattel slavery (Ball, 1999), and disavowed enslavers to expectations of respect, as laws did not exist to protect the enslaved.

Stereotypes of promiscuity and immorality were also weaponized, and portrayed enslaved women as deserving of victimization (Wilson, 2021). This was but one of several means to exploit labor and justify atrocities of abuse. J. Marion Sims, often referred to as the "Father of Gynecology," is quoted as having said enslaved women were "able to bear great pain because their 'race' made them more durable and thus they were well suited for painful experimentation" (Leary, 2005, p. 81). This characterization of African women as superordinately strong served a white supremacist agenda that capitalized off their supposed physical and emotional "strength" and reproductive labor (Mullings, 2006). Scholars believe that applying this label of *strong* to enslaved women allowed enslavers to resolve themselves of feelings of guilt and remorse, thereby justifying their atrocities, and emboldening brutal acts of physical and sexual violence upon their victims without regard for their identity as either woman (and therefore deserving of preferential treatment) or human (Littlefield, 2008). This defeminizing ideology of Black womanhood also served to differentiate enslaved women from the fragile, delicate images of white femininity and "sexual purity" (Wilson, 2021, p. 124), a pattern that continues to this day as African American women are frequently subjected to societal bias with regards to both gender and race (Jones & Shorter-Gooden, 2003). Interestingly, Billups et al. (2022), in a study exploring intersectionality, found that Black women have a "unique perceived absence of status" (p. 1) that is inconsistent with stereotypes associated with being either a woman or being Black. The researchers suggest that this status renders Black women as "differentially vulnerable " (p. 7) to stereotypes associated with race and gender when compared to white women and Black men.

A trauma response

Traumatologist Peter Levine defines trauma as the body's natural response to an overwhelming situation (1997). The overwhelm can be due to a single incident of shock, ongoing relational/developmental threats, or a combination of the two over prolonged periods (Herman, 1997; Solomon & Hiede, 1999; Terr, 1990). Traumatology research reveals that survival neurochemistry, resulting threat detection, and psychological defenses are generated in an immediate response to prepare the body to fight or flee, and if that is not feasible, to fawn, freeze, or *flop* (collapse, much like an opossum in the face of threat). The more survival neurochemistry the body must break down and digest, the more inflammation, developmental interruption, and emotional re-organization in the form of post-trauma growth must be catalyzed across the lifetime (Jayawickreme et al., 2021). The earlier, more chronic and disruptive the trauma, the less likely the sufferer will have opportunities to integrate healthful post-trauma growth (Ault, 2021; LaPierre & Heller, 2012; Tranter et al., 2021;

Widyorini et al., 2021). Because African American women in a *pigmentocracy* (social ranking according to melanin levels [Menakem, 2022a]) are unduly targeted and oppressed on a regular basis, chronic threats without significant respite can interrupt the benefits of post-trauma growth, maintaining the necessity of the archetype as a coping and survival response for many within this category (Chin et al., 2023; Saleem et al., 2020).

In an effort to mitigate the physical and psychological threats of enslavement, African American women adopted a pattern of coping that increased the chances of survival: the ability to sacrifice their own comfort and needs for the sake of nurturing and preserving the family unit (Romero, 2000; Boyd-Franklin, 2003). Rather than succumb to the traumas of legalized sexual, psychological, and physical abuse, enslaved African American women embodied the racist-fueled persona of strength, and learned to minimize emotional expression, recognizing that such displays only intensified the savagery of their white feral (Menakem, 2022a) captors, and put themselves and others at greater risk (West, 1995). Suffering in silence, suppressing emotion and need, engaging in what would later be referred to in the literature as self-silencing (Jack, 1991), and sacrificing their own well-being while caring for others became their only recourse. Being able to do so permitted their survival, and ultimately the survival of an entire culture and race (Mullings, 2006).

Birthed in response to the trauma of enslavement and a need to survive, the SBW archetype exists as a collection of trauma-induced adaptive behaviors. These behaviors include self-silencing of needs and emotion, excessive caretaking, and self-reliance, which enabled the enslaved to survive the horrors of captivity and sit at the intersection of a freeze/fawn trauma response. The characteristic traits of the archetype (self-silencing, suppression of need, self-reliance, and caretaking) demonstrate evidence of anticipatory trauma, as they are enacted even when trauma is not identifiable because of the pervasive and insidious presence of racism and discrimination.

Self-silencing and suppression of need

The ability to silence and ignore one's own distress, known as self-silencing, is a key trait among SBW (Abrams et al., 2014, 2019). As renowned anti-racist professor Ken Hardy states, "silence is the hallmark of oppression" (2016, p. 133). The theory of self-silencing purports that the silencing of self-expression occurs to prevent the disruption of relationships, and to avoid conflict or retaliation (Jack & Dill, 1992). The behavior manifests through four distinct pathways: (a) silencing the self (suppression of emotion and behavior to avoid conflict), (b) the divided self (presenting a socialized version of self that masks inner feelings of anger and hostility), (c) care as self-sacrifice (maintenance of relationships through prioritizing and caring for others over care of self), and (d) externalized self-perceptions. Abrams et al. (2014) contend that externalized self-perceptions are rooted in a socio-cultural context, meaning African American women feel compelled to project images of strength to meet socio-cultural expectations. Any displays of vulnerability are considered a weakness, including help-seeking for emotional or mental health concerns, and are discouraged through implicit comments that encourage suppression of one's needs and emotions. In response to these expectations, African American women engage in self-silencing to maintain the imagery of strength that is historically rooted in transgenerational trauma. Highlighted in multiple studies (Abrams et al., 2014; Watson-Singleton, 2017; Woods-Giscombe, 2010), self-silencing veils psychological distress in African American women, resulting in avoidance or delays in professional help-seeking, avoidance of inconveniencing others by asking for assistance or appearing vulnerable, and engaging in excessive activity and work-related tasks that mask distress.

Traumatologists conceptualize this kind of chronic holding and over-functioning pattern as the necessary and predictable freeze/fawn response to ongoing threat when fight/flight is not a feasible option. Tonic immobility, or freezing, is a survival response when it preserves psychophysiological integrity in the short term by shortening breathing, tightening muscles, heightening overall awareness, and narrowing the field of vision to be focused on environmental threats, while shutting down sensation (Volchana et al., 2017). It is the target or victims' wise embodied survival reaction to inescapable abuse and torture; specifically, when "fleeing or aggressive responses are likely to be ineffective, a freeze response may take place" (Schmidt et al., 2008, para. 2). Tonic immobility

floods the body with inflammatory survival neurochemicals such as glucocorticoids, adrenaline, and norepinephrine (Geracioti et al., 2008; Ford, 2009); these stop the body in its tracks, and prevent the blood from pumping out too fast in case of attack in order to preserve the chances of survival (Levine, 1997). These survival neurochemicals also lead to short-term numbing of the body/mind, a small mercy provided by nature. In post-trauma stress disorder, these neurochemicals continue to be measurable outside the normal range that helps the body respond effectively to short-term stressors, and then return to a resting baseline. *In utero* glucocorticoid programming appears to be one of the mechanisms of transgenerational trauma transmission (Yehuda & Bierer, 2007).

Sacrificial caregiving

Pete Walker aptly described how when danger is perceived as slightly less life-threatening, and yet still imminent and impossibly inescapable, we will have biobehavioral and neurophysiological access to the *fawn* response, also known as "please and appease" (Walker, 2003). Fawning is mediated by the social engagement system of our complex neurophysiology, and thus, we will use all our social skills to unobtrusively negotiate our way out of imminent and ongoing danger from one who has more power than we do (Mandeville, 2021). Fawning behavior is commonly conceptualized – often blaming the victim – as codependency in mental health literature. However, it is a learned survival behavior to try to fend off long-term threats we cannot escape (such as children experience with their caregivers), and can result in abdication of personal needs and voice in exchange for any shred of safety, and access to needed resources (Ryder, 2022). The traumatic entrapment of Stockholm syndrome, often much less brutal than chattel slavery, has been linked to the please and appease behavior of survival through fawning (Cantor & Price, 2007). Both freeze and fawn tend to be equipped with life-preserving anger, more repressed than in the fight/flight response, because its expression can increase the risk of subsequent threat (Owca, 2020). A growing understanding of process addictions, such as overwork, links over-functioning characteristics of fawning to traumatic stress (Wilson & Johnson, 2013). These over-functioning characteristics are often valued by oppressive systems, which makes them more insidious to grapple with when that over-functioning serves the oppressive systems that impart the trauma, and require over-work from the victims. The day-to-day functioning of enslaved women required them to over-function to survive.

In an effort to cope with the fall-out of a racist society, SBW women absorb the trauma of their communities and families, and externalize their experience by converting trauma energy into physical action through labor and production. Releasing stored trauma energy is not a new concept, and is consistent with the modern day practice of bottom-up somatic therapies that encourage the release of stored survival and overwhelm energy through breathwork, humming, and sounding; authentic, protective, and rhythmic movement; healing touch in safe community; and creating a post-intervention coherent narrative to restore emotional equilibrium and connection (Aposhyan, 1999, 2004; Craig, 2015; Hartley, 2004; Heller & LaPierre, 2012; Johnson, 1995, 2018; Johnson, 2018; LaBarre, 2001; 2004; Levine, 1997, 2008; 2010; MacNaughton, 2004; Menakem, 2017, 2022 a & b; Ogden & Fisher, 2015; Pert, 2000; Porges & Dana, 2018; Rothschild, 2000; Solomon & Siegel, 2003; van der Kolk, 2014; Weaver, n.d.).

Self-reliance

Davis (1995) rationalized the necessity of African American women's independence in the absence of their partners to provide protection during enslavement, and the significance of other adaptive coping schemas given the lack of access to much needed resources. The brutality of enslavement often meant that partners were separated in an effort to maintain control, and decrease the chances of revolt in defense of one's mate. This loss of protection required enslaved women to demonstrate an uncommon endurance (Beauboeuf-Lafontant, 2009), often described as an ability to keep moving despite the adversity created by the hardships of enslavement. While self-reliance is often considered evidence of post traumatic growth, underlying schemas that challenge notions of emotional support and endorse self-reliance are demonstrated to increase psychological distress. Watson-Singleton (2017) found that the embodiment of the archetype is inversely associated with perceived emotional support; the more one embraces the schemas of emotional suppression and self-reliance, the less perceived support is experienced, mediating the

relationship between schemas associated with the archetype and psychological distress. The authors suggest that the pressure to *embody* self-reliance by the avoidance of asking for help maintains the facade of strength, and may aid SBW in navigating hardships without support with a cost for psychological wellbeing.

Porges coined the term neuroception to describe the brain's ability to detect danger and safety, and respond accordingly with a fight, flight, freeze, or flop response. Once activated, the detected level of threat determines whether the response is social engagement (seeking out others for help); or, when faced with a more immediate danger, fight or flight; or, when demise is likely, freeze or flop. For enslaved women, the will to survive afforded a shift in trauma energy from fight/flight to production. The importance of the coping behavior cannot be underemphasized as enslaved women's value was often equated to their ability to produce, whether it be offspring or physical labor. In times of distress, the expectation that others would step in to protect against acts of violence was refuted so consistently that reliance upon others for safety quickly took on an element of danger, as those offering support or protection were also subjected to abuse.

Therefore, the authors assert the SBW archetype is a predictable, prosocial, transgenerational post-trauma stress response that requires skillful trauma-informed care to – in particular because SBW may likely continue to face proximal and distal threats to their and their beloveds' safety and dignity in a racially stratified society that often protects offenders.

Transgenerational transmission

Consistent with the theory of historical trauma, the SBW/HT model asserts a shift from an individual deficit perspective of the archetype to a socioculturally-attuned one that considers the ongoing systemic oppression of African American women as the catalyst of the disparities they experience (Otega-Williams, 2017). Specifically, this perspective calls attention to the necessity of the generation-to-generation transmission of the archetype, as African American mothers prepare their daughters to face the realities of a racist and patriarchal structure that continues to regard Black women in dehumanizing terms (Anyiwo et al., 2022; Everet et al., 2016; Oshin & Milan, 2019). Transgenerational transmission occurs when a traumatic event "takes place to either an individual, family, or collective community and gets passed down to subsequent generations…often perpetrated by outside sources rather than within the family itself… (including) discrimination, oppression, violence, sexual abuse, accidental deaths, and suicide" (Stress and Trauma Evaluation and Psychological Services, 2022). The current authors posit the embodiment of strength as a form of transgenerationally transmitted post-trauma growth, collectively demonstrated in response to what Solomon & Heide differentiated as Type III trauma, "when an individual experiences multiple, pervasive, violent events beginning at an early age and continuing over a long period of time" (1999, p. 1). This embodiment of post-trauma growth, while decidedly prosocial and collectively demonstrated, comes at a personal cost, and merits sensitive therapeutic support (Ortega-Williams, 2017). It is our contention that the embodiment of strength, and its unrealistic demands, serve as the vessel through which the trauma of enslavement has been passed.

The image of strength is a hallmark feature of African American womanhood, and the literature is replete with references to its necessity (Woods-Giscombé, 2010). In a study conducted by Wallace and colleagues (2019) examining wellness among SBW, participants reported witnessing strength in the mothers, aunties, and grandmothers who raised them. Participants reported they were bombarded with messages of strength in childhood. Unspoken expectations that they would be SBW were shared through implicit and explicit messaging, with threats of ostracization if expectations were not met. Wallace found that the cultural expectations of strength associated with being a SBW (suppression of emotion, caregiving, and self-reliance) were ingrained through consistent reinforcement of what participants referred to as survival skills. These skills were necessitated by discourse that dictated the culturally sanctioned and expected roles of Black women, one of which was to *be* a Strong Black Woman.

Further evidence of the generational transmission of the archetype is found throughout the literature (Beauboeuf-Lafontant, 2009; Romero, 2000; Harris-Lacewell, 2001). Watson and Hunter (2015) discussed the necessity of these traits as tools for African American girls to address the unique stressors

associated with their race and gender. Abrams and colleagues (2014) found that strength in the form of compulsory resilience, independence, and leadership served as a mandate for survival. Referencing the experiences of their ancestors, participants in this qualitative study gave voice to the lived experiences of hardship and survival through generations of oppression. The descendants of enslaved African women continue to enact and pass down these and other cultural coping behaviors, with little awareness of the archetype's historical roots as a trauma response. Evidence of this generational transmission shows this trauma has bidirectional deleterious effects (Colen et al., 2019; Condon et al., 2021; Wade-Gayles, 1984).

The lingering impacts of historical trauma on future generations of SBW

Discussions of HT in SBW women are incomplete without consideration of the social impact of persistent institutional and systemic discrimination and racism. A growing body of research links the SBW archetype to poorer psychological functioning. Seeking to understand the relationship between the archetype and stress, Donovan and West (2015) found that a high embrace of the SBW tenets increased participants' reports of stress and depression. Nelson and colleagues (2016, 2020) found that underlying schemas associated with the archetype discouraged professional help-seeking behaviors for both physical and mental health concerns. Abrams and colleagues (2019) unveiled evidence of these schemas, and described how they support ideologies of strength and mediate the symptoms of depression linked to the suppression and self-silencing of emotion.

Implications for the SBW-HT framework

Conceptualizing the persona through a trauma lens that acknowledges the façade of strength as a coping mechanism may aid clinicians in efforts toward building trust and rapport. Acknowledging the generational pathways of SBW-hood within the client's family and kinship ties honors their collective best efforts of protecting themselves and those they care about from the lingering effects and dangers of traumatic racism and oppression. Staying present-focused by acknowledging how these efforts show up in the client's daily life demonstrates a respect for the archetype's protective presence, and also creates space for discussing the ways in which it can sometimes feel impairing, particularly when its traits inhibit one's personal. emotional, and physical well-being. Accounts of exposure to microaggressions and racism should be met with validation and acceptance of life-affirming rage, exhaustion, and heartbreak. Broaching the subject of race and racialized stress requires counselors to reflect on their own experiences and training with the topic, which increases cultural sensitivity. For white and white-passing clinicians who have not yet committed to lifelong examination of the implications of living in a patriarchal pigmentocracy, we *implore* you to begin to train in abolitionist and decolonizing approaches in support of SWB (Brock-Petroshius et al., 2022; DiAngelo, 2018; Menakem, 2017, 2022 a & b). Importantly for the present article, deep social and spiritual support are central to flourishing in spite of racialized trauma (Grier-Reed, et al., 2023), reclaiming what chattel slavery systematically attacked, and what white body supremacy continues to try to break in overt and covert ways (DeGruy, 2005; Kendi, 2019; Menakem, 2017, 2022a).

Dr. Donya Wallace is an Assistant Professor at Palo Alto University, Palo Alto, CA and a practitioner of counseling in private practice. Dr. Wallace is a National Certified Counselor, a Licensed Professional Counselor (SC), Licensed Professional Counselor Supervisor (SC), a 2018 National Board for Certified Counselors Minority Scholars Fellow and a 2018 Southern Association for Counselor Educators and Supervisors Emerging Leader. She specializes in the treatment of depression and anxiety disorders in children and adults. Dr. Wallace is a graduate of the Counselor Education and Supervision program at the University of South Carolina. Her research focuses on the intersection of social and historical trauma in the lived experiences of African American women and their mental health. She has published in scholarly journals and presented in state and national conferences on the topics of the Strong Black Woman archetype, Implicit Bias and African American families in counseling.

Dr. Chanta Pressley Moore is a Board Certified Counselor, a Licensed Professional Counselor (TX), a Certified School Counselor (SC, TX), a 2018 National Board for Certified Counselors Minority Scholars Fellow and a Southern Regional Education Board Doctoral Scholar. Dr. Moore is a graduate of the Counselor Education and Supervision program at the University of South Carolina. Her research focuses on issues impacting Black women and students of color. In addition to being featured in Black Mental Health Today, her work has been published in scholarly journals and she has facilitated presentations at the state, national and international levels. Dr. Moore has over a decade of experience providing culturally relevant counseling and consultative support to individuals, families and agencies, in an array of public and private settings. Currently, she serves as Principal Consultant at The Moore Access and is a Contributing Faculty member in the College of Social and Behavioral Sciences at Walden University.

Karen Roller, **PhD**, **MFT**, is an Associate Professor of Counseling at Palo Alto University and-Clinical Coordinator of Family Connections, a parent-involvement preschool system serving-predominantly Spanish-speaking migrant families in the San Francisco Bay Area. Her doctoratefrom Santa Barbara Graduate Institute in Clinical Psychology with a specialization in SomaticPsychology included experiential coursework in pre-and-perinatal psychology. Karen has spenther clinical career in family therapy through community mental health for the marginalized andunderserved including fostered youth, adjudicated youth, and the Latinx migrant community, aswell as international trauma training outreach in Haiti.

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An Anti-Oppressive Quest to Hold a Body

Florie St. Aime

ABSTRACT

This essay is a self-reflection on the embodiment of oppression and the collective desire for liberation from oppressive systems, also known as the practice of anti-oppression. The author shares her own ongoing effort to grapple with de-colonization while facilitating that process for those she serves directly and indirectly. While honoring wisdom traditions outside the mental health industrial complex, she invites the reader to unlearn the violent control paradigms that aim to claim our bodyminds under the guise of fixing them, to instead breathe life into our own healing, and to make space for those we serve to do the same.

Keywords: Anti-oppression, mental health industrial complex, unlearning

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I would like to set you up for reading this essay by offering you the lens through which I write. I am an abolitionist. I work, think, and teach from an imagined future that seems more impossible than not. I think, study, and discuss cultural, social, and institutional oppression. I reject them while working to rid myself of how I have internalized them. I highlight how others overtly use oppression, and bring doubt to places they may quietly linger. I challenge those around me, especially those practicing within the field of psychology, to recognize how our industry plays a vital role in maintaining oppression. I support the people I serve by seeing their internal strategies to survive oppression as important and exhausting, and invite them to lay them down. I have less interest in appealing to the intellect. Although I know it is necessary that it come along, I do want to offer an experience, through this limited tool of writing, for you to feel yourself.

> ***The first result of dispositionalism is a culture reliant on our collective commitment to protect cognitive dissonance.***

I am a Black, Fat, Queer, cis-woman born and raised in Brooklyn, NY, the abused and disfigured land of Lenapehoking, specifically the Canarsee people [1]. My siblings, cousins, and I are the first generation in our lineage to be born within the violently made-up boundaries of the United States of America. My lineage resided last in Haiti; before

that, I am not sure specifically, but at one point in the landmass called Africa. I am a licensed clinical social worker trained in Hakomi[a] and Parts A & B of MAPS[b] MDMA-Assisted Psychotherapy. I currently work, think, explore, create and challenge the emerging Psychedelic Assisted Psychotherapy industry for and with various organizations primarily Gather Well Psychedelics[c]. I spent my career working in community-based organizations and eventually went on to create, manage, and supervise a community-based counseling program with healing justice as our guiding principle. I have and continue to organize with the liberation of Black people at the center. I am an Usui Reiki practitioner, healer, and creator of sacred space. I write all of this so that you understand the seat I occupy.

I am also an English speaker and writer. English was a language forced on me and people all around the world. Literacy has changed the structure of our brains, wiring us towards categorizing rather than making distinctions.[2] Psychological research has been done mostly on university students, who are often English speakers or are very literate, and contain identities that benefit most from systems of oppression. Until this day, 90 percent of psychological research participants are industrialized, literate people who have taken on the Western ideology of analytical supremacy.[2] Research has also mostly been used to provide evidence for elitist ideas of the time. For these reasons, I do not take academic writing very seriously. I do take storytelling very seriously. Most of science today is simply trying to prove what indigenous people have known and passed down for thousands of years, and yet we do not believe their stories.

Everything I have written so far is to illustrate to you the world I am navigating, and how it informs this offering I am going to make below. To understand what I have to share, you must understand something about the vessel it comes from. I think this is sufficient for us to begin the journey towards holding a body.

Somatic therapies are currently heralded as the great equalizers. With a world beginning to take trauma seriously, and to connect body and mind, somatic therapies are exciting because they rely more on the client's inner directedness. There are a few ways we allude to this. In Hakomi, it is the concept of organicity. Organicity in Hakomi is a principle that is "respectful and trusting of a living system's inner wisdom."[3] In MAPS, it is called the inner healing intelligence – the knowledge and power within oneself to move towards wholeness.[4] Even within IFS, there is the concept that under all the protective parts, there is an "undamaged self."[5] These methods ask practitioners to rely on the wisdom of clients, and trust, as my teacher Melissa Grace, trainer at the Hakomi Institute, says often, that "nothing is wrong."

What a welcome shift that was for me when she first said that – a welcome and challenging shift. I was trained to collude with the client, their family, or authority figures mandating them to counseling – that something was wrong, and it was my job to find it. The job of a mental health professional is to make something happen, and we will even force something to happen within the choices we have available to us.[3] So it was relieving to almost rest on "nothing is wrong."

It was also empowering to see my clients as intelligent beings, engaging the unique combinations of strategies they have developed to navigate the world to experience the least amount of pain. However, as I sit with this, "nothing is wrong" coming from a systems-oriented mind. I am realizing the statement may be too narrow. While I agree that nothing is wrong with the people we serve, I think clinicians of psychological models, from psychotherapists to somatic practitioners to psychedelic facilitators, need to spend more time recognizing that there is a *lot* that is wrong in our culture, our social norms, and codes. Something *is* wrong in asking clients to make new adaptations to survive cruel and unusual circumstances. There is a lot of opportunity to learn about what is wrong in our culture from our clients, since they each are unique representations of how to survive a violent, individualist, anti-life world. The burden of cultural issues that are being upheld by systems is falling on individuals. If we can learn to occupy this lens,

a. https://hakomiinstitute.com/
b. https://mapspublicbenefit.com/training
c. https://gatherwell.org/

I imagine we will unburden the body in ways that support the collective.

Dispositionalism

In this American/Western and highly literate culture, individuals are seen as fully responsible for their actions, and their behaviors are always seen as a sign of their character. This focus on individual character leads to *dispositionalism.* [2] Essentially, dispositionalism is decontextualizing humans. There are two major impacts of dispositionalism. The first is a collective and unconscious belief that people are always the same, regardless of circumstance. An example might be "she always gets so angry, and that is why she yelled." The first result of dispositionalism is a culture reliant on our collective commitment to protect cognitive dissonance. We work hard to mask inconsistencies, within ourselves and others, in order to not interrupt the belief that all remains the same.

This hard work of ignoring inconsistencies is a major part of the construction of the mental health industry. Mental health and social welfare programs are integral parts of the non-profit industrial complex (NPIC), medical industrial complex (MIC) and prison industrial complex (PIC). The NPIC eases tensions that American citizens should and do have with wealthy elites and our governments. We uphold the self-protecting barriers the elites impose on citizens. [6] Ultimately, we are the folks who make cognitive dissonance sustainable; more than that, we strengthen it. By the field's commitment to seeing people as individuals with the ability to rise out of their circumstances (with enough help, of course), we continue to turn attention away from the systems that benefit from their oppression. Through our narrow approaches to help, we encourage and offer the support needed for individuals to accept their oppression in society and create more coping strategies.

There is a study I really like (Rayner et al., 2009). In it, people from all over the world were given video clips of underwater scenes to observe. When researchers looked at the eye movements of the participants in the study, they found that Americans focused heavily on the main attraction, and were least able to describe the surrounding landscape of the video – literally choosing to focus in one place, and ignoring the rest. [2] This is cognitive dissonance in action. This study also showcased that members of highly literate Western cultures could describe that main attraction in great detail, and were aligned with prioritizing analytics over holistic approaches.

Although I said earlier that I would not quote studies, I like the span of this one. Like anytime someone quotes research, it aligns with the point I am trying to make. All studies and research do this, because theory is not neutral. Research to prove (or disprove) theory has been used to legitimize cruelty and torture of people, animals, and beings who have lesser societal value. The MIC, research, studies, and cultural values have approved of much of the following, listed below by Mia Mingus:

> Oppressed communities have had long and complicated histories with the MIC. From the continued targeting of disabled bodies as something to fix, to the experimentation on black bodies [d], to the pathologized treatment [e] of and violent attempts to cure [f] queer and trans communities. From the humiliating, lacking or flat-out denial of services to poor communities, to forced sterilization [g] and dangerous contraceptives [h] trafficked to young women of color [i]. From the forced medicalization used in prisons today, to the days when the mental institutions used to be the jails, and the ways that "criminal" and "mentally disabled" are still used interchangeably. From the lack of culturally competent services, to the demonization and erasing

d. http://jme.bmj.com/content/19/1/28.full.pdf
e. http://thinkprogress.org/lgbt/2012/12/03/1271431/apa-revises-manual-being-transgender-is-no-longer-a-mental-disorder/
f. http://www.huffingtonpost.com/jamie-scot/shock-the-gay-away-secrets-of-early-gay-aversion-therapy-revealed_b_3497435.html
g. http://www.msnbc.com/all/eugenic-sterilization-victims-belated-justice
h. http://cwpe.org/files/Norplant%252520and%252520Depo-Provera.pdf
i. https://popdevprogram.wordpress.com/2013/01/30/nyc-public-school-health-plan-pushing-depo-provera-known-to-pose-dangers-for-young-women/

> of indigenous healing and practices. From the never-ending battle to control populations [j] through controlling birth, birthing and those who give birth in this country, to the countless doctors and practitioners who have raped and sexually assaulted their patients and the survivors who never told a soul. From all the violence that was and is considered standard practice [k], to the gross abuses of power. [7]

With information like this readily available, I am often amazed at how much the industry continues to build upon old theories. Somatics is beautiful, yet still builds upon theories that came out of cruel and biased conditions, as described in the above excerpt. It is a miracle (or cognitive dissonance) that with histories and embodied experiences such as those, that people still come to us, asking for our help, wanting to be fixed. I am saddened that we in turn support cognitive dissonance by agreeing we can help, while ignoring that this is the setting we are "helping" within, that much of what our clients are looking to heal may very well be due to the industry they are coming to for help – especially those most oppressed. I am disappointed that we do not instead turn to them and say that nothing is wrong with them, that when living within systems of oppression, our options are actually quite limited, and there are very few that can secure our survival. I wish we would interrupt our own dissonance, and feel the helplessness of the double bind in which we find ourselves, and build tolerance to be in that discomfort, to "sit in the crack," as Bayo Akomolafe would say. I encourage us to remember, especially with those most unvalued in our culture, that we are a location of harm, and that we must tread carefully.

Attribution Error

The second result of dispositionalism is attribution error. The attribution error says that we can make guesses about the internal state of a person based on what we know of them. [2] That information we know about them (or people like them) can explain a present action we witness them taking. This completely excludes the conditions and historical accuracy of the belief about a person in any given scene. We are conditioned in our profession to seek a deep inner reason a person is behaving the way they are. For example, we are more likely to say "she yelled because she was silenced as a child."

But, what if she yelled because a cis white woman was being fucking rude? What if she yelled because people are often making clear that they do not honor her existence as a Black trans woman in quiet nice tones while being dismissive of her humanity? People I serve have had experiences such as this. I have had experiences such as this. There are multiple ways the mental health industry would interject after an incident with these particulars. She could be mandated to a CBT anger management course to learn how to manage her emotions when she is externally triggered. Or if she has the resources, she can see a somatically-trained clinician who will help her get to the core value that she does not feel worthy, and that is how she moves through the world. Or she might see a practitioner who helps her release anger from her liver. Or she could have a psychoanalytic therapist who would help her realize she is really angry with her mom. I am being facetious and oversimplifying here, but I hope you get the point.

Culture as culprit

When do we talk about our culture's oppression of gender and racialized people as the culprit here? When do we grieve that this woman has had to carry the burden of our cultural repression as her own? And that everyone else gets to dump their repression on her shoulders? When do we also get angry, and see that we too could have been the person who ignored her humanity because we colluded with the cultural repression, and that to protect our cognitive dissonance, she gets pathologized?

In September 2020, members of Congress put forth the "Anti-Racism in Public Health Act of 2020" bill (which of course has not passed). The bill states clearly: "Structural racism determines the conditions in which people are born, grow, work, live, and age and determine people's access to quality housing, education, food, transportation, and political power, and other social determinants of

j. http://racialequitytools.org/resourcefiles/The-Color-of-Choice----Public-Version-with-footnotes-1.pdf
k. http://thestringer.com.au/public-stripping-9424#.VNRTnUIlOTA

health." [8] Two results of these conditions are that 61% more Black young people will attempt suicide than white youth, and black pregnant people are 243% more likely to die from pregnancy-related issues than white people.

Can we take a moment here and just feel into that statistic? 243% more likely to die from pregnancy complications. How does that land for you? However, you are feeling, hold also that we have politicians who are asking the world to ignore Black people when calculating U.S. maternal mortality rates, thus continuing the culture's lineage of dehumanizing Black bodies. [14]

It is no longer debatable (although people still do) that anticipation of being treated poorly and unfairly, and experiencing discrimination affects the same neural circuits that would inform the body of physical pain. [9] Due to our growing understanding of allostatic load, we know that the measurable accumulation of stress on the body causes physical ailments. [10]

Again, with this information freely available, our cognitive dissonance continues to create other places to look for the issue, instead of at our culture. In somatic modalities originating from the lineages of the medical industrial complex, we are still not seeing bodies as the grounds of social and political conflict. We are not paying attention to our protection of oppression as a primary lens we are using in our work. We are refusing to see that our cultural leaders, formal and informal, codify their own body shame and beliefs about bodies into official and unofficial expectations of how we must adapt to remain in citizenship. [11] It is not professionally necessary for clinicians to evaluate our own values; we are asked instead to feign neutrality. Neutrality in this culture is always in favor of oppression. That is an issue, because we are the ones who support people to make meaning of their experience.

Impact on the inner healer

Our inner narrators, our inner healers, are not exempt from those messages. I notice there is an assumption that the inner healer is not influenced by the world. To learn how the inner healer has been impacted, it does require a clinician to be able to take a non-neutral stance, and support the inner healer to shed the burdens they are carrying on their bodies for this culture. The sad and honest truth is that accepting ourselves will not stop the onslaught of violence towards bodies in this culture. [12]

The road to that non-neutral stance invites us to be liberated from figuring things out. [11] To seek out the conflicts, the confusion, the inconsistencies, the insecurities, [12] and to build tolerance to be in those spaces. The only world we really can change is our internal one, but we are deluded if we attempt to do so while still pretending that our internal world is not a reflection of our environment, culture, and social structures.

An undoing process

I have some advice for the road. I must warn you; it will be deeply unsatisfying. I will not offer resources, links, or books to read, because it is not an intellectual accumulation task. This is an undoing process. I also am still moving along the path myself, and mine looks different from yours. My advice is that you, the practitioner, and only you, will know what needs to happen once you interrupt your own dissonance and start looking. You must listen to other people's experiences of our shared world. You must see them as the missing perspectives you need to understand your world. This is not a call to action to talk to those people as a means towards your own liberation; it is an invitation to trust those stories when you come across them. Invite others into your process. People who are close to you and love you, allow them to witness you fumble, and trust that they want to be there when you make mistakes and unlearn. Trusting others is an absolutely necessary part of unburdening ourselves of this culture, because our culture is built on accumulating power and mastery, not vulnerability, humility, and curiosity. You must be your own practice ground for liberation.

Your practice ground must extend to the world around you. It must look to destroy the systems that have caused you this harm and grief, and imagine new possible worlds. This lens begs us to move past the individual and into the collective. To see ourselves in right proportion to the culture we are living in, and shatter dissonance; to be responsive and make norms uncomfortable.

Then, recreate that practice ground for the people you serve. I strongly believe that we have the priv-

ilege of being in close proximity to the inner self. We get to practice with the body, psychology, and spirit of a person, creating through limbic revision.[13] But if we hold the same unexplored beliefs of the culture that inflicted the pain, we are very much still carrying the message that their adaptation is the issue, not the world around them. Build a practice ground that does not ask them or us to pretend that there is not plenty to grieve about the conditions that have been enforced around our liberation, expression, and ability to live unbarred.

Being in relationship with other bodies in our culture is not neutral; it is oppressive automatically. Being in connection to other bodies with an anti-oppressive lens often leaves me humbled by how much I still do not know and understand about myself, honored to have my inner world and this other inner world trying to navigate the culture together, heartbroken by the conditions of our suffering, with a righteous anger as well as righteous hopelessness. That is the somatic field I want to work in. That's the conference I want to go to; those are the colleagues who will give me a spark of hope. This is the container where I think we can hold the sacredness of life contained in the fragility of a body.

Until then, let us all struggle towards liberation.

Florie St. Aime (she/hers), **LCSW**, is a Fat Black Queer Cis Woman and Relationship Anarchist born and raised in Lenapehoking, particularly the Canarsee people's land now known as Brooklyn, NY. Florie is one generation removed from Haiti, the land of the Tainos, and before that, the landmass now known as Africa, people unknown. She describes herself as a liberation-based clinician.This label roots her work in naming and blaming social constructs instead of individuals, encouraging curiosity and feeling as resistance, and practicing human connection and care towards all beings as radical action. Florie invites others into liberation practices through organizing/activism, group facilitation/workshops, individual counseling, holding sacred space, and clinical supervision.

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Oppression and Addiction Break Families

Calling Somatic Practitioners to Repair Attachment

Rachel Jacoby, Karen Roller

ABSTRACT

This article reviews the literature related to the disproportionate representation of Black, Indigenous, and other People of Culture children raised in the foster care system. We address the role of bias in referrals made to Child Protective Services, and situate that bias in the greater systems of traumatic oppression that both shape referring professionals' perspectives and systematically wear down families who are pressed to the margins of society, increasing their risk for referral. We explore the role of addiction as a common trauma response and etiology implicated in foster care involvement and question how families are inequitably punished for it. Finally, we call on trauma-informed, anti-oppressive somatic practitioners to help break the cycles of addiction, insecure attachment, involvement in the foster care system, and compassion fatigue for those in its trenches.

Keywords: Addiction, attachment, disproportionate representation, foster care, oppression

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The foster care system in the United States has previously maintained roughly 440,000 children entering into state-run care since 2012 (ACF, 2021; VFC, 2023). With the onset of the COVID-19 pandemic in 2020, the number of children residing in the state-run system decreased to consistently remain at roughly 400,000 children (ACF, 2021). There are also possibly hundreds of thousands more in informal kinship or community care that are not accounted for in official federal or state numbers (Gupta-Kagan, 2021), known in foster care culture as "sweetheart placements." These placements do not seek state funds to subsidize the cost of caring for these children, and therefore are not trained or regulated by the state-run system in their oversight.

> ***Racial disparities occur at nearly every major decision-making point along the child welfare continuum.***

The foster care system was originally intended to provide a safe haven for children as they or their families of origin experience adversities. According to the National Children's Alliance, parents have lost custodial rights because Child Protective Service workers determined "more than 75% of victims were neglected, 16% were physically abused, 9% were sexually abused, and 0.2% are sex

trafficked" (2023, p. 1). However, statistics show that grossly disproportionate numbers of children are referred to and remain in the foster care system based on race and ethnicity (ACF, 2023; Merkel-Holguin et al., 2022; Yi et al., 2023). In the 2020-2021 fiscal year, 391,098 children were living in the state-run foster care system, with 222,110 (60%) identifying as a race other than white (U.S. Department of Health and Human Services, 2022). Given the United States is 75.8% white alone, and therefore approximately 34% Black, Indigenous, other People of Culture (BIPOC; Menakem, 2022), and mixed (United States Census Bureau, 2023), this egregious disparity requires critical examination and anti-oppressive intervention.

For instance, compared to white children, Native American children are 18.2 times more likely to enter foster care. Children identifying as two or more races are 5.1 times more likely to enter foster care. African American children are over 2.9 times more likely to be placed in foster care (U.S. Department of Health and Human Services, 2022). Also of consideration is that a systematic review found "a parent with a learning disability or substance abuse concern, or a family with a larger number of children, receiving public benefits, or experiencing housing instability were significantly associated with decisions to investigate (for abuse)...suggest(ing) that decisions to investigate need to be considered in a wider context, including how vulnerable populations are supported in communities and society" (Damman et al., 2020, p. 801).

The National Coalition for Child Welfare Reform works to make these racially and economically-driven disparities known, and to change the law accordingly (2023). Areas of concern that highlight oppressive experiences for foster children and families include the mandated reporting and investigation referral process, removal process, family team, decision-making meetings, treatment planning meetings, and medical or mental health treatment toward reunification or permanency planning (AAP, 2015; Merkel-Holguin et al., 2022; NCCWR, 2023; Raz, 2022). Additionally, many planning meetings resemble more traditional case management meetings that are directed by one or a small group of child welfare system employees in power, further limiting the voice of birth families, foster families, and the child directly (Merkel-Holguin et al, 2022). As summarized by Merkel-Holguin, "what is supposed to be a support system to protect the most vulnerable has morphed into a fortified composite of structures and administrative barriers that are not only dismembering the family network and thus harming children, but also perpetuating discrimination" (2022, p. 1). This is further clarified by the Child Welfare Information Gateway:

> Racial disparities occur at nearly every major decision-making point along the child welfare continuum. At the national level, African-American families are overrepresented in reports of suspected maltreatment (Krase, 2013) and are subjected to child protective services (CPS) investigations at higher rates than other families (Kim et al., 2017). In addition, African-American and American Indian or Alaska Native children are at greater risk than other children of being confirmed for maltreatment and placed in out-of-home care (Yi et al., 2020). Families of diverse racial and ethnic backgrounds also experience disparate treatment once they are involved with child welfare. Relative to other children, African-American children spend more time in foster care (U.S. Government Accountability Office, 2007a) and are less likely to reunify with their families (Lu et al., 2004), and compared with White children, they are less likely to receive services (Garcia et al., 2016). In addition, African-American and American Indian or Alaska Native children are more likely than other children to be removed from their homes (Maguire-Jack et al., 2020) and to experience a termination of parental rights (TPR) (Yi et al., 2020; CWIG, 2021, p. 3).

These unjust facts mean that marginalized families are at higher risk for systematic disruption of their potential to develop secure attachment between generations, and merit enhanced therapeutic attention toward the goal of secure attachment.

Attachment factors

According to the American Academy of Pediatrics (AAP), attachment is defined as "the relationship between two people and forms the basis for long-term relationships or bonds with other persons" (AAP, 2000, p. 1146). Attachment theory is used to explore the relationships between a primary caregiver and child. Grounded in his early study of maternal deprivation (1951), Bowlby proposed that an infant child requires a stable, ongoing relation-

ship with a loving caregiver as foundational for a healthy experience of their development (Bowlby, 1988; Bretherton, 1992; Nowacki & Schoelmerich, 2010). Through a comprehensive global research program now spanning six decades, attachment studies have found the expanded elements of how biopsychosocial attachment can influence a child's ability to connect with caregivers and peers, as well as the lifelong conferral of benefits or pitfalls depending on how well attachment forms across a spectrum (Coker et al., 2023; Harlow, 2021; Karen, 1998).

Children form either more secure attachments or more insecure attachments (which further differentiate into anxious-ambivalent, anxious-avoidant/resistant, fearful-avoidant/disorganized). Secure attachment is established by having at least one caring and consistent parental figure during their early childhood developmental years, thus encouraging the positive view of self-worth and confidence in the child's relationship with themself and with others (Bowlby, 1969; Miranda et al., 2019). Counter to this, insecure attachment occurs when a child does not feel a stabilizing secure and/or emotional bond with their primary caregiver. This may be influenced by the child's experiences with caregiver inconsistencies, abuse, neglect, maltreatment, or other adverse experiences (Miranda et al., 2019). Insecure attachments experienced in childhood can lead to higher risks of chronic medical diagnoses (e.g., higher blood pressure, risk of stroke, etc; Lewczuk et al., 2021; McWilliams & Bailey, 2010; Pietromonaco & Powers, 2015), personality disorders, mood disorders, lower educational attainment, relational instability, and fiscal instability in adulthood, as well as conferring insecure attachment on one's offspring (Miranda et al., 2019).

For those who end up insecurely attached, the key missing feature appears to be *secure base provision*, which includes soothing a baby to a "fully calm and regulated state while in chest-to-chest contact ...(so the) infant learns...whether the caregiver can be counted on to be available as the infant achieves a calm state or whether (they) typically must stop crying alone" (Woodhouse et al., 2020, p. 249). When babies are born into situations where this regularly occurs, the emotional stability and availability of the caregiver is more likely to remain consistent over time and adjust accordingly as the baby matures (Coker et al., 2023). However, when this preliminary co-regulation is not provided due to caregiver limitation, the available evidence suggests that subsequent adjustment for developmentally-appropriate caregiving continues to be lacking, for any host of reasons (Coker et al., 2023).

Many children living in the foster care system are faced with limitations in consistencies that may further impact their development and ability to form secure attachments after their preliminary opportunity with family-of-origin caregivers was interrupted. Their developmental interruptions are continuous and multifaceted due to ongoing movement between placements and providers; they face the obstacles of building lasting attachments with foster parents/caregivers, peers, teachers, and family members, as well as medical and mental health providers (Mountjoy & Vanlandingham, 2015). Additionally, they face limitations in building socioemotional attachments that can buffer against the development of chronic physical health conditions and increased mental health concerns (e.g., PTSD; Bartlett & Rushovich, 2018; Jacoby, 2021). As one foster youth stated to a current author in their role as newly assigned counselor, "I'm just gonna call you #14".

Unfortunately, limited research has been published to date on the relationship between attachment styles and foster or alternative care (Garcia Quiroga & Hamilton-Giachristis, 2016; Miranda et al., 2019; Schofield & Beek, 2009). However, research on children raised in orphanages, and the known experiences that children living in foster care often have, the available literature suggests that children who feel like they lack control, have experienced caregiver and placement inconsistencies, and who have experienced abuse or neglect in some form are much more likely to form insecure attachments (Jacoby, 2021; Karen, 1998; Miranda et al., 2019; Schofield & Beek, 2009). Systematic review has found that the more diffuse the caregiving across disparate providers, the more disorganized the child's attachment strategies are likely to be (Garcia Quiroga & Hamilton-Giachristis, 2016).

Addiction's role

Addiction is increasingly understood as a symptom of coping with a toxic culture (Maté, 2022). For multiple stress families continually pressed

to the margins of society in the pigmentocracy of a white body supremacist structure (Menakem, 2022), numbing the pain of chronic oppression with substances makes perfect sense (Maté, 2022; Menakem, 2022). Based on the rates of substance use in the last year across racial and ethnic demographics (Center for Behavioral Health Statistics and Quality, 2021, pp. 36-40), it appears financially and racially privileged families (i.e., insured and white) may be presumed to often receive the benefit of the doubt and enhanced access to support where substance use and addiction may be implicated in any form of CPS involvement, given white families' underrepresentation in the foster care system.

As affective science moves somatic interventions from the niche to the gold standard, somatic practitioners will increasingly be needed by addiction centers. The United States Association for Body Psychotherapy is making inroads with addiction treatment centers to begin including somatic interventions in their holistic treatment (LaPierre, personal communication, May 2023). This is a pathway for somatic practitioners to prevent or reduce child abuse and neglect, intervene with adults who suffered child abuse and neglect, and therefore play a significant part in reducing the attachment trauma moderated by addiction and child welfare. For somatic practitioners who do not enjoy working with children directly, working with adults and parents on harm reduction and abstinence programming through skilled somatic care can reduce their risk of relapse, and potentially, child welfare involvement.

Oppression as moderator

Marginalization in a capitalist society. Historically, children were removed from their homes of-origin predominately for living in poverty (Raz, 2022). The framework of the foster care system shifted to include removal due to poverty and other adverse experiences in the late 1960s, when the development of Parents Anonymous support groups led to panic about child abuse rates, predominantly targeting African American families (Raz, 2022). This foundation for removing children based on familial wealth and historical racialized trauma has perpetuated the ongoing marginalization of children and families. Although the foster care system has been reorganized and redeveloped since its inception, the structure and bias that still exists in the child welfare system reinforces the undesirable outcomes of oppressive experiences upon children, particularly people of culture (Merkel-Hoguin et al., 2022).

The issues of marginalization and racial disproportionality in the foster care system are representative of the ongoing systemic prejudice within the U.S. (Ackerman, 2017). When a child enters foster care, their birth family and foster families are in need of support and services to help facilitate the child's healthy development and attachment (Ackerman, 2017). Unfortunately, birth families involved in the foster care system report many barriers to receiving support and services for themselves and in attending to their child's needs. Foster parents also report feeling inadequately trained to offer a safe space for a child in their home, and receive poor compensation from the foster care system to support the needs of the child (Ackerman, 2017).

Resource limitations

As addressed previously in this article, inequities regarding access to resources for children living in foster care, as well as for their birth families and foster families, are implicated in the quality of intervention necessary to maintain families intact. There is a tremendous amount of medical and social services literature that addresses the needs of children in foster care; however, recommendations on the frequency of care and care coordination remain scarce (AAP, 2015). Additionally, the literature is focused on white individuals and built on persistent systemic and institutional racism, with limited information on how to support BIPOC children. BIPOC children living in foster care are at increased risk for unmet culturally-affirming mental health and physical health needs. However, they are less likely to receive or benefit from the services available due to accessibility and availability limitations, appropriateness of treatment or provider, and stigma-based experiences that clients or families hold towards providers based on negative personal experiences (Metzger et al., 2023).

Public education. Families pressed to the margins need public education to introduce and develop skills to break problematic patterns arising from unresolved historical trauma and ongoing oppres-

sion. For instance, it is increasingly standard for basic sexual education to be taught through physical education courses, or specific guest lectures structured for the developmental stage of the audience in elementary and junior high public schools. However, it is not standard for all public education students to be taught about healthy boundaries, domestic violence, how to protect themselves from abuse, or how to prosocially assert themselves when raised with neglect. It is also not common for all students to be taught about the centrality of attachment, how human beings are wired to stick to people and be deeply shaped by them, whether or not the relationship is healthy. This means that the general public often copes with whatever attachment or substance use pattern they have been handed without really knowing there are other options, unless they happen to end up in therapy at some point with an attachment-oriented or recovery provider.

Therefore, another way somatic practitioners can improve the lives of the public. and hopefully reduce child welfare involvement, is to provide outreach psychoeducation through their local school districts. Providing family information nights and large-scale presentations to entire classes and schools is another way to make explicit how important sobriety and secure attachment are, how to get help to improve attachment or harm reduction at home, how to heal our own attachment wounds, and how to connect with local providers for more in-depth, ongoing help. Sending out information and resources about earned secure attachment to all families in a district through a weekly email can also begin to plant seeds for families who may know they need help, but aren't sure where to start.

Limited access to services. Unlike adult clients with means, who can choose to self-refer to a consistent provider of their preference, families at risk and children who have been pulled from their families are at the mercy of county mental health safety net systems. These safety net systems have a very high bar for entry due to the limited public funding they draw upon to run, and have high turnover due to burnout, low pay, little room for advancement, and other quality of life impingements that can make these jobs unsustainable (AAP, 2015; SAMHSA, 2022). Furthermore:

> Healthcare access for traumatized children is time-consuming and challenging. Care coordination is particularly difficult for children in foster care because of the transient nature of the population and diffusion of authority among parents, child welfare, professionals, and courts. Receipt of health care is often fragmented and crisis-oriented rather than planned, preventative, and palliative. Evidence indicates that FP and CW may not fully appreciate all of the child's health conditions and lack the expertise to access and negotiate a complex health care system on behalf of children with significant needs (AAP, 2015, p. 1133).

Clearly, somatic practitioners can help these overwhelmed systems by offering sliding scale services for the frontline workers and foster care providers and children. Monthly trainings and support groups for workers, and consultations with management to support more coherent and cohesive functioning, is also another way bottom-up processing can be infused into systems these marginalized clients must navigate. Regularly bringing embodied regulation into these systems that must down-regulate so much activation can help reduce the load on frontline staff, which theoretically will reduce fragmentation and crisis reactivity over time.

Lack of public systems investment. The Mental Health Services Act does occasionally support basic professional development (i.e., completion of a master's degree) of some qualifying county safety net workers. Unfortunately, public mental health workers are largely undervalued, much like public school teachers, and find themselves barely able to care for their own financial and physical needs month to month. Chronic stigmatization about mental health needs crosses all demographics, but the result is that widespread acknowledgement about what is needed for human beings to function well still isn't part of the cultural fabric in most countries, and being a part of the public mental health workforce can therefore be a lonely experience for workers (Stuber et al., 2014). The grant funding necessary to provide enhanced trauma resolution training for the public mental health workforce is very scarce, which creates competition amongst lateral programs to fight over who is worth training. Given there is not much power or glory from working in public safety net settings, one must have a deep sense of internalized purpose and calling to sustain the emotional demands,

while knowing there is no natural stopping place with the work. This results in predictable risk factors for all levels of public systems workers, some of which can become irreversible if not tended to vigilantly.

Compassion fatigue. Compassion fatigue, also known as vicarious traumatization in the helping professions, is a chronic risk factor for child welfare workers (Allen, 2010; Campbell & Holtzhausen, 2020; Conrad & Keller-Guenther, 2006; Zerach, 2013). The vulnerable populations they serve, their high caseloads, the helplessness to change the systems they operate in, and the sense of inevitability of poor outcomes can compound general burnout and ongoing exposure to traumatized clients into a sense of being traumatized by one's work (Audin et al., 2018; Rothenberg et al., 2008). Compassion fatigue can affect entire organizations, thus reducing the perception of available support for workers to recover from the ongoing demands they face, and normalizing a dismissive tone to human needs and feelings (Sinclair et al., 2017). This erosion of the capacity to empathize with client stories and needs can result in the silencing response, whereby the helping professional directly or indirectly shuts down client processing of overwhelm and pain (Chun et al., 2023).

Compassion fatigue can also impact foster care providers' sensitivity to foster children's needs (Teculeasa et al., 2022). Given the shortage of foster care providers and workers, the resource limitation of compassion satisfaction likely effects everyone who finds themselves trying to navigate the demands of this system, and merits therapeutic support from skilled trauma professionals who are not absorbed in the system itself. This is another way somatic practitioners can bring their advanced skills to bear for the good of all involved, by offering bottom-up training and group support to the care providers and workers who uphold the majority of front line service.

Placement instability. While living within the foster care system, the fluidity of placement creates instability for many. Children may experience placement disruption for a number of reasons, including demonstrated negative behaviors, maltreatment from caregivers, unsafe living conditions in foster homes, and state mandates indicating removal (Jacoby et al., 2023). Additionally, factors including age and race also indicate higher rates of placement instability among children living in foster care (Jacoby, 2021; Koh et al., 2014). Within the current literature available, it remains unclear as to why children of culture experience higher rates of placement disruptions. Some studies have predicted that this may be due to the over-representation of Black children living in the foster care system, while others have indicated that this may be because BIPOC children seem to have longer stays in the foster care system compared to white children (Foster et al., 2011; Kennedy et al., 2022; Sattler & Font, 2021). However, literature is available on the psychological impact experienced by children living in foster care due to placement instability (Ackerman, 2017; Greiner & Beal, 2017; Turney & Wildeman, 2016, 2017). At this time, a lack of adequate samples is available to provide further explanation for this inconsistency in the foster care system. The current authors posit that the historical and persistent institutional trauma of racism does not have a null effect on the over-representation of BIPOC children placed in foster care, the lack of consistency and equitable care provided to them once in it, and the length of time they are held in it rather than returned to their families because culturally-affirming, anti-oppressive, effective intervention has been provided.

In utero substance exposure. Fetal alcohol spectrum disorder is an over-simplified diagnosis that is prevalent and yet underdiagnosed (Weir, 2022); Alcohol-related neurodevelopmental disorder also does not clearly capture the synergistic effect drugs of abuse tend to have when any combination cross the placental barrier and impact the developing fetal brain and nervous system (AK Child & Family, 2020; Chasnoff et al., 1982-2015; Hagan et al., 2016; Peterson et al., 2020; Ross et al., 2015). The DSM-V has most recently attempted to capture the effect of *in utero* substance exposure with the "other specified neurodevelopmental disorder associated with prenatal alcohol exposure" (American Psychiatric Association, 2013; p. 86). However, none of these diagnoses acknowledge exposure to any other substances. Thus, the general mental health practitioner attempting to anchor services to an accurate diagnosis justifying medical necessity and related treatment planning may overlook research and training for nervous system and behavioral implications of a wide variety of drugs of abuse. This gap in understanding by clinical faculty and supervisors can result in misdiagnosis of chil-

dren, resulting in well-intended but insufficient treatment planning (Chasnoff et al., 2015). This problem is statistically significant, as Peterson and colleagues found that more than 60% of pregnant women report using illegal substances, and 15% have a substance use disorder. These women are often younger and experiencing material and social deprivation. Owing partially to its decriminalization, marijuana use during pregnancy has increased nearly seven-fold in the past decade. The U.S. opioid crisis has been associated with a concomitant epidemic of use among pregnant women, and with withdrawal syndromes in their prenatally exposed newborns. Cocaine use remains relatively stable, with approximately 750,000 pregnant US women using this drug annually (2020, p. 832).

Training to identify the genetic and epigenetic risk factors, facial dysmorphology, sensory processing and nervous systems difficulties, and complex learning and behavioral disorders typical of substance-exposed newborns (SEN; West et al., 2020a), neonatal abstinence syndrome (NAS; Wachman et al., 2018), and *in utero* substance-exposed children can be obtained through Arizona Trauma Institute (2021), Children and Family Futures (2023), Children's Research Triangle (2015), and the National Center on Substance Abuse and Child Welfare (n.d.), among other options local to practitioners' region of service. Wraparound service on a team addressing various family members and their relational needs is indicated. Thus, somatic practitioners with a heart for this work are encouraged to network through training sites to offer bottom-up trauma resolution and self-regulation skills via family therapy whenever possible (DiClemente et al., 2021).

Clinical and advocacy considerations

Prevention. Ideally, families at increased risk of referral to Child Protective Services would consistently be offered preventive support and intervention through community mental health agencies and preschools that are funded by grants so that the service is not experienced as a punitive requirement that must be chosen over food, rent, or medicine. Unfortunately, such prevention is not widely available. Larger metropolitan cities and some more rural towns are home to community-based agencies that seek related grant funding. Such funding sources are often kept private-facing by the agencies in question to reduce stigmatization of families receiving services through them. However, the savvy clinician can run a search on child abuse prevention grant award winners in their area to find a list of recent awardees who would likely be grateful to have skilled trauma therapists provide prevention services, supervision, and/or line staff training. Therefore, somatic practitioners who have a heart for multiple-stress families and attachment trauma work are encouraged to consider offering supervision and/or direct preventive outreach to families at elevated risk through local community-based agencies that seek funding from the Office of Child Abuse Prevention (OCAP, 2023), Community-Based Child Abuse Prevention (Children's Bureau, 2022), etc.

Practitioners working in these or primary care settings may help interrupt *in utero* substance exposure by training as a perinatal educator, facilitating pregnancy dialogues (APPPAH, n.d.), and/or integrating Chasnoff's 4 P's Plus (2005), or the "I am Concerned…" booklet and shaking baby video with pregnant parents (NTI Upstream, 2020). Consultation with primary care providers and extended family networks to support substance recovery efforts are often necessary to support gestating parents who are early in Prochaska's stages of change (DiClemente et al., 2021). Those who specialize in this family development stage need to know that while many medical doctors were trained to believe that up to one drink per day is healthy for a pregnant parent, Chasnoff's decades of research have shown that no amount of alcohol or other substances, including tobacco, are safe for the developing fetus (Chasnoff et al., 1982-2015).

Another form of prevention for foster care involvement that attachment-oriented somatic practitioners are particularly well-suited for is the evidence-based practice for *in utero* substance exposure, Theraplay (https://theraplay.org/), which provides psychoeducation and gently sculpted attunement interactions to parents in recovery from substance use (Weir et al., 2021), domestic violence (Bennett et al., 2006), early developmental neglect and abuse resulting in relinquishment to adoption (Munns, 2015), and a host of other developmental delays from genetic and epigenetic risk factors that interrupt optimal development and secure attachment (Money et al., 2021).

Theraplay training happens in two stages. The first is a four-day cohort introduction to principles and skills, followed by a two-day trauma-informed assessment and skills practice intensive for either parent-child dyads or groups of children (e.g., for school settings). The second stage is an individual supervised practicum that supports skills development toward certification. For the purpose of supporting family networks, the parent-child dyad training is more relevant.

Intervention. Children whose families do not receive the preventive services they need to stay together healthfully may spend their young lives raised in the institution of foster care. They suffer multiple interruptions to their attachment systems and developing nervous systems, sometimes in addition to the lifelong implications of acquired brain and nervous system injuries for those who suffered *in utero* substance exposure (Chasnoff et al., 1982-2015). These folx predictably manifest reactive attachment disorder and insecure attachment across the lifespan at much higher rates than children who never enter the system (Garcia, 2021; Miranda et al., 2019; Perry, in press). Those with *in utero* substance exposure may be misdiagnosed with up to 13 diagnoses that they indeed qualify for; however, the etiology for the behavioral concerns is not captured (Chasnoff et al., 2015). This misdiagnosis can lead to ineffective treatment planning and intervention.

Such attachment trauma and ineffective intervention results in lifelong complications with achieving and sustaining stable relationships with peers, partners, and their own children. Simply having alternative caregivers who are themselves securely attached can increase the earned security of those insecurely attached they serve, even without the provision of logistical support (Saunders et al., 2011). Therefore, trauma-informed care is vitally important across the child welfare system (Beyerlein & Bloch, 2014), as is helping these youth get embedded in logistical support networks that can substitute for some of the life skills training typically scaffolded by one's family of origin.

It is well understood in the attachment literature that as social mammals, all human beings depend on at least one stable, predictable, calming relationship to develop towards earned secure attachment. Unfortunately, for children in foster care, this need often goes unmet (West et al., 2020b). Therefore, the current authors urge somatic practitioners to realize that advanced trauma training centered in somatic approaches makes body-inclusive practitioners ideally suited to serve foster youth, alumni, or families trying to reunify. Offering a youth in foster care this quality of predictable co-regulating support can forever change their quality of life for the better.

A Home Within (n.d.) is a national volunteer network with 18 chapters that vets and trains mental health professionals of any clinical background to commit to a foster youth or alumni for life. While most A Home Within volunteers are traditionally-trained talk therapists with varied theoretical understandings of trauma, somatic practitioners' nuanced training in bottom-up trauma processing modalities increases the likelihood of sensitive relational trauma resolution and integration for foster youth and alumni. Such skilled support can literally be lifesaving, as it can engender the felt experience of professional help-seeking resulting in beneficial outcomes, while also developing portable self-regulation skills that many well-intended professionals simply are not trained to provide (Kozlowska et al., 2020; Kuhfuß et al., 2021; Neal, 2021; Rothberg, 2014).

Advocacy. Another organization desperately in need of skilled trauma therapists is Court Appointed Special Advocates (CASA). CASAs maintain a less formally therapeutic container and relationship with the youth they serve. They are similarly vetted and trained to understand the needs unique to the child/youth they will serve, and are provided group consultation for support around those needs as the child develops. CASAs are a voice for the child in child welfare court, often speaking to needs and desires that the child has no other way of expressing directly to their placement representatives or families (CASA/GAL, 2023). Spending more organic time with such a supportive, regulated adult whose intention is to articulate the child's voice in court likely affords many of the same benefits of focused trauma treatment, in particular for youth who developmentally cannot yet engage with a high degree of motivation in therapy.

Children's Advocacy Centers (CACs) are another avenue for somatic practitioners to engage in advocacy for foster youth and their families, where organizational structures already facilitate intentional movement toward family systems interven-

tion, rather than dismemberment. The primary goal of CACs is "to ensure that children are not further victimized by the intervention systems designed to protect them" (National Children's Alliance, 2023, p. 5). CACs recognize that the administrative and bureaucratic barriers erected by the child welfare system can perpetuate the overwhelm and loss of control that children pulled from their families already feel, and aspire to provide trauma-informed care through every process and relationship inserted into the life of a child navigating the foster care system. CACs also aim to place families of origin back in the wraparound treatment model to "better provide(s) help, support, and protection to children and families as they pursue healing and justice" (p. 5). This approach likely reduces compassion fatigue and burnout among workers; however, no published research to date addresses this attachment-centered prioritization of reunification.

Skilled clinical care that advocates for logistical support, and integrates embodied clinical skills for relational trauma resolution, will likely increase attachment security more effectively for the clients, while preserving compassion satisfaction for the workers. Such holistic care can transform clients' insecure attachment patterns toward more earned secure attachment. Therapy and/or advocacy resulting in earned secure attachment can then be paid forward via transgenerational transmission, as securely-attached parents, whether that security is continuous or earned, are more likely to confer security of attachment on their offspring than insecurely-attached parents (Bosquet Enlow et al., 2014; Saunders et al., 2011; Shah et al., 2010).

Conclusion

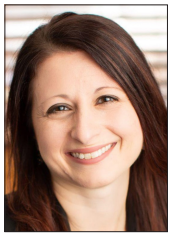
In the U.S., BIPOC children are disproportionately represented in the foster care system by nearly double their population ratio. Available literature points to bias and discrimination in mandated reporting practices, removal decisions, placement decisions, retention rates in maintaining stable placements, and reunification rates with families of origin. Furthermore, because the field of mental health is a predominantly white institution (Roller et al., 2023), front line staff and supervisors statistically do not match racially or ethically with this vastly underserved population. The insidious embodiment of prejudice makes accountability in hierarchical systems of power that can break families apart very difficult to combat, therefore foster youth need decidedly anti-racist and anti-oppressive mental health practitioners to advocate for them as they navigate these decision-making processes beyond their control.

There is much work to be done to reconstruct a mental health system that does not replicate oppressive racist patterns seen at every level across the country. Efforts need to be made to prioritize family preservation over child removal (Littell & Schuerman, 2002, 2021; Ryan & Schuerman, 2004). Toward that end, the advanced skillset of anti-oppressive somatic practitioners makes them uniquely suited to prevent and intervene upon the impact of this form of systematic oppression, to optimize children's and families' strengths and resilience, and to support family preservation wherever possible.

Where children have already been removed, anti-oppressive somatic practitioners can help families work through the transgenerational transmission of trauma toward secure base provision and earned secure attachment by advocating toward reunification and sculpting attuned interactions. Where reunification has been irreversibly truncated by custody courts, somatic practitioners can support foster youth and alumni to effectively process their grief and rage, and to find emotionally available substitute caregivers who can also help with logistical support. Every consistent, skilled clinical effort to resolve attachment trauma serves fostered youth themselves, and also those who may some day depend on them to overcome their inheritance while hoping for a more stable and connected future.

We therefore call somatic practitioners to contribute to repairing attachment for marginalized families. We ask you to reduce their risk of engagement with oppressive systems by preventing substance use, as well as neglect and abuse between family members. By providing your highly skilled bottom-up processing for unresolved trauma that drives problematic coping, you will help reduce both danger-to-self and danger-to-other behaviors that result in transgenerational attachment trauma. For those families who have already been broken apart, we ask you to help resolve the attachment trauma of those foster youth and alumni who cannot be returned to their families. We ask that

you offer your advanced training in trauma resolution to the next generation of parents and community members, giving them the skilled support necessary to heal from the harm done by oppressive systems and substances that break families. We ask that you embody hope, connection, support and belonging for regulating, reliable, responsive care and healing.



Rachel Jacoby, **PhD**, **LPCC-S**, **NCC**, is an Assistant Professor at Palo Alto University. She passionately enjoys working with children, adolescents, and families. Rachel's clinical experience includes working with the foster care system, neurodiverse populations, and individuals who have experienced trauma. She is passionate about enhancing the counseling field through education, advocacy, and scholarship, and has been recognized for her leadership and advocacy work with the 2023 Robert H. Rencken Emerging Professional Leader Award and the 2021 Carol Bobby Pioneer for Visionary Leadership Award.

Karen Roller, **PhD**, **MFT**,is an Associate Professor of Counseling at Palo Alto University and Clinical Coordinator of Family Connections, a parent-involvement preschool system serving predominantly Spanish-speaking migrant families in the San Francisco Bay Area. Her doctorate from Santa Barbara Graduate Institute in Clinical Psychology with a specialization in Somatic Psychology included experiential coursework in pre-and-perinatal psychology. Karen has spent her clinical career in family therapy through community mental health for the marginalized and underserved including fostered youth, adjudicated youth, and the Latinx migrant community, as well as international trauma training outreach in Haiti.

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Out of the Fog and into Consciousness

A Model of Adoptee Awareness

Susan F. Branco, JaeRan Kim, Grace Newton, Stephanie Kripa Cooper-Lewter, Paula O'Loughlin

ABSTRACT

Critical consciousness models illuminate processes by which marginalized groups develop awareness, both individually and collectively, about oppressive systems and structures in order to ultimately engage in activism for social justice. One marginalized group, adoptees, have relied on "out of the fog" language to delineate emergent adoptee awareness of the impact of adoption to include systemic problematic practices. The adoptee consciousness model, templated from Anzaldúa's *conocimiento* process, moves beyond emergent awareness to describe the ongoing individual and collective movement toward social activism that adoptees may encounter throughout their lifespan. The model is conceptualized with five touchstones within the spiral: 1) status quo, 2) rupture, 3) dissonance, 4) expansiveness, and 5) forgiveness and activism. The model considers intersecting racial, ethnic, and cultural identities while also promoting empathy for adoptees wherever they are on the spiral of adoptee consciousness, and informs body-inclusive therapists working with adoptees' somatic needs.

Keywords: critical consciousness, adoptees, social activism, adoptee consciousness, body-inclusive therapists

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You are no longer who you used to be. As you move from past presuppositions and frames of reference, letting go of former positions, you feel like an orphan, abandoned by all that's familiar. Exposed, naked, disoriented, wounded, uncertain, confused and conflicted, you're forced to live en la orilla – a razor-sharp edge that fragments you.

—Gloria E. Anzaldúa
This Bridge We Call Home: Radical Visions for Transformation

... adoptee experience of consciousness may trigger adoptee-related somatic and psychological responses that merit somatic healing.

The development of a critical consciousness has deep roots among oppressed and marginalized peoples (Freire, 1970). More than merely becoming educated or attuned to one's oppression, critical consciousness suggests a call to action and political activism on multiple levels, including as an individual as well as part of a community (Diem-

er, 2020). Research examining consciousness development among a variety of marginalized populations proliferated in the past decade (Diemer & Rapa, 2016; Mosley et al., 2020; Pillen et al., 2020; Uriostegui et al., 2020). However, the process of consciousness has not been critically examined among adoptee populations. Despite the broader social narrative of adoption as a heartwarming way to provide for the "best interests of the child," adoption practices have historically included actions that many adoptees find harmful, including prohibiting access to their own birth and adoption records, separating siblings (including twin or triplet siblings), discouraging adoptive parents from engaging in open relationships with the child's family of origin, placing children transracially and transnationally into homes where their racial, ethnic, and culture of origins are minimized or erased, enforced assimilation (e.g., Indian Adoption Project), and prioritizing placement into non-relative homes over relatives (Carp, 2004, 2014; Herman, 2009; Thibeault & Spencer, 2019).

Adoptees have been at the forefront of political activism and legal and systemic reform to address these historical injustices (Carp, 2004, 2014). In this article, we define critical consciousness and its origins, and explore how consciousness unfolds within the adoptee community, an under-examined and marginalized group. We also discuss implications for adoptees in general, and body-inclusive therapists specifically. We recognize that the adoptee experience of consciousness may trigger adoptee-related somatic and psychological responses that merit somatic healing. Our goal as a group of adoptee-scholars is to use our professional, personal, and community activist experiences and lenses to propose a theoretical model of adoptee consciousness. The model may serve as a framework to support body-inclusive therapists understanding of adoptee experiences so as to inform their treatment approaches.

A note about terminology: debates about adoption language have led to the creation of Positive Adoption Language (PAL) and Honest Adoption Language (HAL). Positive Adoption Language was created to reduce negative associations about adoption, yet is adoption microfiction (Baden, 2016; Butterbaugh, 2013; Myers, 2014). Examples of PAL include using terms like "birthmother" instead of "natural mother," or saying their birth/first parent "made an adoption plan" rather than "abandoned" or "gave up." Those advocating for PAL tend to be adoption professionals and adoptive parents who argue that PAL reduces stigma associated with adoption. However, critics have countered that PAL serves to sanitize and benefit adoptive parents by enacting their parenting as more legitimate than the birth/first family, and silencing adoptees and birth/first parents. Some terms are contested; for example, the term "birth parent." In this paper, we choose to use birth/first parent to acknowledge the different identifiers the birth/first parent community uses, and we acknowledge that some may use a different term. We also recognize that the term "adoptee" is not universally accepted.

Critical Consciousness

Paulo Freire's seminal work, *Pedagogy of the Oppressed* (1970), delineated a model whereby members of marginalized and oppressed groups develop awareness, or consciousness, of the institutional and societal structures that maintain their oppression, and engage in activism to dismantle the status quo. Freire (1970) indicated that critical consciousness emerges with problem identification, continues with the deep reflection that initiates motivation for change, and ultimately brings forth transformation and liberation. Important concepts include generative themes, or those words or issues that matter the most to marginalized persons; codes, which are the related events or words connected to the general themes that ignite learning and motivation to act; and dialogue, where oppressed persons have equal collaboration and partnership in problem identification and eventual transformation (Foley, 2021; Freire, 1970). Critical consciousness research has examined how awareness of socio-political and cultural oppression influence those in marginalized and minoritized positions to engage in individual and collectivistic action (Diemer et al. 2016; Diemer et al., 2021; Lee & Haskins, 2022; Mosley et al., 2020; Uriostegui et al., 2020).

Models of critical consciousness explore how individuals and groups develop socio-political awareness of oppressive structures, and then move to community action to disrupt them. For example, Martin-Baró outlined an anti-oppressive theory, Liberation Psychology, centered on exposing the voices of marginalized clients via a process of

conscientization, "the awakening of critical consciousness," to enact transformational change (Torres Rivera, 2020, p. 46). More recently, Mosley and colleagues (2020) explored the process by which Black Lives Matter (BLM) leaders developed critical consciousness as a buffer from racial trauma. Specifically, they noted BLM leaders first witnessed racism and/or experienced racial trauma, which initiated self-reflection to process the experience, and culminated in individual and collective action against anti-Black racism. A systematic content analysis of 20 critical consciousness research studies spanning 1970 through 2017 revealed a general synthesis of consciousness development (Pillen et al., 2020). The framework described included the following: "1) priming of critical reflection, 2) information creating disequilibrium, 3) introspection, 4) revisiting frames of reference, and developing agency for change and acting against oppression" (p. 1519).

Chicana scholar Gloria Anzaldúa described coming into consciousness as a seven-stage process she calls *conocimiento* (literally translated as knowledge), in which individuals move through a process of deconstructing what they thought they knew toward a higher consciousness as a form of decolonization (Anzaldúa & Keating, 2013).

The process of consciousness includes:

1. *El arrebato*, the initial rupture that occurs when we are confronted with the realization of what we thought we knew was false
2. *Nepantla*, or feeling torn between our previous self and our new knowledge
3. *Coatlicue*, confronting the pain of new knowledge
4. *El compromiso*, a process of letting go of the former self in order to prepare for the next stage of consciousness
5. *Coyolxauhqui*, the act of reconstruction, often accompanied by the act of writing new stories and narratives
6. *Growing*, *changing*, *being mindful and thoughtful* of those who do not share our perspectives
7. *Acting out the vision* – forgiveness and activism

Anzaldúa's consciousness process emphasized tolerating ambiguity as one straddles the borderland territory of belonging to neither one world nor the other, and, at the same time, belonging to both. Additionally, Anzaldúa encouraged the development of empathy and respect for both worlds as a buffer from divisiveness.

Out of the Fog

In her seminal work *Lost and Found*, Betty Jean Lifton (1979) highlighted how adoptees may experience "waking up from the great sleep" (p. 71) to describe the adopted person's awareness of repressed feelings and thoughts related to their lived experiences, often perpetuated by closed systems and communication. According to Lifton, the awakening is a period when adoptees are asking themselves, "at what point did they give up and go along with the prevailing system, as if sensing intuitively that acquiescence meant emotional survival, and struggle meant disequilibrium?" (1979, p. 71). The awakening ushers in a period of searching for identity markers, including birth family, and information gathering. Since publishing *Lost and Found*, Lifton's belief that adoption is often enshrouded in a "veil" of opaque silence and secrecy has been widely echoed (1979, p. 16). Of its origins, Evans (2016) suggested:

> "In the years since Lifton's book was published in 1979, the idea of the great sleep has evolved into a fog: the sense that some folks connected with adoption are in a fog, not wanting or able to see the clear, full reality of adoption (para 4)."

Regardless of the origins of out-of-the-fog terminology, it is ubiquitous among adoptee-led blogs and social media influencers, and exemplifies the type of generative-themed language, per Freire (1970), that is deeply meaningful to many in the adoptee community. For example, Bruce (2021) stated: "The term 'being in the fog' is often used to describe the way adoptees feel, think, operate and relate before they come out of the denial, conditioning and ignorance that cloaks the impacts of adoption." Similarly, Pittman (2020) suggested:

> The phrase "coming out of the fog" refers to adoptees coming to terms with feelings– often suppressed [sic] emotions–and realizations about adoption and their adoption experience. It is an awareness that evolves, or comes on slowly, that the reality of the adoption experience may not fit the mold society or adoptive families have constructed for adoptees (para 4).

Tucker (2020) further expands upon the "out of the fog" terminology by enfolding concepts relevant to transracial and transnational adoptees:

> "It's then allowing yourself to go further and begin to critique the ways that you became part of a system that is predicated on #saviorism, racism and the underlying belief that your birth parents aren't good enough."

Moving Beyond the Fog

"Out of the fog" allows adoptees the opportunity to critically explore adoption-related dominant narratives that may no longer be held true. Such examinations may bring forth a period of deep reflection and questioning of the adoption as a "win-win" (Baden, 2016). Coming "out of the fog" sets the stage for adoptee consciousness. For example, Newton (2022) described their journey through a trauma of consciousness where they uncovered the socio-political realities of their unique transnational adoption, paired with the realization of oppression towards others with a shared identity. Newton's (2022) conceptualization also accounts for adoptee re-examination of racial identity now situated within a new awareness. The trauma of consciousness paves the way for a new paradigm of adoptee critical consciousness encompassing adoption-related and socio-cultural and political identities.

Outside of Newton's account, little literature exists on the ongoing process once adoptees move past the veil, as described by Lifton (1979). Reculturation (Baden et al., 2012), or the process of reclaiming birth culture for transracial and transnational adoptees, suggests five phases:

1. Enculturation in birth country
2. Relinquishment and temporary care
3. Adoption when enculturation stops and assimilation begins
4. Immigration (for transnational adoptees)
5. Assimilation continues,
6. Reculturation

Baden et al. (2012) emphasized that reculturation may commence when transracial and transnational adoptees explore the world out of the protective "White honorary status" (p. 393) of their adoptive families. Reculturation primarily occurs via three modes to include (1) education, (2) experience, and (3) immersion. The reconstruction model of Penny et al. (2007) is similar in creating distinct "phases" of adoptees' awareness, including (1) no awareness/denying awareness, (2) emerging awareness, (3) drowning in awareness, (4) re-emerging from awareness, and (5) finding peace.

Our model conceptualizes the process as a spiral rather than a stage model, thus allowing for a fluid and non-static journey. These different touchstones may create spaces for adoptees to further their own identity, as well as form community with like-minded others, often as a means of challenging the dominant narratives about adoptees and adoption.

Adoptees and Trauma

Body-inclusive therapists often collaborate with clients who seek to alleviate trauma-related symptoms, many of which are experienced both psychologically and somatically. The adoption experience itself is replete with varying degrees of traumatic events spanning from pre- to postadoption status. Brodizinsky et al. (2022) describe three potential risk areas for trauma in the lifespan of adoptees, including neurobiological impacts on brain development and functioning: (1) preadoption adverse experiences, including neglect and abuse, (2) postadoption recovery of early life adverse experiences, largely predicated on adoptive parenting, and (3) contextual factors contributing to the lived experience of adoption as traumatic. Specifically, to the adoption lived experience as traumatic, Brodzinsky et al. (2022) state:

> When their adoption experiences and feelings are ignored or disrespected, and when there is a lack of support by key people in their lives for exploring the meaning of being adopted, it can lead to feelings of marginalization, diminishment, fragmentation of self, and emotional destabilization. And, for some, it can also feel traumatic (p. 7).

To this end, in their autoethnographic research, Samuels (2022) extrapolates on the experiences of transracial adoptee status as epistemic trauma. The distinct type of traumatic experience is one defined by numerous scholars of color, including Anzaldúa (1987), as the discrediting, undermining, or diminishing of individuals and entire populations as "knowers" and credible information hold-

ers of their own lived experiences. Samuels (2022) outlines their own preadoptive adverse experiences, postadoption experiences of racism, and adoption microaggressions (Baden, 2016), and their professional quest via research and exploration of the transracial adoption experience. These experiences, viewed through the lens of "hermeneutical smothering – the deployment of dominant meanings that drown out, distort, or obscure one's own meaning-making process" (p. 5), underscore the injustice embedded within the lived experience of their transracial adoption experience. Newton's (2022) description of the trauma associated within their consciousness process illuminates how consciousness may trigger adoptees in a variety of somatic ways. For example, sleep disturbances (Askeland, 2020), dissociation (Vinke, 2020), and eating disorders (Rossman et al., 2020) can be potentially manifested parallel to consciousness. Merritt (2022) describes their experiences uncovering latent trauma held implicitly within their body from their adoption as an infant.

It is important to highlight how traditional mental health therapists themselves can be harmful to adoptees seeking treatment, as evidenced by practices collectively known as "attachment therapy" (Chaffin et al. 2006; Haney, 2021). Adoptee children, adolescents, and those within the foster care system who are unable to consent to participate are often vulnerable targets. Attachment therapies purport to address "attachment disorders" and/or reactive attachment disorder, yet no scientific basis or evidence has demonstrated their efficacy (Chaffin et al., 2006; Haney, 2021). Practices such as holding, rebirthing, and rage induction use physical coercion of the adoptee by the practitioner and adoptive family members to "correct" perceived unhealthy attachment strategies (Haney, 2021; Mercer., 2014; Stryker, 2010). Adoptees who have been forced to participate in attachment therapy under duress are frequently traumatized by the practice itself, and may be especially hesitant to engage in any form of mental health treatment as adults.

Reflexivity

We identify as transracial, transnational, cisgender female adoptees. Individually and collectively, we began a journey towards awareness of adoption-related institutions, systems, and practices many years ago. Four of us met as a full group in 2011 at a transracial adoptee-centered event, and have continued to collaborate over the years. Our personal, individual, and collective critical consciousness development narratives informed this model.

Adoptee Consciousness Model

Our conceptualization of a process of adoptee consciousness is best thought of as a spiral in which touchstones or turning points propel the adoptee to a different aspect of consciousness, rather than a linear set of stages with a "final" or desired outcome. We patterned our model after Anzaldúa's process of consciousness, given their unique emphasis on navigating dual identities, similar to the adoptee experience, as well as their call for respect for those in all levels of consciousness. As adoptees of color, we were intentional in drawing upon scholar-activists of color to develop our framework.

The dotted lines in the model (see Figure 1) represent pathways between touchstones. Individuals can and often do move between these touchstones in non-linear ways. For example, some adoptees who encounter a rupture may experience slight dissonance and decide to go back to status quo. Other adoptees may go through parts of this spiral process, or the entire spiral, multiple times over the life course, prompted by different touchstones. Most adoptees do not settle in and remain in just one period of consciousness through their lives.

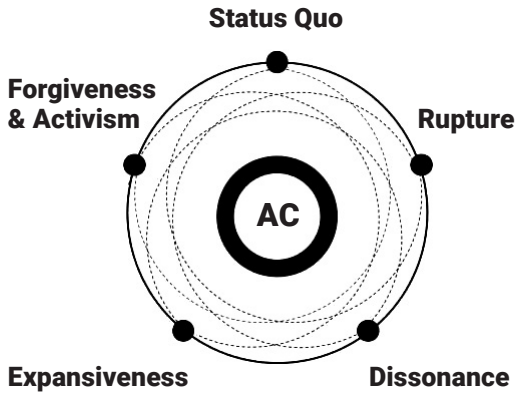

Figure 1: *Adoptee Consciousness model*

Touchstone or turning point	Definition	Example
Status Quo	Believing the dominant narrative of adoption, which employs only affirmative or asset-based perspectives about adoption. Does not or will not question individual or structural factors leading to adoption.	The adoptee sees adoption as a blessing. May see life as so much better than it would have been if they hadn't been adopted. Their actions support the dominant paradigms about adoption; for example, participating in panels at adoption agencies representing the "grateful adoptee." They may participate in social media defending adoption practices.
Rupture (El arrebato)	Encountering information or experiencing an incident or event that disrupts the status quo. Discovers own or others' adoption information is inaccurate, false, unethical, and/or illegal. For transracial adoptees as they may realize they are seen as BIPOC despite internal identification as White.	The adoptee may shut down and reject evidence or may decide to dive deeper. They may become even more committed to the dominant narrative of adoption, and may reject or feel threatened by adoptees who they see as "angry" or disruptive.
Dissonance (Nepantla and coatlicue)	The tension or contradiction between what seems to be opposing beliefs or truths. Adoptees experiencing dissonance may feel emotional pain, anguish, anger, angst, or dysregulation from the awareness brought to light during the rupture.	The adoptee feels torn between multiple identities, and struggles to see the both / and aspects of adoption. Adoptees may seek community spaces to validate their positions, but may struggle with boundaries to articulate their positions as they are still negotiating where they fit in with this newfound information. Many adoptees walking through dissonance may want to participate in social activities with adoptees, as long as the group refrains from more political discussions about adoption.
Expansiveness (el compromiso, coyolxauhqui)	Sitting in the paradox, adoptees are able to see multiple perspectives, and be mindful and thoughtful of those who do not share their perspective. Adoptees at this touchstone are learning to tolerate the discomfort the paradox may initially create. This is a time of re-invention and/or re-incorporation of their multiple selves, seeing themselves intersectionally rather than being forced into one identity.	The adoptee chooses to acknowledge the social injustices that are inherent in adoption. The adoptee may join communities of other like-minded individuals to elevate a more complex understanding of adoption, create adoptee-centric art, and engage politically in adoptee-centric activism. The adoptee can give up the aspects of the former beliefs that do not work to serve them anymore (dominant narrative) without feeling they are giving up their whole identity or self.

Touchstone or turning point	Definition	Example
Forgiveness & Activism	Extrapolating beyond oneself; noting systemic oppression in adoption practices and history. The individual begins the process of forgiveness when needed, and commits to challenging the dominant narrative.	The adoptee can forgive their adoptive parents for not knowing better, can understand it is a mechanism of the adoption industrial complex that upholds dominant narratives about gender roles and family procreation, and holds others accountable when needed. The adoptee continues to collaborate with other adoptees in advocacy in activism to dismantle adoption oppression (i.e., adoptee citizenship legislation, postadoption services, etc.).

Table 1: *Adoptee Consciousness process definitions*

Touchstone: Status Quo

The current dominant narrative about adoption is that adoption is a feel-good solution to a problem. According to Baden (2016), dominant narratives can often also be classified as microfictions or purposely "deceptive practices" that shield adoptees from accurate adoption information (p. 8). In the status quo narrative, adoption is seen as an individual action undertaken without any systemic or cultural influence. Those who adopt are seen as rescuing a child whose only other alternative would be to languish in foster care or an orphanage. If a birth/first family is ever factored into this dominant narrative, they are cast as brave, self-sacrificing individuals who want a better life for their child than they think they can provide, or they are seen as negligent and abusive individuals who do not deserve to be parents. Adoptees who believe in the status quo narrative do not question or critique structural factors that lead to adoption; adoption is considered solely from an individual and micro-level perspective. Adoptees may reference, believe, or use Positive Adoption Language (Butterbaugh, 2013; Myers, 2014). When referencing their own or others' adoptions, they may use language such as: feeling special, grateful, or lucky to have been adopted; embracing the sentiment that their first parents "loved them so much they made an adoption plan," or believing dominant myths about why children are in need of adoption. If someone critiques adoption, adoptees believing the status quo narrative might respond with dominant binary counterpoints (i.e., the alternative to adoption is abortion; adoption is better than remaining in foster care or "languishing" in orphanages). Adoptees in the status quo mindset may also become easily offended or defensive if adoption is not framed from an asset lens. They may subscribe to their beliefs about adoption solely based on a desire to align with their adoptive family's narrative because they do not feel the need or feel safe to explore what adoption means for them individually (aligning with Marcia's (1966) identity foreclosure in which an individual commits to an identity without exploring other options). Adoptees may seek spaces and opportunities to be the "model adoptee" where they can be lauded and affirmed by adoptive parents.

The dominant adoption narrative minimizes the disruption of the adoptees' first family and the adoptees' preadoption experiences; adoptees who believe in the status quo narrative agree with the belief that adoptees are a blank slate or *tabula rasa*, and argue that environmental (adoptive family) factors shape an adoptee more than their genetic or hereditary (first/birth family) history. As a result, they may attack adoptees with different experiences on social media platforms, write opinion pieces defending adoption, write books and articles about their own "successful" adoption, be asked by and comply with adoptive parents to defend controversial practices in favor of adoption or adoptive families, or work to maintain adoption practices that fit with the dominant narrative.

Touchstone: Rupture

At some point, many adoptees encounter information that challenges the status quo. Anzaldúa calls this a period when a person experiences a rupture (arrebato), fragmentation, or wounding that forces them to rethink what they know about who they and/or others are who upheld the dominant narrative/status quo. The initial seismic shifts are followed by aftershocks, as when an adoptee thinks they have found an answer or resolution to this disruptive information, only to be confronted with another event or piece of information. For example, an adoptee learns the information about their relinquishment or adoption is false, or perhaps they learn their adoption was unethical or illegal (Branco, 2021). Or they might learn information about the history and practices of adoption that challenges their beliefs. The rupture might occur when an adoptee meets another adoptee who experienced abuse at the hands of their adoptive parents. Transracial adoptees may experience rupture when they encounter racial, ethnic, or adoption microaggressions within or outside the adoptive family home. The rupture, according to Pillen et al. (2020), is when information creates a sense of disequilibrium. When disrupting information is revealed, adoptees may shut down and reject the information, or they may choose to dive deeper and explore. Adoptees who reject the information may "double down" on public actions in favor of the dominant narrative of adoption. However, others may begin active exploration by starting to read adoptee authors, view adoptee-centered films, or participate in adoptee-centric community spaces.

Touchstone: Dissonance

Once adoptees confront a rupture to their status quo belief, there is potential for the adoptee to experience dissonance if they choose to explore the information at the center of the rupture. Dissonance is tension or contradiction between what seem to be opposing beliefs or truths. Adoptees experiencing dissonance may feel emotional pain, anguish, anger, angst, or dysregulation from the awareness brought to light during the rupture. They may also become overwhelmed and feel stuck in limbo, torn between multiple identities, and/or both drawn to and fearful of other adoptees. For example, an adoptee may begin to empathize with first/birth parents who were coerced into relinquishing children for adoption, but refuse to believe their own first/birth parent was coerced. Or an adoptee acknowledges that adoption involves loss, but thinks that adoptees who believe adoption is traumatic are "angry" adoptees. Adoptees in dissonance struggle to see the both/and aspects of adoption. A transracial or transnational adoptee may internally identify as White, and feel uncomfortable when others consider them as a member of the Black, Indigenous or People of Color community. Adoptees living through dissonance may push back against others who point out the injustices or participate in adoptee activism, and may seek spaces and opportunities to be the "grateful" or "model" adoptee where they can be lauded and affirmed by adoptive parents. In doing so, they may also participate in defensive behaviors in online or other spaces as they attempt to figure out their own position about adoption. Adoptees may notice emergent adoptive parent resentment and/or jealousy towards their birth/first families, and feel stuck trying to navigate between speaking up or staying quiet to protect their adoptive parents' feelings. Adoptees may seek community spaces in which to validate their positions, but may struggle with boundaries or articulating their positions as they are still trying to understand how they fit in with this newfound information. Many adoptees walking through dissonance may want to participate in social activities with adoptees, if the group refrains from more political discussions about adoption.

Touchstone: Expansiveness

When adoptees begin to explore the paradoxes inherent in adoption (Lee, 2003), they can discard aspects of the former beliefs that no longer serve them (dominant narrative) without feeling they are giving up their entire identity or self. Expansiveness is a time of re-invention and/or re-incorporation of adoptees' multiple selves, seeing themselves intersectionally and rejecting attempts to force them into a singular identity. The work of expansiveness is about being able to embrace both/and related to adoption, and learning to tolerate the discomfort that recognizing the adoption paradox may initially create. Adoptees embracing expansiveness are often quite generative, diving into projects addressing adoption from an adoptee-centric perspective. Such projects may involve artistic statements like painting and playwriting, the creation of new oral histories through pod-

casts, or written work, including poetry, blogs, and memoirs. Whichever avenue adoptees pursue, these creative expressions allow the adoptee to integrate new awarenesses into their identity, reconstruct their narrative, and tell their story on their terms. Divisiveness may still occur at this touchstone; as adoptees work to solidify their point of view and values related to adoption discourse and practices, they may not realize other adoptees before them have also done this work, and think of their newfound enlightenment as unique. In this current age of social media, much of the seminal work by adoptees may not be accessed as easily as modern social media platforms.

Touchstone: Forgiveness and activism

The individual begins the process of forgiveness (compromiso) when needed (i.e., they may forgive their adoptive parents for not knowing better, understanding it is a mechanism of the adoption industrial complex), and also holds others accountable when needed (i.e., still wanting their adoptive parents to acknowledge their role in upholding the system). During this touchstone, the adoptee actively chooses to acknowledge the social injustices inherent in adoption. Many adoptees embracing forgiveness work towards building empathy and respect, in place of defensiveness or divisiveness, for adoptees holding dissimilar or contradictory beliefs. Activism in this touchstone can take on various forms to include anti-adoption discrimination efforts such as petitioning for open birth certificate access legislation, examining transnational and domestic illicit adoption past and present practices, and repealing and replacing inequitable transnational adoptee citizenship laws.

Intra-Community Division

Newton (2022) called out how the process of consciousness risks potential divisiveness within adoptee communities themselves. Specifically, Newton warns:

> Adoptees already face divisive labels, such as angry and maladjusted compared with grateful, that pit members of our community against one another. Whether from existing classifications or new ones, avoiding these binary distinctions is essential, because they do not acknowledge the full spectrum of experiences that encompass the adoptee identity or allow room for change over time (2022, p. 8)

Friere (1970) also warned of internal conflict and division as a tool of the oppressor to hinder potential actions towards liberation and social justice. We advocate adoptees reject a framework of scarcity, acknowledging there are many ways for adoptees to collectively build adoptee-centric programs, organizations, tools, and creative works. As an example, we acknowledge the work done by adoptee ancestors we referenced in this article as foundational and integral to providing language and frameworks that serve as a basis for our view. We hope others will find this model of adoptee consciousness helpful as a framework for further development. By templating Anzaldúa, our adoptee consciousness model emphasizes building empathy to embrace all perspectives, and to include those in status quo and across the consciousness journey. Such understanding buffers against coercion, conflict, and division by promoting acceptance, and ultimately encouraging solidarity as a unified adoptee community.

Discussion, Implications, Future Research

The adoptee consciousness process describes touchstones leading to adoptee awareness of oppressive structures and practices in adoption to include heightened awareness of the adoptee's intersecting identities. The consciousness process offers a framework by which adoptees and stakeholders may build awareness, and identify and normalize their experiences within the various touchstones encountered. Such a framework is especially relevant in the era of increased societal awareness of racial, ethnic, and sociocultural structural oppression. This consciousness model is important as adoptees encounter rupture at earlier ages through social media content, reels, and other platforms. Within adoption, there is a tendency to want everything to be conflict-free, and those in an adoptee's life may misunderstand or pathologize the consciousness process as being overly dramatic, angry, ungrateful, or contrary. In addition, many adoptees may already be reluctant to speak of the consciousness process for fear of being rejected, invalidated, or dismissed. Therefore, it is crucial for stakeholders, including adoptees and

body-inclusive therapists specifically, to actively support rather than diminish, suppress, or subjugate the process. We offer recommendations to support stakeholders below.

Adoptees

- Adoptees may, as part of the process of consciousness, distance themselves from those who question or are unsupportive when they "suddenly" are critical of, or question, previous views, or begin to apply broader critical frameworks (i.e., critical race theory, capitalism, colonization) to adoption. For adoptees: embrace the process, acknowledge the distancing as a protective measure during this phase of the consciousness journey.
- Adoptees undergoing the critical consciousness process may experience a myriad of emotional and somatic states. We encourage them to seek out support via individual adoption-informed mental health providers, including body-inclusive therapists, to support healing. Seek out adoptee support networks to normalize and validate the consciousness process.
- Adoptees in the critical consciousness process may also publicly share insights and ideas about problematic practices in adoption as a form of expansiveness and social activism. We encourage and celebrate knowledge dissemination, with a reminder to acknowledge adoptee activist ancestors by citing their work when sharing ideas or commentary. For an adoptee just beginning the consciousness process, what may be "new" knowledge to them could also be work that should be accredited to an adoptee activist ancestor.

Body-Inclusive Therapists

- Explore and examine personal bias and values surrounding adoption stereotypes, myths, and stigma associated with adoptees, first/birth parents, and adoption in general (Branco Alvarado, 2013).
- Ensure adoptive status is included in the intake process (Branco Alvarado, 2013).
- Broach the topic of adoptee clients' experiences of adoption, with attention to varying racial, cultural, ethnic, and other salient intersecting identities (Branco Alvarado, 2013).
- Be aware of the potential for adult adoptee clients to experience traumas as a result of forced and harmful "attachment therapy" practices they survived during childhood or adolescence.
- Utilize the adoptee consciousness model when conceptualizing where an adoptee client may be on the spiral.
- Assess for pre- and postadoption adverse and traumatic events, including attunement to the adoptee's lived experience of adoption as traumatic (Brodzinsky et al., 2022). Seek to become adoption-informed practitioners, particularly as it pertains to addressing pre- and postadoption experiences of trauma.
- Acknowledge the consciousness process itself can be experienced as traumatic by some adoptees (Newton, 2022) at various touchstones along the consciousness model spiral.
- Consider the impact of transracial and transnational adoptee identity on psychological and somatic experiences of racism and racial trauma.
- Develop an understanding of ambiguous loss frameworks (Boss, 1999). The ambiguous loss framework not only supports the adoptee, but also encourages family members, significant others, adoption professionals, and mental health therapists to tolerate the ambiguity as well in solidarity with the adoptee.
- Avoid both pathologizing adoptees during the consciousness process and engaging in adoptee microaggressions (Baden, 2016).

Conclusion

Critical consciousness is a natural aspect of individual and collective development for adoptees. Models of critical consciousness include Freire's work, *Pedagogy of the Oppressed* (1970), liberation psychology (Torres Rivera, 2020), and the generalized model of Pillen et al. (2020). We applied Anzaldúa's conocimiento/consciousness process (Anzaldúa & Keating, 2013) as a template for an adoptee consciousness model to describe how adoptees move past "the fog" into awareness of structural and systemic oppressive systems embedded in adoption practice. Pre- and postadoption adverse experiences, the lived experience of adoption itself (Brodzinsky et al., 2022; Samuels, 2022), and the consciousness process may be experienced as traumatic by some adoptees (Newton, 2022). Body-in-

clusive therapists can offer appropriate support and healing interventions. The adoptee consciousness model describes a spiral process ranging from status quo to forgiveness and activism. Crucially, the model emphasizes an examination of adoptee intersecting identities to include racial, ethnic, and cultural paired with empathy towards all adoptees, regardless of where they are in the process.

Disclosure

Susan Branco https://orcid.org/0000-0002-0414-8921

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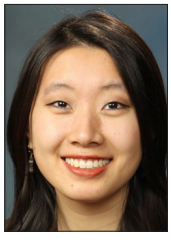
Susan Branco (she/her/ella) is an Assistant Professor in Counselor Education at St. Bonaventure University. She holds a MA Ed in Rehabilitation Counseling from the George Washington University and a PhD in Counselor Education and Supervision from Virginia Tech.

Email: dr.susanbranco@gmail.com

Correspondence concerning this article should be addressed to Susan Branco, Counselor Education, St. Bonaventure University, B52 Plassmann, Box AB, 3261 West State Road, St. Bonaventure, NY 14778.

JaeRan Kim (she/her) currently works as an Associate Professor in Social Work at the University of Washington at Tacoma. She holds both a MSW and PhD in Social Work from the University of Minnesota.

Email: kimjr@uw.edu



Grace Newton (she/her) is an incoming doctoral student in Social Work at the University of Chicago. She holds an MSW from Washington University.

Email: gracenewton@wustl.edu

Stephanie Kripa Cooper-Lewter (she/her) works in philanthropy. She holds a MSW from the University of Minnesota and PhD in Social Work from the University of South Carolina.

Email: stephanie.kripa.cooperlewter@gmail.com

Paula O'Loughlin (she/her) is an Education Consultant. She studied Organizational Leadership at New York University and holds a BS in Elementary Education from St. Catherine University.

Email: paula.oloughlin1989@gmail.com

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Disappearing Act

Disabled Embodiment and the Haunting of the Biopsychosocial Model of Chronic Pain

anna s. kunin :: חיים קוכלעפעל

ABSTRACT

Chronic pain, illness and disability are widespread phenomena. The biopsychosocial model of pain has been broadly adopted as the dominant paradigm for understanding chronic pain in psychological and medical fields. However, neoliberal capitalist forces have steered the implementation of this model in ways that reduce the complex etiology of chronic pain to individual psychological and behavioral factors. This effectively disappears the somatic experience of sick/disabled people, and occludes the biological, psychological, social, and systemic harm of ableism. This paper offers a perspective on chronic pain from a disability justice lens, laying out the life and death stakes of accessibility (especially during the pandemic age) It explores both the limitations and potential of somatics to support a client's sense of agency within their experience of chronic pain. It is at once a memorial, a call to reflection and action on the part of clinicians, and an inquiry into the liberatory potential of sick/disabled embodiment in the therapeutic container and beyond.

Keywords: Somatic psychology, chronic pain, biopsychosocial, ableism, disability justice, accessibility

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Dedicated to Teighlor Countessa McGee
beloved friend, poet, prophet

There is nothing I say, write or do about disability that does not have you in it

יהי זכרה מהפכה

May your memory be for a revolution

> ***This loop once again implies that being disabled from chronic pain is our own fault.***

Crip New Year Mantras

1. A broken body is still able to climb out of God's palm and see the world
2. I do not live in the hands of those who do not see my worth
3. It is not my time to return to ash and dust
4. I will not be half consumed and left as table scraps

—Teighlor McGee
Black Disability Collective

Chronic pain and illness are clinically prevalent phenomena, with chronic pain affecting an estimated 20% of people worldwide (Meehan et. al, 2021). 1 in 4 people in the US have a disability of some kind (CDC, 2019).[1] I personally have had 17 years of ongoing (and ever-evolving) experience due to Hypermobile Ehlers-Danlos Syndrome and associated comorbidities. With the Covid-19 pandemic unfettered by global vaccine inequity and eugenicist US public health policies, millions more are having their lives transformed by chronic pain and sickness due to Long Covid. The paradox is that within this ubiquity, peoples' lived experiences with chronic pain are unseen – amounting to that of an "invisible disability" (Meehan et al., 2021). This is due not only to the apparent appearance of (and ensuing assumptions around) "health;" this *invisibility* extends to how society treats disabled people at large. We are a population that is exiled, ignored, and deemed expendable. Our needs for access to participation in the public domain are routinely forgotten, or we are exhorted to "overcome" (meaning, hide) our pain in order to comply with the white supremacist, capitalist, homogeneous ideal of the "abled body:" one that is able to be exploited for labor. Most of the articles I reviewed introduced their research into chronic pain by simultaneously bemoaning the millions of dollars of lost economic productivity, and the burden of millions sunk into healthcare costs. Whose pain are we actually concerned with as healing practitioners – that of the person, or that of capitalism?

How do we define pain? From whence does it arise? In 2020, "for the first time in 40 years, the most widely accepted definition of pain" from the International Association for the Study of Pain "was updated to reflect advances in understanding." The IASP defines pain as *"an unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage"* (Raja et al., 2020) (Meehan et al, 2021). They elaborate that "pain is always a personal experience that is influenced to varying degrees by biological, psychological, and social factors." There is further clarification that "pain cannot be inferred solely from activity in sensory neurons", which confirms that pain is capable of arising without actual tissue damage or dysfunction (Meehan et al, 2021). This updated IASP definition reflects the deep impact of the biopsychosocial (BPS) model of pain, which was originally developed by Dr. George Engel in the 70s in an effort to shift care to be more "holistic and patient centered" (Hunt, 2022). This was a "radical break" from the traditional biomedical model that always "considered pain as a direct consequence of an underlying pathology" such as disease or injury (Vlaeyn, 2007). The biomedical (BM) paradigm, epistemologically born from the Cartesian mind/body split, has been widely critiqued for being "reductionist and dualistic." On the other hand, the BPS model "ostensibly acknowledges" the impact of social and psychological variables of a person's "interpersonal patterns, relationships, social support, and thoughts, feelings and behavior" (Hunt, 2022) on their experience of pain. The BPS model has now become a mainstream approach to pain management for those lucky few who have access to specialized treatment (Meehan et al, 2021) – although anyone who scrolls through the content of social media "wellness" coaches will be familiar enough with the discourse. It has been "argued to add value particularly in the field of mental health (Gask 2018)" (Hunt, 2022). As I consider joining this growing field of pain psychology, I face a landscape where cognitive behavioral therapy (CBT) has thusly become a frontline treatment (often within a multidisciplinary medical program) for such wide ranging conditions as chronic back pain, chronic fatigue, fibromyalgia and arthritis (Vlaeyn, 2007).

How has this widespread shift from a biomedical to a biopsychosocial (BPS) model borne out for those most directly impacted? Has chronic pain care actually become more "patient-centered" in its approach? While a veneer of BPS rhetoric has been popularized, "the BM model remains deeply entrenched within the culture of medicine and the general public"; for example, the clinical implementation of "psychosocial therapies are often prescribed and delivered within a framework

1. It is important to note that not all disabled people have chronic pain and not all people with chronic pain identify as disabled, although there is extensive crossover. The scope of this paper is on the intersection of these phenomena. However, disability experience is vast, and can include physical impairments, neurodivergencies, developmental disabilities, sensory disabilities, mental health conditions, autoimmune disorders, terminal illness, environmental injuries, and more. As always, follow the lead of the client in how they refer to themselves.

similar to an injection or medication" (Maridan et al, 2020). As a result, this therapy still operates through an ideology of medical authority, pathology, and cure that objectifies the client instead of centering around their humanity and the expertise of their own bodymind.[2] Meehan and Carter further question mainstream BPS services by establishing that "the evidence base for effectiveness" is not as robust as one might assume, "mostly due to limitations in study design which is reflected in many reviews reporting low quality" (Meehan et al., 2021). While I appreciate that they call for further research with "the participation of people with lived experience to guide" the work in order to delineate barriers to care (Meehan et al., 2021), Hunt cuts to the core of the matter: barriers to care are indeed the point. Hunt reveals how the BPS model "has been manipulated to serve a neoliberal agenda to reduce state health and social expenditure, increase corporate profits, and protect the market and interests of the privileged (Jolly 2012; Berger 2014; Stewart 2019)." The resultant "undue psychologization of chronic illness through BPS theorizing...and associated agendas" has caused "enormous harm to chronically ill and disabled people" (Hunt 2022).

This harm spans the entire breadth of bio, psycho and social experience, as well as structural and systemic experience. However, throughout my initial research pertaining to the BPS model of chronic pain, it was enraging to see the violence of ableism across these realms rendered invisible over and over again. While Meehan and Carter gesture toward access issues, they are unable to articulate the cause. Only Hunt named ableism directly. As developed by Talila A. Lewis "in community with other Black and negatively racialized disabled people", the definition of ableism is:

> "a system that places value on people's bodies and minds based on societally constructed ideas of normality, intelligence, excellence, desirability, and productivity... [and deeply rooted in anti-Blackness, eugenics, misogyny, colonialism, imperialism and capitalism. This form of systemic oppression leads to people and society determining who is valuable and worthy based on a person's language, appearance and/or their ability to satisfactorily [re]produce, excel and 'behave'" (Lewis, 2022).

Even within a graduate program literally based in *somatics*, where we are constantly reminded of the downstream physical impacts of trauma, one would think topics of disability, pain, or ableism would be especially relevant; instead, materials remain scant – and where they appear, optional. Indeed, the influence of the BPS model actually "downplays biological considerations whilst the 'psychosocial' dons a mantle of victim-blaming: chronic illness and disability are considered to be perpetuated by maladaptive' thoughts and behaviors" (Hunt, 2022). Once again, we are haunted by the conveniently disappearing sick/disabled body. By de-emphasizing the body's material somatic reality in the etiology of chronic pain, systemic issues such as the inaccessibility of health care services, benefits, social supports, public spaces, housing, etc. are excused; instead, the onus of responsibility is cast upon the individual and their (un)willingness to "heal," in an ableist neoliberal idealization of "self-sufficiency, autonomy, personal responsibility, free will, and self-determination (Adams et al., 2019)" (Hunt, 2022). Also erased is the tangible harm the bodyminds of sick/disabled people go through at the hands of the structures we live within. The physical harm caused by the denial of care justified by the medical gaslighting operationalized within the BPS model is apparent. However, inaccessibility, "stigma and epistemic injustice" also have "biological impacts:" they act as "chronic and uncontrollable stressors...[leading to] allostatic(over)load"[3] which in turn "increases susceptibility to further ill-health (Heise et al., 2019; Metzl and Hansen, 2014)" (Hunt, 2022). Put more simply, the stress of ableism itself flares our pain; being in more pain (i.e., having a bodymind that more greatly deviates from the norm) typically means facing more ableism, both internally and externally. It is a vicious loop, one the BPS model

2. "Bodymind" refers to "the relationship between the human body and mind as a single integrated entity... to affirm our minds and bodies cannot be separated" (Sins Invalid, 2019).
3. "Allostatic load refers to the cumulative burden of chronic stress and life events [involving] the interaction of different physiological systems...when environmental challenges exceed the individual ability to cope, then allostatic overload ensues" (Guidi et al, 2020).

obscures in favor of promoting the idea that it is our personal *fear* of pain that limits our movement, thereby increasing pain and impairment. This loop once again implies that being disabled from chronic pain is our own fault.

I do not deny that there are many, many people who have found chronic pain relief with treatment approaches that utilize the BPS model, such as with pain coaches, CBT workbooks, or the app Curable. For some people, reprocessing past trauma through a few sessions of Somatic Experiencing® sessions may indeed cure their chronic back pain. But there are myriad more of us whose very *lives* are not something to *cure*. As the viral Twitter campaign (started by writer Imani Barbarin after the CDC commented it was "encouraging" that most people dying of Covid were "unwell to begin with") declared: *our disabled lives are worthy* (Barbarin, 2022). Even if it were our trauma that predisposed disabled people to our chronic pain/illness, no amount of therapy would be able to make our chronic pain – that is, our *bodies* themselves – completely disappear from whence they came. Can somatic psychotherapy – with its "focus on valuing the sensed experience of the individual as a whole person (Dowler 2013) and not just as a set of painful body parts" – actually resist this habitual erasure? Can the "common themes of somatics" such as "pleasurable movement, validation of subjective experience, sensory exploration, play and contemplation" conjure our embodiment back from the other side (Meehan et al, 2021)? No longer willing to view it as an apparition flitting at the corners of our clinical eyesight, I seek to resurrect the sick, tired, painful body within the therapeutic space by centralizing an exploration of (especially queer) disabled embodiment in my approach towards chronic pain treatment. (*Queer*, not as the umbrella term it has become for non cis-heterosexual identities – *queer*, as in embodiments of non-cisheteronormative identities that actively agitate against and create alternatives to systems of oppression.) Toward this end, I have greatly appreciated the proposals Meehan and Carter offer as an initial road map to how somatic practices can play a supportive role for people in pain. While several of the perspectives they explore remain entrenched within the neoliberal rhetoric of "self-management" and "self-authority" (with all their attendant implications of control and dominion over the flesh), there is a vital somatic principle at the core of these semantics: there is powerful and liberatory healing available to us in having an expanded capacity for and sense of *agency* in our relationships with both our bodyminds and the world.

In fact, it was my claiming of disabled embodiment and identity – not a refusal of it, as suggested by the BPS model – that restored my agency within a life of incurable and constant physical pain. Through a (never-ending) process of releasing my internalized ableism by engaging with the disability justice movement,[4] I build supportive relationships with sick/disabled communities, cultures, and histories. I grant myself permission to use the mobility aids I was told would only enfeeble me further, which in fact enable me to do more. Empowered within this collective embodiment, I restore my sense of self-worth into alignment with *my* deepest values, instead of letting it be dictated *to* me by my value to capitalism. As an anarchist, I am deeply inspired by the idea of "agency *without mastery* (Gilmore 2012, p. 95)" (Meehan et al, 2021) as a model for relating with chronic pain phenomena. This languaging highlights how agency within sick/disabled embodiment necessitates a dialectic with *surrender*. I'm not suggesting passivity in the face of chronic conditions; I still navigate my pain through physical therapy, psychotherapy, acupuncture, meditation, community care, and more. Rather, by learning to surrender to painful sensations, pain transforms from an enemy that needs conquering on the battlefield of my bodymind to a well of wisdom within myself that deserves listening to. Pain invites care, uplifting the needs we've been taught to ignore by systemic oppression. Somatics for chronic pain could offer a potent "means of…becoming an expert in one's own needs and capacities" (Meehan et al, 2021). Indeed, the liberatory potential of sick/disabled embodiment goes

4. Disability justice (DJ) is an alternative framework to the disability rights movement, which has "historically centered white experiences" and "focuses exclusively on disability at the expense of other intersections of race, gender, sexuality, age, immigration status, etc." DJ "centers the leadership of disabled people of color and of queer and gender nonconforming disabled people" (Sins Invalid, 2019).

far beyond any one individual bodymind. As Aurora Levins Morales writes, "what our bodies require in order to thrive, is what the world requires. If there is a map to get there, it can be found in the atlas of our skin and bone and blood" (Morales, 2013). Why assume the most therapeutic goal would be to eliminate pain and illness entirely, as if we even could? These experiences can be a pathway to wisdom, liberation, and transformation at the level of both the individual and collective bodies.

That being said, the experience of chronic pain is still fundamentally a deeply uncomfortable one, which elicits suffering from challenging physical sensations as well as ableism. While I utterly reject the eugenicist stream within somatic psychology, it is still very much worthwhile to consider how we can support clients living with chronic pain to suffer less. Meehan and Carter outline the potential benefits of somatic practices in chronic pain treatment by first considering *interoception*, our felt sense of "our physiological condition of the whole body" and "the basis for the subjective image of the material self as a feeling (sentient) entity" (Meehan et al, 2021). Interoception plays a key role in fundamental "coping strategies such as becoming aware of body cues for rest, pacing or decreasing hyper-alertness to pain signals," as well as in "relaxing the nervous system, and therefore tensions or emotions that increase pain." For example, I can invite a client's interoception to take an oscillating quality by "modulating our attention, sometimes attuning to pain experience, and other times bringing attention to pleasurable" (Meehan et al, 2021) or neutral sensations, or even numb spaces in the body. While these approaches have the potential to powerfully augment a client's sense of agency within their experience of pain, I am grateful Meehan and Carter recognize upfront that " the focus on sensory stimuli can be overwhelming" for many people (and can be for many reasons beyond pain – trauma histories, neurodivergencies, etc.). It is vital to never assume that somatic interventions will be grounding or resourcing for a client. Therefore, "(Farb et al., 2015) suggests that the central question actually is "understanding how to skillfully relate to interoceptive sensations, and under what circumstances they should be attended to'" (Meehan et al, 2021). Also considered are explorations of *exteroception* (the sense of "outer environment through 'touch', including sensations such as pressure, heat, cold, pain, and vibration") and *proprioception* ("awareness of balance, movement and body position in space"). They focus on these as interventions in (purported) pain catastrophizing, encouraging "appropriate levels of movement" by "sensing the environment, exploring triggers for fear, and developing strategies for moving with confidence" (Meehan et al, 2021). However, in my experience the most common challenge for disabled people with chronic pain is not that we catastrophize our fear of pain to the point that we pathologically limit our movement. I observe (and myself experience) people routinely pushing through our pain to *over*-exert ourselves, again and again, due to lack of support and the inaccessibility of the systems we live within. The pathology here is societal, and therefore can be healed only by way of collective liberation. However, proprioception and exteroception are still beneficial tools to explore increasing the range of agency-expanding strategies available to sick/disabled clients, especially as many of us are surviving this forced overexertion by way of bodily dissociation. For example, we can experiment with moving through our environments with more ease and less bracing in order to conserve energy and reduce the risk for flares.

These initial proposals around interoception, exteroception, and proprioception are all very useful on a pragmatic clinical level. It is enough to resurrect the embodiment of chronic pain; however, it falls short of a true *revival*. Despite holding the whole self in an avowed sanctity, I fear somatics for disabled people will take on a zombified approach, in which we (symbolically) stagger about in an endless search, tracking not for "braaains!" – but for "sensaaations!" to consume in order to help us manage dragging out our miserable, marginalized existences a little longer. The ableist necrosis of shame and isolation remains untouched. Indeed, as "physical pain and social pain (from rejection, exclusion, or loss) appear to share neurobiological mechanisms" (Maridan et al, 2020), we find our chronic pain amplified not just by our central nervous systems, but by the constant onslaught of unrestrained ableism during the pandemic age. Being seen as disposable by neo-fascist anti-vaxxers is one thing; it cuts to the very quick to be abandoned by spaces that we called home, by movements that avowed community care. I hold close to my heart how these "challenges to ontological security (isolation, stigma, inaccessibility and disconfirming

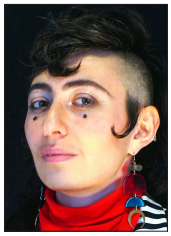
experiences with people/systems)" – as well as the exhausting somatic reality of chronic pain – "often leads to increased suicidality" (Hunt 2022). Indeed, my heart has already been rent by the people in my sick, disabled, queer, trans communities who have died by suicide during the pandemic. It aches for the many more alive and struggling with suicidal ideation. How can somatic psychology reaffirm *our right to life* with pain, while also honoring just how much it can hurt? How might we exorcize the rampant ableism of the field, in order to increase accessibility to the life-nourishing potential of somatics?

Just as the real work of spiritual cleansing cannot be bypassed through a quick trip to buy herbs at the crystal shop, accessibility is not merely a matter of accessories – of adding a ramp to your building or a Diversity Equity Inclusion training to your resumé. If it weren't already clear, let me be perfectly plain: my choice of words is not a metaphor. The ghosts behind the haunting of the BPS model and other ableist paradigms are of real people. Access is a matter of life or death. Access is a matter of dismantling colonialism, capitalism, and white supremacy. My beloved friend Teighlor McGee (writer, activist, and founder of the Black Disability Collective) was literally killed by medical gaslighting and over-psychologization of their symptoms, fueled by the toxic racism, misogyny, and homophobia of the professionals they were forced to entrust with their "care." Their story, and others like it, are not rare. With Black and brown people bearing the brunt, the pandemic is causing mass disablement and mass death. In the U.S., over a million people have died from Covid, with at least 3,756 people dying the week I submitted this paper alone (CDC, 2023). Studies estimate up to 23 million people are impacted by Long Covid so far (GAO, 2022). Black people die from Covid at twice the rate, and are hospitalized at two and a half times the rate of white people (CDC, 2020). I am curious; in light of the failure of our public health systems, are you doing what you can as an individual to reduce Covid community transmission – namely, getting the bivalent booster and masking in public settings? Do you have layers of Covid harm reduction built into your delivery of in-person services?[5] If not, I invite you to sit with this question: Are you comfortable with your complicity in their maiming? In their deaths? The likely answer is, no. Thankfully, as far as the bare minimum goes for the pandemic, these are simple behavioral changes the vast majority of people can make. It is a more challenging shift to transform one's personal internalized ableism (never mind that of society as a whole!). Remember, ableism affects us *all*, regardless of if we are disabled or have chronic pain – it is the root of the shame you feel when you take a day off, the whisperer of the lie that the only reason you should rest is so you can go back to work harder, faster, longer. Likewise, accessibility pertains to every human alive. We "all function differently depending on context, environment" or somatic state; "all bodyminds have strengths and needs that must be met" in order for our presence – our very lifeforce – to be in the room (Sins Invalid, 2019).

I am still dreaming beyond the BPS model of chronic pain, envisioning an approach that sees sick/disabled embodiment as "unique, whole and essential", just as "all bodies are" (Sins Invalid, 2019). "In the face of systems that want us dead," that want to disappear our bodyminds outside of clinical purview, "sick and disabled people have been finding ways to care for ourselves and each other for a long time" – a life-sustaining practice often known as "care webs" (something that is and has been embodied for millennia in the "Black, Indigenous, and brown communities [that] have complex webs of exchanges of care") (Piepzna-Samarasinha, 2018). I want to develop somatic approaches to mapping both internal and external care webs, integrating moments of nourishing intimacy, support, and solidarity from relationships with human and beyond-human kin, allies, and ancestors alike. I wonder how we can engage practices of interoception, proprioception, and exteroception to support a client's felt sense of self-compassion and of interdependence. How can we explore pain as a vital and urgent bellwether of the wellness of the collective body – humanity's and the earth's? What does trauma treatment look like when recovering one's sense of "safety" out in the world is not an option, given the vast scale at which sick/disabled bodies are endangered by mass pandemic

5. Please refer to the Appendix for more information on The People's CDC, which has abundant free resources on how to implement Covid harm reduction protocols and practices.

apathy? How might we hold space to grieve lost capacities and lost relationships, while honoring the rage, creativity and perseverance it takes to thrive as a disabled bodymind? Tools stemming from the BPS approach to chronic pain (such as a cognitive reframes, behavioral change and sensorial mindfulness, as well as the broader practice of somatics) can all potentially bring what attenuated relief is possible while we are still surviving within unjust systems by modulating our experience of chronic pain. However, first clinicians must relocate their orientation to these practices within an ethic of disability justice, in order that they might *see us* amid the forces that seek to occlude the full bio, psycho, social, and structural breadth of our suffering. Don't keep the living exiled in the realm of ghosts. Don't ignore the dead. Don't let us haunt you. In this Internet age of widely available information, ignorance of the stakes at hand is a choice. Clinicians have the agency to choose differently. I offer an initial list of disability justice resources, centering the leadership of those most impacted, below. I invite you to start the journey, with humility and with accountability, to see us here with you in the land of the living. There, we might all "move together," as "people with mixed abilities, multi-racial, multi-gendered, across the sexual spectrum" with "a vision of collective liberation that leaves no bodymind behind" (Sins Invalid, 2019).



anna s. kunin :: חיים קוכלעפעל (they/them) is a performance artist, cultural organizer and trainee therapist currently attending the somatic psychology graduate program at the California Institute of Integral Studies. A white, radical, queer, disabled Ashkenazi Jew from Minneapolis (Dakota and Anishinaabe land), they are committed to asking inconvenient questions and stirring the pot toward collective liberation.

Email: akunin@mymail.ciis.edu

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Appendix 1: Disability Justice Resources (a very incomplete list)

Essential Articles

- "10 Principles of Disability Justice" by Sins Invalid
  https://www.sinsinvalid.org/blog/10-principles-of-disability-justice or in their book
  "Skin, Tooth, and Bone: The Basis of Movement is Our People – A Disability Justice Primer" (Berkeley, CA, 2019)
- "Care Webs: Experiments in Collective Access" by Leah Lakshmi Piepzna-Samarasinha
  https://static1.squarespace.com/static/5a354481a9db0961249f52ec/t/5f5c2593ce23ec19f7cae9f8/1599874451239/Care+Webs.pdf or in her book
  "Care Work: Dreaming Disability Justice" (Vancouver, BC: Arsenal Pulp Press, 2018)
- "You are Not Entitled to Our Deaths: Covid, Abled Supremacy and Interdependence" by Mia Mingus
  https://leavingevidence.wordpress.com/2022/01/16/you-are-not-entitled-to-our-deaths-covid-abled-supremacy-interdependence/

Additional Books

- *Brilliant Imperfection: Grappling with Cure* by Eli Clare (Durham, NC: Duke University Press, 2017)
- *Kindling: Writings on the Body* by Aurora Levins Morales (Palabrera Press, 2013)
- *Black Disability Politics* by Sami Schalk (Durham, NC: Duke University Press, 2022)

Podcasts

- Disability Visibility by Alice Wong, https://disabilityvisibilityproject.com/podcast-2/
- Disability After Dark by Andrew Gurza, http://www.andrewgurza.com/podcast

Additional DJ Visionaries and Content Creators

- Walela Nehanda, https://itswalela.medium.com/
- Leroy Moore, https://kriphopnation.com
- Imani Barbarin, https://crutchesandspice.com
- Talila "TL" Lewis, https://www.talilalewis.com/
- Lydia X. Z. Brown, https://autistichoya.net
- Rabbi Elliot Kulka, https://elliotkukla.com/
- Dr. Caleb Luna, https://www.caleb-luna.com/
- Teighlor McGee, https://instagram.com/blackdisabilitycollective

Disability Justice + the Pandemic

- **The People's CDC** – https://peoplescdc.org/category/resources/

  The People's CDC is a coalition of public health practitioners, scientists, healthcare workers, educators, advocates and people from all walks of life working to reduce the harmful impacts of COVID-19. We provide guidance and policy recommendations to governments and the public on COVID-19, disseminating evidence-based updates that are grounded in equity, public health principles, and the latest scientific literature.
- **Long Covid Justice** – https://longcovidjustice.org/

  Long COVID Justice is building and strengthening networks of people with Long COVID and associated conditions (LCAC). Together, we are building collective efforts and campaigns for research, healthcare, the caring economy, and racial, social, economic and disability justice. Our work is done by and for chronically ill and disabled people, our families and communities.

Somatic Practices in Disaster-Based Global Supervision

Tending to Shared Trauma and Recovery

Juanita Barnett, Elizabeth Farrah Louis, Karen Roller

ABSTRACT

This review article examines the literature on global supervision in post-disaster settings. It reveals a gap around specific culturally-responsive embodiment practices that may be considered best practices for effective supervision in post-disaster settings. The authors reflect on trauma models and somatic practices employed by their team in post-disaster supervision to prevent vicarious traumatization and compassion fatigue, and offer suggestions for further research.

Keywords: Global supervision, post-disaster settings, compassion fatigue prevention

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Disasters are natural and human-made phenomena that disrupt people's lives in a catastrophic manner physically and emotionally. The United Nations Office for Disaster Risk Reduction (2009) describes disasters as disrupting the function "of a community or society involved in widespread human, material, economic, or environmental losses and impacts, which exceeds the ability of the affected community or society to cope using its own resources" (para. 1). The widespread effect of disasters influences how people respond, cope, rely on support systems, and process individually and collectively. The role of counseling professionals provides a unique perspective that is relevant and effective for victims and survivors of disasters. The current literature provides examples of the role counseling professionals play, and the intersection of supervision within the different contexts where disasters take place. However, there are still gaps in the literature that require attention to address the implications of the practice of supervision and recommendations for future research.

> *There was a time when marginalized groups... were not deemed valuable communities to research and provide clinical services.*

Historically, mental health professionals have dictated which settings and populations are relevant to the field. There was a time when marginalized groups, such as racial and ethnic minorities, wom-

en, and the LGBTQ+ populations were not deemed as valuable communities to research and provide clinical services. The recent shift in mental health research has expanded to validate and include diverse contexts such as disaster settings. One reason why mental health practitioners should remain involved in disaster work is the fact that disasters "create psychological distress" (Jacobs et al., 2011, p. 1077).

Psychological distress manifests differently in diverse cultures. The discipline of mental health is increasingly trained to "recognize and work with distressed individuals and families" while identifying culturally appropriate approaches (Jacobs et al., 2011, p. 1077). Socially just allied mental health practice for disaster outreach places a great emphasis on multicultural components that inform its work and encourage members to reflect upon their own backgrounds as researchers, service providers, supervisees, and supervisors in disasters.

Other core values of mental health professionals such as "vocational and career endeavors, strength-based approaches, and a focus on multiple concerns to facilitate interpersonal functioning across the life span and in multiple contexts" are areas that this discipline can contribute to disaster work (Jacobs et al., 2011, p. 1078). Disasters are important to this discipline because they appear in a context that involves many levels of oppression and historical injustices that cannot be ignored. As mental health professionals, disasters provide an opportunity to implement various interventions, advocate for victims and survivors, and use a social justice framework when we interact with different systems. Also, the rich history of career and vocational counseling in counseling professionals is especially essential after a disaster when people relocate, look for jobs, and attempt to get back into a routine (Jacobs et al., 2011). Counseling professionals attend to the developmental concerns of victims and survivors while recognizing their strengths, which are imperative for their recovery process.

Moreover, disasters play a key role in how supervision is conducted within this unpredictable setting. When mental health professionals provide clinical work, supervision is necessary when working in diverse yet complex locations. Disasters are relevant contexts in the world of supervision because they involve situations where mental health providers will require the guidance of supervisors from a counselor, consultant, or teacher perspective in order to foster an optimal supervisory relationship and counseling for victims and survivors (Bernard & Goodyear, 2014). Traditional ways of conducting supervision do not apply in disaster locations because, according to Jacobs and colleagues (2011), supervision is "typically conducted informally by team leaders, some of whom may not be licensed psychologists and ...may be social workers, counselors, or nurses" (p. 1079). Also, after a disaster, order is interrupted, and the environment may exhibit physical and emotional distress. A post-disaster situation calls for more proactive direction from mental health supervisors to inform mental health professionals about important considerations when working in an environment that has been uprooted from its normal routine. Instead of viewing disasters and supervision as separate entities, they are both involved in the process of how victims, survivors, and mental health providers are affected internally and how they recover to a stabilized baseline after a disaster.

Regardless of the type of disaster, mental health issues can develop from the aftermath of that traumatic exposure. Reactions to disasters can manifest in the form of trauma, posttraumatic stress disorder, depression, anxiety, substance abuse, and relationship problems (Aten et al., 2008; Bickbell-Hentges & Lynch, 2009; Dominey-Howes, 2015). For mental health providers who choose to respond to the aftermath of a disaster, there is the risk for vicarious trauma. According to Dominey-Howes (2015), vicarious trauma is "the response of those persons who have witnessed, been subject to explicit knowledge of or, had the responsibility to intervene in a seriously distressing or tragic event." (p. 2). Mental health responders listen to survivors' stories, witness their challenges, and experience their distress as they try to manage their own emotions. Factors that may influence the onset of vicarious trauma can include the length of exposure to a particular disaster, previous exposure to traumatic situations, gender, age, and the lack of support (Dominey-Howes, 2015). Also, mental health professionals in post-disaster environments may experience compassion fatigue. Symptoms of compassion fatigue resemble the psychological, physiological, and cognitive symptoms of victims (i.e., PTSD for work) and are developed through exposure and

empathy (Lahad, 2000). These responses warrant the effective presence and therapeutic support of a trauma-competent supervisor during this difficult moment.

Haiti's history of natural disaster

Haiti is the poorest country in the Western hemisphere (World Bank, 2021). The vast majority of residents have very low socioeconomic statuses and live in poverty. Residents experience great difficulties and burdens in simply meeting the basic needs of life. According to Zanotti (2010), 76 percent of Haitians learned to survive earning less than $2 per day, and 56 percent with less than $1 per day. Following the recent coup and invasion by Columbian mercenaries resulting in widespread gang activity, Haitians are living in terror (Gamba, 2022). With the citizens of this country in such an impoverished state, yielding revenue or income for the state through taxation is not plausible. A country with such extreme poverty typically lacks the resources required to assist with disaster relief and recovery. According to Benjamin and colleagues (2011), natural, technological, or human-made disasters can pose even more extreme outcomes in poor countries.

Haiti has a great deficiency of infrastructure, economic opportunities, and services. In 2008, Haiti experienced four hurricanes that further exacerbated and impacted the country's poverty conditions, economic situation and resources, and building infrastructure. Thus, Haiti became very dependent on foreign and international support. Nongovernmental organizations and many other international support agencies provided aid to Haiti to help them circumvent the hardship of meeting basic needs for daily living.

In January of 2010, Haiti suffered a natural disaster in the form of a 7.0 magnitude earthquake that resulted in mass fatalities. Today, it is still unclear exactly how many lives were lost. It is estimated that there are approximately 200,000–300,000 casualties, about 200,000 injured, and nearly 2,000,000 who are displaced and/or homeless as a result of the earthquake (McKersie, 2010). Considering the lack of infrastructure in Haiti's buildings and facilities, an earthquake of that magnitude would naturally cause many homes to be destroyed, even to the point of crumbling. According to Zanotti (2010), the earthquake "destroyed over 80 percent of Port au Prince, but also delivered a serious blow to the thin layer of state administrative structures that were in place in the country" (p. 756).

Mental health response

There is great disparity in health services in Haiti, especially mental health services. Improving mental health services in Haiti with such poor resources can be even more challenging. While many national, international, and other organizations jump in to respond to emergency disasters by providing financial support, medical services, and basic necessities such as food, shelter, clothing, and many other services, many residents also deal with the reverberating trauma of natural disasters – particularly earthquakes, and this trauma is not well-tended. Raviola and colleagues (2012) clarified that Haiti does not have its own tiered formal mental health system. While most Haitians are forced by circumstance to focus more on meeting their basic survival needs before attending to their mental health needs, there is great correlation between both areas. Mental health treatment is necessarily secondary to other needs, especially medical conditions. Haitians and Americans typically collaborate together on stabilizing these needs through Partners in Health (PIH) after natural disasters (Raviola et al., 2012).

After the 2010 earthquake, many Haitians demonstrated psychological distress, such as fear, anxiety, depression, sleep disturbances, etc. Phobias were quite prevalent, as many people would not take refuge in safe and intact structures and elected to sleep outdoors, and in unsafe environments (Benjamin et al., 2011). Seeing the dead and management of the dead also had a great impact on the community's mental health. Even today, many people have not heard from or seen their relatives, and must assume they are dead. It is imperative for crisis management teams to be cognizant of this tragic reality, and also include a plan for disposing of mass numbers of bodies. One strategy implemented by PIH was to arrange many memorial ceremonies in honor of the dead to facilitate collective grieving, provide comfort, and begin emotional healing (Raviola et al., 2012). PIH was very instrumental in engaging in research to assess the needs of Haiti, and understand the culture's view of mental health within that population. It became

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involved with training and education, utilizing local professionals to interpret and incorporate the language into the training. PIH also advocated by organizing mass events that increased mental health awareness, and reduced stigmas associated with trauma responses (Raviola et al,, 2012). Incorporating Haiti's cultural practice, coordinating the services with local health agencies, and implementing these strategies in a collective dynamic fostered a sense of belonging and altruism amongst the citizens. It helped build resilience and strength, knowing that although Haitians were in a state of despair with limited to no resources, they were still able to help one another.

Disaster recovery

Disaster recovery typically begins right after the initial disaster has lessened, and consists of restoring the original country or community back to its original state before the disaster. Unfortunately, countries like Haiti that lack resources will have to rely on external assistance, such as that provided by national and international organizations, which can further exacerbate hardship (Benjamin et al., 2011). In Haiti, there was great support from NGOs, national and international organizations, collaborations and partnerships, although the country continues to lack resources and sanitation, and continues to recover from the earthquake and subsequent disasters. Many people were so eager to provide support that a challenging part of that process was managing workers who lacked adequate skills to meet the needs at the time, such as intensive trauma medical care. An additional issue with the Haiti recovery process was having appropriate and adequate equipment and supplies, such as medical supplies, clothing, water, etc. (Benjamin et al., 2011). Despite the generosity provided by many, there was still a great shortage and lack of appropriate supplies to match the services needed. After a disaster, a great need and emphasis is placed on security and law enforcement. After the earthquake in Haiti, there was a noticeable absence of police presence on the streets, partly because many officers were attending to their own families. Additionally, there was a scarcity of basic resources needed to enforce the law and provide security, such as ammunition for firearms and fuel for police vehicles (Zanotti, 2010).

After the 2010 earthquake in Haiti, the country was also faced with the challenge of the cholera epidemic, and a hurricane that further oppressed and deprived the residents. The greatest weaknesses resulting from this natural disaster are the lack of resources available for effective crisis management planning, and the country's dependence on external aid for recovery. Haiti does not have the adequate resources to properly implement and execute a crisis management plan. Even with international aid workers and local Haitian citizens available to help, fatalities are definitely higher when immediate local response and resources are not available. The neighboring country of the Dominican Republic is also not adequately self-sufficient to assist

Haiti in natural disasters of this magnitude that result in great casualties.

A complaint regarding the recovery process is the quick and hurried decisions that Haitian authorities made during the crisis, which was due to the magnitude of the humanitarian crisis. According to Feldman (2013), authorities made decisions to relocate, rather than revitalize and industrialize in the midst of great chaos. Rather than making comprehensive plans, they simply made minimal efforts to address immediate needs without focusing on underlying long-term issues. Haiti already lacked resources, and trusted such assistance from organizations that could not be trusted with the expertise to rid the country of its despair from the disaster. Many can now see the multiple errors or mishaps after the disaster that devastated Haiti in 2010 and continues to impact the lives of its citizens, but unfortunately today Haiti still lacks the resources to effectively recover and restore the country's infrastructure if such a disaster were to recur.

Supervision preparation

While reactions to disasters have been well documented, there is a dearth of literature regarding supervision in global outreach disaster settings. Current studies have addressed important considerations that supervisors and supervisees should be prepared to discuss and be aware of dynamics that may impact supervisees' service delivery (Aten et al., 2008; Goodman et al., 2014; Lahad, 2000; Petttifor et al., 2014). Before supervisees and supervisors arrive at a post-disaster site, they have already been exposed to information about the disaster through the media, or learned about the extent of its aftermath from an agency. Supervisors and supervisees may experience an "immediate identification with the survivors" with an "increase in empathy" (Lahad, 2000, p. 276). Although supervisors and supervisees should not refrain from having empathy, they still need to recognize their roles when providing mental health support to victims, survivors, and rescue workers. Supervisors must critically reflect upon which role (e.g., teacher, counselor, or consultant) would be appropriate within a disaster setting to foster the supervisee's professional development and ensure client welfare (Bernard & Goodyear, 2014). For supervisees, being in a disaster situation may affect their engagement with their supervisors and clients in the form of resistance, shame, anxiety, competence concerns, and transference (Bernard & Goodyear, 2014). It is imperative that the supervisor and supervisee have a strong supervisory alliance prior to arriving at the disaster site in order to effectively serve clients and supervisees while engaging in ongoing reflection on their experiences in a chaotic condition.

Supervisors and supervisees will have to adapt to the parameters of disaster work because the situation will be different from the usual "traditional clinical practice" (Spokane et al., 2011, p. 1152). Post-disaster interventions are usually brief, with an opportunity to incorporate informal support and techniques, and acquire informal roles such as distributing supplies, food, or clothing (Spokane et al., 2011). In addition, supervisory relationship concepts such as parallel process may play out in supervision between the survivor and supervisee (Lahad, 2000). Supervisors and supervisees will need to be flexible as they work in informal environments, and participate in activities that might not be considered therapeutic. To protect the supervisory relationship from problematic ruptures, ongoing self-regulation and co-regulation of predictable trauma responses must be continually monitored and processed effectively.

While research has focused on supervisors and supervisees, there is an absence in the literature in differentiating between individual supervision and group supervision. Supervision appears to be synonymous with individual supervision unless the phrase "group supervision" is explicitly used to make the distinction between these two forms of supervision. Goodman and colleagues (2014) explored peer group supervision within a liberation psychology and critical consciousness theory framework, which encompasses a social justice perspective in disaster work. The authors explained how peer group supervision focused on "introspection and personal awareness" for counselors and psychologists to develop counseling skills in critical consciousness and liberation psychology (Goodman et al., 2014, p. 230). The results of the peer group supervision reflected upon the context of community members (e.g., culture, strengths, and sociological issues), process (e.g., practitioner role, connection and respect), and post-outreach follow-up (e.g., outgrowth of community outreach), which all reflect cultural competence, so-

cial justice, and community collaboration (Goodman et al., 2014). Additionally, this nontraditional group supervision required practitioners to advocate for clients, conduct outreach, reflect on their commitment to social justice, and shift from the traditional individual perspective to community-based "collective healing and empowerment" (Goodman et al., 2014, p. 234).

Another form of group supervision used a social justice lens to provide supervisees with interventions and address countertransference issues in post-disaster communities. Bemak and Chung (2011) used a Disaster Cross-Cultural Counseling model, a multicultural responsive group that integrates social justice into post-disaster work and group supervision within and outside the United States. Bemak and Chung (2011) argued that group interventions "offer the strongest means of protection against trauma and despair following a disaster and redefines group counseling," and that traditional counseling fails to "adequately address the immediacy and critical need to manage post-disaster trauma and stress" (p. 5).

Bemak and Chung (2014) explained how traditional counseling guidelines are unrealistic for disaster mental health outreach – in particular, "clearly defined times for counseling sessions, confidentiality, special private physical locations for counseling sessions, or clearly defined counselor-client boundaries" are not feasible most of the time (p. 6). There is currently a lack of empirically-based guidelines for group therapists to implement in disaster settings, especially when considering these nontraditional components. Socially-just group supervision can offer resiliency narratives, address the contexts, remain sensitive to clients' cultural beliefs and values, and facilitate culturally-responsive skills. Such skills include "active listening, problem definition [and] solution, establishing a post-disaster therapeutic partnership, active comforting, heightened compassion, discussions about the limits of confidentiality, and follow-up survivor actions steps" (Bemak & Chung, 2014, p. 8-9). These skills are structured and supported by the supervisor to ensure that the community's needs are being met and that the supervisee is competent in these skillsets. On the other hand, team selection for socially-just group supervision requires that the supervisee is flexible, multiculturally aware, self-reliant, has skills to digest countertransference, and proactively engages in the debriefing process in supervision (Bemak & Chung, 2011).

However, there are exceptions when "group supervision" is not explicitly stated. Studies that involve professors and students who serve in disaster settings usually do not acknowledge the type of supervision. For example, Ball State University's counseling professionals' disaster training program is involved with the American Red Cross (ARC). In the past, Ball State master and doctoral students volunteered in Mississippi post-Hurricane Katrina under the supervision of their professor, a licensed psychologist. Dr. Bowman selected students based upon their "maturity level, counseling skills, and ability to take supervision" (Bowman & Roysircar, 2011, p. 1167). Before heading to the disaster, Dr. Bowman discussed with her students their roles, responsibilities, self-care issues, "appropriate decorum, health issues, and the importance of flexibility" (p. 1168). Dr. Bowman and her supervisees reviewed brief directive counseling approaches, crisis intervention knowledge, diversity, and cultural differences (Bowman & Roysircar, 2011). From this supervision experience, students reflected upon their interdisciplinary collaboration and "applied their training as counselors and as consultants" (p. 1168). However, details regarding group supervision process were not tracked.

Another disaster response program is Disaster Shakti of Antioch University New England. Created by Dr. Roysircar, Disaster Shakti follows ARC's psychological first aid approach, and uses a single-session framework and short basic counseling interventions (Bowman & Roysircar, 2011). Prior to arriving at a disaster site, Dr. Roysircar engages her students in discussions related to the needs of people who are globally affected by different natural disasters. Students are trained to prepare for disaster trauma through crisis management and self-care techniques, and they learn about cross-cultural adaptation and resiliency (Bowman & Roysircar, 2011). Further training is also provided in "multicultural competencies, racial identity development, disaster response competencies, social justice advocacy, community collaboration, knowledge about communities to serve, and vicarious traumatization" (Bowman & Roysircar, 2011, p. 1171). At the disaster site, supervisees incorporate skills they learned, such as trauma-focused cognitive behavior strategies, grief counseling, empowering survivors, and participating

When operating in a new setting, an awareness of historical oppression, cultural mental health practices, previous disaster encounters, and an understanding of the limits and biases of Western psychology can prepare both supervisors and supervisees to engage in ethical supervision and community outreach.

in self-assessment of their strengths and protective factors under the direction of their supervisor (Bowman & Roysircar, 2011).

Vulnerable population

Even within a natural disaster, there are individuals who are vulnerable and at greater risk during recovery or restoration of the community. In Haiti, after the 7.0 magnitude earthquake in 2010, many small local organizations intentionally focused on providing assistance to women and children, whose safety and rights were of great concern due to the "fragile and post-catastrophe environment" that increased the likelihood of rape and violence (Bell, p. 30, 2010). Individuals with a disability are also at greater risk, and must be included in crisis management planning.

Camps designated as safe spaces for children were implemented during the Haiti earthquake recovery process to keep children safe from risks and hazards that posed a threat to their physical, emotional, and psychological well-being. In these environments, relationships were established, and screening and assessment were done to identify high-risk children who needed additional services. Education and training was provided to incorporate lifesaving skills in disastrous situations, and routines were established to foster a sense of normalcy, security and building self-esteem (Madfis et al., 2010).

Among the limitations of such camps is that there was funding to provide only short-term services. Although there are long-term consequences of disaster, and children benefit from these camps in psychosocial, mental health, and educational realms, issues arise when attempting to locate a displaced parent. Some parents intentionally forsake their children in these camps, hoping for a better life and outcome for their children due to the despair and poverty of their own living conditions. These camps therefore inadvertently increase orphaned children in need of homes in Haiti.

Professionals' self-care

Current literature highlights the ethical implications of supervisee self-care and group supervision. Within the supervision relationship, a collaborative process where "supervisory expectations are clearly delineated; the effect of the worldviews of the supervisor, supervisee, and client are addressed" is needed for ethical standards to be integrated (Pettifor et al., 2014, p. 202). A disaster setting exacerbates the importance of upholding ethical standards where there are different cultural considerations. Power differentials between the supervisor, supervisee, and client are emphasized, and diversity factors can be introduced by both supervisors and supervisees. When operating in a new setting, an awareness of historical oppression, cultural mental health practices, previous disaster encounters, and an understanding of the limits and biases of Western psychology can prepare both supervisors and supervisees to engage in ethical supervision and community outreach.

At the same time, supervisors are responsible for modeling and practicing appropriate self-care for supervisees in the event of a disaster (Aten et al., 2008). Aten and colleagues examined how the parallel process theory is applicable for supervisors to model self-care because supervisees tend to "observe and internalize representations of their supervisors" (p. 77). Supervisors need to be mindful of how supervisees may view their actions, which can impact how supervisees respond to a disaster. Supervisors can normalize and validate supervisees' experiences while maintaining professional boundaries. During the post-disaster period, supervisors may need to provide supervisees with additional empathy and support, but not extend their role to counseling or exploiting supervisees to meet their personal needs (Aten et al., 2008).

Also, supervisors can educate supervisees about stress-management resources, common problems in providing psychological services in disaster settings, and can develop "an informational self-care packet" (Aten et al., 2008, p. 77). Studies have illustrated how supervisors can encourage supervisees to practice positive coping and monitor their process towards incorporating self-care in their lives (Aten et al., 2008; Lahad, 2000). Nevertheless, supervisors should be aware of supervisees' personal struggles, and address any challenges because they may adversely affect the client and the supervisory dyad. Supervisors must be cognizant of supervisees' behaviors because, according to Ladany and colleagues (1996), approximately 97% of supervisees withhold information in supervision. This may be due to shame, lack of confidence in their clinical skills, anxiety, and self-doubts that can affect how they experience their clients and supervisors (Aten et al., 2008; Yourman & Farber, 1996).

McKersie writes about his experience with the Haiti earthquake disaster relief as a medical professional and how it impacted his life, expressing strong emotional feelings, a sense of closeness with other professionals who also volunteered in Haiti, a sense of connectedness with current clients of Haitian or Dominican descent, an overwhelming feeling of inadequacy, and many other feelings that he did not experience prior to his time in Haiti (2010). It is imperative that professionals also seek trauma-informed counseling to process their embodied experience and the emotions and thoughts associated with such experiences. It is known that many disaster recovery workers commonly deal with post-traumatic stress disorder and many other mental health disorders because of the disasters. Working in these types of environments is quite physiologically demanding and overwhelming. Although it can be an altruistic experience, it may also have other grave impacts to the psychological wellbeing of the helping professional. As professionals are intentional about their self-care, especially in disaster response and recovery, the quality of care and services provided to those in need will improve. Lastly, engaging in reflection about the experiential learning is essential to meaningfully integrate and resolve the many lessons that cannot be learned without direct experience (Kolb, 1984; Kuk & Holst, 2018).

Somatic practices for socially-just group supervision in disaster outreach

With these ethical considerations in mind, the current authors posit that socially just and ethical global supervision depends upon supervisors role-modeling and facilitating a multitude of somatic relational skills to discharge trauma in real-time so the outreach team can effectively serve the target community post-disaster, while protecting themselves from vicarious trauma and compassion fatigue. Using Rothschild's (2017) autonomic nervous system precision regulation measure as a guide can help supervisors self-monitor for stress modulation in themselves, supervisees, and members of the community being served. Pendulating between private discharge of intense affect, and public facilitation to regulate movement, breath, and attuned touch can expand supervisees' self-care tools to digest vicarious trauma throughout an outreach mission. The current authors share reflections from on-the-ground outreach in Haiti over several years.

There are multiple factors in holistic, culturally-responsive, embodied supervisory preparation, implementation, and integration that lead to success with the Global Trauma Research: Haiti Trauma Project team. The executive director builds a relational container through year-round monthly meetings with the core team to reflect upon past missions and upcoming programs, documenting lessons learned and planning for anticipated needs using a framework of Strengths, Weaknesses, Opportunities, and Threats (SWOT).

- Core team members are assessed for strength-based skills, placed in roles that play to those strengths, and supported in intentional recruitment of appropriate volunteers for the multiple training and direct service projects that will unfold.
- Orientation to each mission's objective is outlined clearly, and realistic expectations are set for each component.
- Each month's global group supervision provides space for each member to share felt sensations, emotional responses, and meaning-making about past projects, as well as anticipation of upcoming projects.

- Explicit inquiry about self-care practices folx are implementing encourages diversity, creativity, and normalization of methods employed. Anxiety is embraced, and support is explicitly offered throughout the year's planning process.

These processes are modeled from the executive director to the trauma treatment team, as well as the trauma treatment team to the targeted community with whom we collaborate in on-the-ground outreach and ongoing telesupervision after each deployment.

Once on-the-ground for outreach:

- Each trauma team member is gifted a reflection journal and encouraged to write in it daily.
- Each group supervision team member is invited to take turns leading a somatic grounding technique to start each day's group supervision.
- A cohering sense of connection is prioritized through holding hands in a circle while setting intentions, so that the social nervous system of the team is a resource from which all members draw throughout the day's work.

  Group supervision members are deployed for the day in pairs intentionally matched for optimal ease, connection, support, and mutuality; this action reflects a deep relational awareness on the part of the executive director to know how to support all members effectively, and reduce overwhelm in practitioners.
- This group cohering process is then facilitated by each pair with the community group they serve; the community is supported to decide how they wish to come together to join, which often involves holding hands in a circle, singing psalms, and committing the day's service to the community and a higher power. Throughout the morning's work, community members come together in small groups to share stories of loss, overwhelm, and hope; spontaneous attuned touch is regularly employed between community members to facilitate discharge of trauma narratives and provide regulating support, while trauma treatment team members move between groups and facilitate regulated processing of overwhelm toward a coherent narrative. *Mimesis* (matching and mirroring without mocking) in intentionally employed to facilitate co-regulation of trauma narratives, and trauma team members take over as necessary to model trauma processing.
- A lunch break is protected fiercely each day. All trauma treatment team pairs are brought back to the group for a shared meal, where group members are encouraged to share both stressors and highlights of the morning. Concerns are documented for deeper processing in the evening, and the executive director prioritizes providing live supervision each afternoon to the subgroups needing more structure and support.
- The entire community is called together in one large town hall at the end of each day for members to share their experiences with the large group, and then self-selected subgroups are facilitated to discuss needs for the coming day, which are also shared back with the large group so that members are connected across groups. At the end of the work day, the trauma treatment team is recalled to rest. Group members stay in shared housing, so are encouraged to communicate directly about their needs for solitude or connection. External processors are supported with a shared living space to connect and unpack the day informally, while internal processors are supported with quiet time in their rooms before dinner.
- Dinnertime is also fiercely protected. The group comes together to celebrate healing moments and be intentional about shifting into rest-and-digest. After about an hour of informal digestion time, group supervision leaders facilitate a SWOT analysis to complete any remaining emotional charges of the day. Various embodied self-care options are then offered and facilitated between group members to wind down for sleep, to include: yin yoga, evening walk, music and dance, soccer, hair braiding, facials, journal writing, shoulder rubs, and improv games.

The cycles of this team's approach to the year and each service day are mapped onto Judith Herman's triphasic model for trauma resolution: safety and stabilization, trauma memory processing, and reconnection (1992). Using this embodied model for group supervision in disaster outreach settings minimizes the impulse for supervisees to block their physiological and/or emotional responses to the overwhelm they experience, while realizing the limits to how their service can improve the lives of the impacted community. Making space for role

modeling a variety of co-regulatory embodiment practices throughout the day strengthens the resiliency responses of each member, as they are able to choose from approaches that best suit their nervous system and needs in the moment. Normalizing the body's response to group trauma processing creates more emotional bandwidth within and between the members, who then embody that capacity for the community served. Providing psychoeducation to the community served about how they are already implementing this model, and ways to further enhance that through the group and individual practices they are learning with the trauma treatment team, helps increase their self-sustainability and maintenance of embodied gains from the outreach.

Discussion

According to Bersh (2010), Haiti could have had less destruction and fewer casualties if the government had been more vigilant in preparing for disasters and advocating for improved building standards. Benjamin and colleagues (2011) clearly express that it is the responsibility of the country to have a minimum standard of preparedness to maintain, despite receiving assistance from other organizations. Considering all that has occurred with the devastation in Haiti and the continued suffering of its residents from their lack of resources, it is imperative that governing officials and foreign/international supports assess a more effective crisis management plan to prepare for future disasters. Many have thought that Haiti should not continue to operate as a country due to its lack of resources and provision, but many people in that country believe in the slogan that "Another Haiti is Possible" (Bell, 2010). Despite the deprivation and overwhelming oppression of poverty, this population has a shared resilience and resourcefulness to one another, which has proven to foster hope, encouragement, and the continued will for life (Bell, 2010).

Whether supervision is conducted individually or within a group setting, the structure of supervision can influence supervisors' and supervisees' approach. The previously mentioned studies depict important contributions of supervision in diverse disaster environments. Yet the studies provided limited information on the implementation of supervision within a particular disaster setting, in particular operationalizing embodied practices to prevent vicarious trauma and compassion fatigue. Although hurricanes and earthquakes are recognized as types of disasters where supervision takes place, it is difficult to grasp from the literature the differences and similarities within these forms of disasters. The role of the supervisor is mentioned, but specific examples of how they deliver supervision are missing. In the current literature, the practice of supervision in disaster settings is vague, and provides surface-level terminology that fails to provide supervisors and supervisees who may be interested in disaster clinical work with a conceptualization of the hour-to-hour supervisory process. Even though the current literature effectively provides examples of the expansion of traditional roles of supervisors and supervisees in post-disaster situations, it falls short in providing examples of boundaries of nontraditional roles, and the lived experience of how to process the overwhelm while role-modeling for supervisees in real-time.

Another important implication involves mental health professionals' programs that do not have community outreach as an integral part of their program, where training in disaster clinical work must therefore occur outside the classroom, usually during school breaks. There is a limit of available opportunities to engage in this vital experiential work, and there are no job security incentives for supervisors and supervisees in traditional clinical settings to gain international supervision experience in disaster settings. Also, for supervisors and supervisees who do have experience in disaster supervision, there is a lack of evaluation of supervision, the cultural appropriateness of interventions,

… the studies provided limited information on the implementation of supervision within a particular disaster setting, in particular operationalizing embodied practices to prevent vicarious trauma and compassion fatigue.

and ethical behaviors in these diverse communities. The shortage of empirical evaluations of supervision in disaster settings creates a risk for clients, supervisees, and supervisors who may be unaware of detrimental strategies or beliefs that could have long-term effects. Since disaster interventions and supervision are time-sensitive and brief, an effective evaluation system is needed to ensure that multicultural competence and social justice principles are adhered to in diverse contexts.

Future recommendations include promoting graduate training; increasing disaster supervision guidelines for supervisors and supervisees; and providing continuing education opportunities (Pettifor et al., 2014). More research is needed to address whether theoretical orientations such as trauma-focused cognitive behavior therapy, liberation psychology, and psychological first aid are effective for different types of disasters. Somatic specialists are also encouraged to center culturally-responsive disaster outreach research into the field's development. More emphasis is needed to recognize the role of supervision within these orientations to address the needs of victims and survivors. Additionally, supervisors and supervisees need to be aware of international ethical codes and mental health professionals' ethical standards in order to understand their roles and boundaries as they practice ethical guidelines in supervision (Pettifor et al., 2014).

Furthermore, greater awareness of supervision as a "distinct professional competence" and formal training in disaster-based competencies is needed (Pettifor et al., 2014). On the same note, more clarity is necessary to understand how the supervision processes would look similarly and differently among professors, psychologists, and other mental health professionals with students and early career practitioners. These unique dynamics can inform these professional relationships and increase professional development by acknowledging the different needs and important considerations of the supervisors and supervisees within disaster work. Further research can shed light on the difference between individual and group disaster supervision while recognizing effective supervision models. These are vital recommendations that need to be considered to appropriately and effectively participate in supervision in disaster settings that affect supervisors and supervisees, but more importantly, the victims and survivors, our clients.

The role of supervision continues to be transformed from a traditional to nontraditional structure that involves supervisors, supervisees, and clients in post-disasters. Current evidence can attest to the effectiveness of supervision in disaster settings, but important areas of growth remain that are needed by mental health professionals. While we understand the significant consequences of disasters, we still lag behind in fully comprehending how our unique training values can influence the lives of victims and survivors with whom we have brief encounters, but can create a lasting impact on their lives. Moving forward, let us not forget about our contributions thus far, but renew our commitment to gain competency in an area that is greatly needed in a setting that can forever change someone's life in a split second. Survivors of disasters are not concerned about our theoretical orientation or type of supervision, but what they do care about is that we are prepared to support them in a difficult time, so let us strive to exceed their expectations of what supervision can offer them.

It is incumbent on those in various roles in the helping profession to reach out and provide service to those in need, both domestically and abroad. The realization that there are people right here in the United States who don't have access to minimal mental health services due to a lack of resources pushes us to look at the necessity of community outreach in our own backyards (McKersie, 2010). Such disparities in skillful trauma resolution and general mental health services can be seen all over the world.

Juanita Barnett, **PhD**, **LPC**, **NCC**, is an Assistant Professor of Counseling at Alabama State University. She is the faculty advisor for the Counselor Education Student Association and Chi Sigma Iota for the ASU Counselor Education programs. She received her doctorate degree in Counselor Education and Supervision from Auburn University; master's degree in Clinical Mental Health Counseling from Alabama State University; and her bachelor's degree in psychology from Florida State University. Dr. Barnett is a Licensed Professional Counselor in the state of Alabama and a National Certified Counselor with NBCC.

Dr. Barnett's research interests include mental health related issues within the Afro-Caribbean immigrant populations, global mental health, spirituality in counseling, and professional development amongst faculty and counselors-in-training. Dr. Barnett is currently a member of the Haitian Research Task Force. She is passionate about bridging the gap and eliminating the disparities in mental health services for underserved and underrepresented minority populations through research, advocacy, training, leadership, service, and outreach activities.

Dr. Elizabeth Farrah Louis is a Haitian-American psychologist at Harvard Medical School. She is engaged in clinical work and conducts global mental health research. She provides clinical work to immigrants, refugees, asylum seekers and survivors of torture from Latin America, the Caribbean, Africa, and Asia. Dr. Louis also provides therapy to children and adolescents, and supports their families.

Since 2015, Dr. Louis has been engaged in extensive community-based work in Haiti, focused on trauma, disaster relief, mental health, and training laypersons and health and mental health professionals. She is a recipient of the U.S. State Department Boren Fellowship and has worked with Zanmi Lasante/Partners in Health. She completed the National Institutes of Health – Harvard University, Boston University, Fogarty Global Health Fellowship with Partners in Health/Inshuti Mu Buzima in Rwanda (2019-2020). Dr. Louis teaches counseling skills at Boston College to masters students. She is a diversity, equity, inclusion and feminist consultant, and advocates for marginalized populations.

Karen Roller, **PhD**, **MFT**, is an Associate Professor of Counseling at Palo Alto University and Clinical Coordinator of Family Connections, a parent-involvement preschool system serving predominantly Spanish-speaking migrant families in the San Francisco Bay Area. Her doctorate from Santa Barbara Graduate Institute in Clinical Psychology with a specialization in Somatic Psychology included experiential coursework in pre-and-perinatal psychology. Karen has spent her clinical career in family therapy through community mental health for the marginalized and underserved including fostered youth, adjudicated youth, and the Latinx migrant community, as well as international trauma training outreach in Haiti. She co-authored *Lifespan Development: Cultural and Contextual Considerations for the Helping Professions* (Coker et al., 2023) where she was charged with the Infancy into Childhood chapters; she centered force migration and other social determinants of health for underserved and marginalized families.

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Voicework and Sound Healing

Overcoming the Silencing Response and Unlearning Voicelessness

Nicole Cowans, Karen Roller

ABSTRACT

This review article outlines the theoretical and practical consonance between voicework, Integral Sound Healing, and traditionally studied somatic practices. It highlights the trauma processing and empowerment value of structured voicework to reclaim one's voice from systematic silencing by oppressive structures and individuals. The authors propose voicework and integral sound healing as relevant to incorporate in somatic psychotherapy to support clients in resolving systematic silencing and self-assertion.

Keywords: Fitzmaurice Voicework, Integral Sound Healing, silencing response, voicelessness

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Fitzmaurice Voicework (FV) and Integral Sound Healing are rooted in ancient healing modalities, with the potential to be powerful somatic intervention tools for clinicians' self-care and as therapeutic interventions. FV and Integral Sound Healing may be used in a trauma-informed manner to "unlearn voicelessness" (Hardy, n.d.) that has been incorporated to cope with the *silencing response* of privileged, domineering authority figures across the lifespan. The silencing response has been studied with a validated scale as a measure of compassion fatigue in therapeutic relationships (Chun et al., 2023). The current authors posit that patriarchal and white body supremacist systems also use the silencing response to maintain control of the narrative over individuals and groups, shutting down life-affirming self-assertion. This macro application of the silencing response is why movements such as Black Lives Matter, the Arab spring, women's and Pride marches, and student and peasant uprisings across the world organically arise in the relative safety of numbers. We are beginning a qualitative study to explore somatic responses to group delivery of trauma-informed FV and integral sound healing in order to assess if mental health student participants indeed unlearn voicelessness in any way that is empowering for them. The current ar-

> ***... therapeutic sound is a process that can shift brain waves into a more optimal state of desired consciousness...***

ticle is a conceptual argument for how FV and integral sound healing are anti-oppressive somatic interventions.

Both FV and Integral Sound Healing invite us to channel the breath to avail ourselves of our most regulated and authentic embodiment. These therapeutic tools offer us the ability to live in the realm of observation, known in somatic and trauma research as the parasympathetic or ventral vagal state (Dana, 2018). The ventral vagal state is available only when the human nervous system is resting in a deeply regulated biobehavioral rhythm. Returning to this state requires time and effort after an emotional upset, and can be completely co-opted by chronic stress and trauma (Porges, 2022). Therefore, potential methods for increasing clinicians' skillset for self-care and client facilitation of returning to this regulated state merit formal study to develop the evidence base.

This literature review and study proposal serves as a preliminary investigation into links between the theory and practice of FV and Integral Sound Healing, as well as related research in scientific literature on somatic therapy and interventions. The intent of this literature review is to examine intersections between FV, Integral Sound Healing, and research on somatic modalities used in clinical mental health counseling. The researchers will then describe a pilot study intended to introduce clinicians-in-training to FV and Integral Sound Healing for their self-care and, eventually, as therapeutic interventions with counseling clients in clinical settings.

Voicework

Voicework can be defined as the eclectic collection of methodologies combining ancient and modern breathing techniques to unlock the fullest potential of an electric, vibrating human being (Campbell, 2000; Linklater & Slob, 2006; Hampton, 1997). Voicework helps to tap into the power of communication, understand how to use language to inspire meaningful change, and supports individuals to use the variety and texture of their voice to express truths with honesty and integrity. Voicework offers tools for transformation and self-empowerment.

Voicework depends on effective breathing, the primary function of which is oxygenation. The respiratory system in the body draws oxygen into the bloodstream, where it is distributed by the circulatory system throughout an individual's entire anatomical structure. The voice can be conceptualized as conscious energy in motion (Dyczkowski, 2006). Phonation (i.e., voicing) occurs as a result of the central nervous system (CNS) and autonomic nervous system (ANS) engaging in a dynamic bioenergetic interplay (Lowen, 1975; Pierrakos, 2005). In this process, the CNS and ANS allow and engage access to the necessary energy, oscillation, organization, relaxation, flexibility, and freedom in the body so that breath can fuel and support intentional phonation (Farhi, 1997; Calais-Germain, 2006).

Core facilitative conditions of therapy have traditionally included intentional assessment of emotional state and co-regulation of negative affect through modulation of vocal tone, pacing, and prosody to co-regulate stress and effectively communicate safety and empathy. Recent advances in therapeutic interventions and technology are now incorporating polyvagal theory with auditory soothing and voicework to regulate overwhelmed and dysregulated states such as anxiety, and sensory processing difficulties typical of clients on the autistic spectrum (Kawai et al., 2023; Porges et al., 1995-2022). Research is also underway applying polyvagal theory with voicework to down-regulate trauma activation (CTG Labs-NCBI, 2023; Porges, 2022). Somatic interventions for stress and trauma widely incorporate intentional use of breath and voicing to access and discharge held states of overwhelm, and bring them to resolution (Lucks & Lucks, 2015; MacNaughton, 2004; Porges, 2022; Zaccaro et al., 2018). Much of this work may be considered consonant with ancient traditions that have incorporated intentional entrainment to a coherent state through individual and collective voicework (Cabral-Calderin & Henry, 2022; D'Angelo, 2000).

Fitzmaurice Voicework

Fitzmaurice Voicework was established in the late 70s by Catherine Fitzmaurice, and is a holistic approach to vocal training used with performers (2018). FV is now a globally recognized vocal technique used with students at the undergraduate and postgraduate levels in some of the most prestigious academic and research institutions in the world. FV is also used in corporate and clinical settings (Watson et al., 2019).

The results from a 2019 pilot study using fMRI to measure participants' brains in response to FV suggest that FV could positively impact executive cognitive control networks in the brain, and potentially offer therapeutic effects to the central nervous system (Watson et. al, 2019). FV adapts the voicework of bioenergetic tremors, yoga positions, and a focus on a fully relaxed torso to invite and allow maximum spontaneous breathing movement (Fitzmaurice, 2003). Additionally, FV incorporates supported and witnessed tantruming with vocal expression to facilitate a cognitive assimilation or coping process necessary to alchemize an overwhelm of cortisol with healthy efficacy (Bohart, 1980). FV skills (i.e., mindful body scanning, breathwork, tantruming, bataka work, vocalizing emotions) are self-regulation tools meant to encourage the nervous system to bravely and healthfully process highly-charged emotional and somatic experiences.

FV can be divided into four main parts: presence, destructuring, restructuring, and play.

- ***Presence*** is meant to help build a personal awareness of the internal landscape using proprioception.
- ***Destructuring*** uses a sequence of modified hatha yoga positions meant to develop freedom in the voice and body. Tremors may occur during the destructuring sequence as the body's natural healing response for digesting and processing cortisol. More specifically, FV invites the use of sound on every outbreath, no matter how the body is breathing (without changing the placement or rhythm of that breathing) in order to retrain the CNS to understand that it can allow voice with ease, and that breath flow and voice can be released through the vocal tract without excess stress or restriction.
- ***Restructuring*** is meant to develop focus for clarity of thought and emotion in oral communication by engaging the primary muscles of breathing to efficiently support intentional sound-making.
- Finally, ***play*** invites a holistic embodiment of the vocal variety available. This part of FV engages the dynamic communication between the freedom of spontaneous inspiration and the focused choreography of primary breathing muscles to express intention and explore possibilities.

Integral Sound Healing

Human beings are unique among the animal kingdom in that our evolutionary relationship with sound has allowed us to manipulate our production of it for a wide variety of social engagement and self-regulatory purposes (Porges 1995, 2003, 2011, 2022). We use sound to express our emotions and needs, which makes it a potent healing tool centered in therapeutic intervention since Freud founded the "talking cure" of psychoanalysis.

Integral Sound Healing can aid us in shifting between brain waves (or levels of consciousness) in order to allow healing to occur at a neurological and neurochemical level (Chanda & Levitin, 2013; Porges, 2003). Neuroscience research has shown that there are multiple levels of consciousness that can be measured with a variety of technologies affording various levels of precision, and therapeutic sound is a process that can shift brain waves into a more optimal state of desired consciousness beyond stressed states or a typical resting baseline (D'Angelo, 2000; Gao et al., 2020; Kučikienė & Praninskienė, 2018; Madsen et al., 2019; Tai & Lin, 2018).

Sound healing is an ancient modality that is said to improve wellbeing and balance the body's entire system through life force energy and neurochemical balance (Chanda & Levitin, 2013; Goldsby and Goldsby, 2020). Integral Sound Healing is a form of complementary and alternative natural medicine that utilizes sound and vibration to deeply penetrate and address physical, emotional, mental, and ethereal/spiritual challenges. Sound healing can treat chronic stress in a non-invasive manner by reducing inflammatory stress states and invoking natural recuperation (Chanda & Levitin, 2013; Goldsby & Goldsby, 2020; Nagdhi et al., 2015). Integral Sound Healing can be considered a combination of evidence-based approaches (sound, meditation, and music therapy) that use sound as a tool to help improve brain function, develop physical resilience, process cortisol, regulate emotions, improve attention skills, enhance learning abilities, and rewire neural circuits (Merzenich, 2010). This form of holistic healing operates from a psycho-acoustics lens that posits that the body is one complete and dynamic unit, and that each human being has a phenomenological relationship to the way they experience sound and sound-making (Jung et al, 2012; Will, 2022).

Fitzmaurice Voicework & Integral Sound Healing as somatic practices

Today, somatic practices and bottom-up processing modalities are increasingly recognized across mental health treatment fields as moving toward the gold standard for trauma resolution (Brom et al., 2017; Kuhfuß, et al., 2021; Payne et al., 2015; TICTI, 2023). As a tool for performance, Fitzmaurice Voicework taps into this wisdom; however, because FV does not originate from the field of mental health, it does not automatically integrate a trauma-informed lens. For instance, FV trainers who are not also trained as clinicians may push for emotional catharsis of vulnerable FV students in a group setting without awareness of how that can potentially retraumatize their students, and without providing tools for trauma resolution and integration.

The purpose of the current proposed pilot study is therefore threefold. First, it will elaborate on the philosophical and practical consonance between somatic bottom-up processing and Fitzmaurice Voicework so that mental health practitioners-in-training can intentionally use these practices for their own self-care, as well as trauma-informed intervention with their voice and body. Second, this study will introduce a trauma-informed lens to FV with the intention of benefitting future FV students and trainers. Third, it will add to the somatics and trauma literature about intentional use of breath, movement, and sound to facilitate self-care and emotional regulation in therapeutic sessions for practitioner and client.

Trauma-informed approaches

Trauma-informed psychotherapy is a multifaceted process that requires planning and preparation on the clinician's part, and the willingness to be flexible and responsive to unexpected situations. This can sometimes result in a stressful environment for both clinicians and clients. Music and sound can have a profound multifaceted impact on the therapeutic process. Research has provided evidence of the ways in which music and sound facilitate healing for people suffering from dementia, relieve pain for people suffering from AIDS, and reduce the side effects of chemo and radiology treatment for cancer patients (Will, 2022; Harvard Health, 2015). Mental health research has begun to recognize the ancient wisdom and traditions of yoga and mindfulness as essential self-care practice for practitioners and clients in coping with trauma and stress (Boyd et al., 2018; Caplan et al., 2013; Cole et al., 2015; English et al., 2022; Gulden & Jennings, 2016; Kelly & Garland, 2015; Park & Slattery, 2021). The current proposed study is rooted in that foundation, while making more explicit how breath and sound may be incorporated for healing with yoga and mindfulness techniques.

Many FV techniques can be practiced with little time and space, making them ideal options for clinicians-in-training and clinical supervisors to incorporate at busy practicum and internship sites. Teaching voicework techniques to clinicians-in-training may help them to engage in better self-care, and find ways to relieve stress during their internship and practicum placements. In addition, these practices can be used within therapy to help clients prepare for, participate in, and/or exit therapeutic sessions following Judith Herman's triphasic model for trauma resolution (1992; Webber et al., n.d.).

Therapists can incorporate trauma-informed voicework techniques to help clients practice relaxing and attuning their focus during stressful times. Once introduced to these techniques, clients may utilize them on their own. FV has been shown to be helpful in reducing stress and increasing focus (Watson et. al, 2018). FV implements modified hatha yoga positions and mindfulness into its techniques, with the added value of increased awareness of emotional states tied to breath and sound (Watson and Sadhana, 2014). This intersectionality has been known traditionally, but not necessarily used intentionally in the mental health professions. Therefore, this pilot study will systematically seek feedback on benefits and needed changes to the proposed curriculum for introducing FV to clinicians-in-training.

Autoethnographic Case Study

The first author is a certified trainer of FV and an Integral Sound Healing practitioner. As an Afro-Latina raised in Puerto Rico and across various states in the U.S., she has witnessed and experienced firsthand the silencing response of pigmentocracy discourse in school, work, and social situations (i.e., existing in the isolation of being the only student of color in higher academic settings,

receiving discriminatory treatment due to her non-Caucasian physical appearance, and being demonized for speaking Spanish in English-speaking settings).

In self-empowerment and life-affirming response to these diminishing control behaviors, she has trained at the highest level in reclaiming her voice and using it as a liberating advocacy tool on behalf of those who are still unlearning voicelessness. *Voicelessness* results from a conscious choice to exercise power or refuse to exercise power, and can also be a silence enforced on one by others in the absence of choice (Kritzinger, 2012). The first author's unlearning of voicelessness shows itself in (1) pausing group process when white dominance is monopolizing time; (2) naming group dynamics and modeling how to attune to the activation in the room; (3) speaking directly to power with embodied courage and steadiness.

The implementation of sound healing and FV techniques as a somatic self-care practice nurture an ability to advocate for positive change and become an active part of the process of transforming systematic inadequacies into something radically new. In systems that perpetuate cultural oppression and structural inequality, self-advocacy through voicework and sound healing offer a necessary form of self-care.

As embodied mental health professionals dedicated to advancement, equity, diversity, and inclusivity in the mental health field, we have a duty to be leaders in self-advocacy. If we do not raise our voices against unjust treatment, we will continue to be silenced and oppressed by those same institutional structures that claim to support us. Integral Sound Healing and FV introduce, build, and create ways of operating that hold space for integrity, transparency, and the wellbeing of all involved as essential in decision-making processes.

Conclusion

From a trauma-informed lens, the mental health field would benefit greatly from opening its doors to voicework as a therapeutic somatic intervention. Somatic psychology recognizes the importance of a mind-body connection to processing trauma and stress. Somatic interventions offer skills to learn how to gently reprogram the mind and body to respond and engage with others from a brave and regulated state, rather than a traumatized, reactive state. Furthermore, normalizing the discussion and engagement of ongoing self-care with clinicians-in-training can reduce stigma and encourage proactive skills development to avoid vicarious traumatization, burnout, and compassion fatigue. Finally, for clinicians and clients who find themselves pressed to the margins in a white body supremacist, patriarchal structure, methods that facilitate the unlearning of voicelessness in response to power are necessary to bring the right relationship and balance to lived experience, while leading the way forward with communal awareness and wellness.

Nicole Cowans, **MFA**, is pursuing her MA in Counseling at Palo Alto University and is the current President of the PAU Chi Sigma Iota – Pi Upsilon Honors Society Chapter, President of the DIASPORA Black Student Mental Health Organization, and an active member of the Latinx Task Force at PAU. As an Afro-Latina, she is bilingual (Spanish), and specializes in coaching and performing in both languages. She has a passion for empowering ethnically diverse voices, and a wealth of experience teaching students of all ages and skill levels in group and private settings. As a collegiate level Voice, Speech & Drama educator, her pedagogy includes: Fitzmaurice Voicework®, Knight-Thompson Speechwork, Accent Acquisition, Contact Improvisation, classical vocal performance, musical theatre singing, and Integral Sound Healing.

Karen Roller, **PhD**, **MFT**, is an Associate Professor of Counseling at Palo Alto University and Clinical Coordinator of Family Connections, a parent-involvement preschool system serving predominantly Spanish-speaking migrant families in the San Francisco Bay Area. Her doctorate from Santa Barbara Graduate Institute in Clinical Psychology with a specialization in Somatic Psychology included experiential coursework in pre-and perinatal psychology. Karen has spent her clinical career in family therapy through community mental health for the marginalized and underserved including fostered youth, adjudicated youth, and the Latinx migrant community, as well as international trauma training outreach in Haiti.

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Neo-Functionalism Applied to the Lived Experience of a Transgender Person During Gender Affirmation

Letizia Sturiale, Roberta Rosin, Irene Leo

ABSTRACT

Transgender people embody and express a gender identity that transcends sociocultural expectations about gender traditionally linked to binary biological sexes. There are forms of pathologization and medicalization of the transgender phenomenon with regard to legal proceedings, as well as medical and psychological practice, where a binary view of gender persists. Focusing on psychological support before initiating any hormonal and/or surgical interventions is a delicate and often debated phase during gender affirmation. The aim of this paper is to outline a reading of a transgender person's lived experience according to the psychological model of Modern Functionalism. Through thematic analysis, significant themes that shaped this experience were identified. More generally, the neo-functional approach has allowed us to illustrate a perspective of the transgender reality that intends to overcome a dichotomous view of body and mind by approaching the person in its entirety. In this way, we assume, the limiting effects of pathologizing, medicalizing, and binary gender conceptualizations have been minimized. Finally, the results of the data analysis were discussed, and links to relevant scientific literature were provided.

Keywords: Transgender, mind-body relationship, functional body psychotherapy

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> ***What do people experience who define themselves as transgender?***

Theoretical Framework

Transgender people transcend prevailing expectations of gender by living a gender identity that may not be aligned with the sex assigned to them at birth, and by expressing themselves in ways that overcome common gender conceptualizations that are traditionally linked to binary biological sexes, i.e., female and male (Dalle Luche & Rosin, 2017, p. 15). They wear clothes in line with their chosen gender identity, adopt new names that better reflect their desired gender, take hormones to modify the sexual characteristics of their body, and/or undergo surgical procedures (Di Gregorio, 2019, p. 40). In recent years, the transgender phenomenon has received more attention

both within sociocultural contexts and the scientific community (Crapanzano et al., 2021). There is a critical encounter with a dominant sociocultural model of a binary notion of gender that has shaped the history of psychological science as well as popular theories, and is based on the belief that all human beings are born either female or male, that they identify as such, and that they embody certain social roles during their lifetime. This binary view of gender continues to persist despite empirical evidence to the contrary (neuroscientific, psychological, evolutionary; Gallagher & Bodenhausen, 2021; Hyde et al., 2019). Sociopolitical activism and changes in the way psychologists classify mental disorders are attempting to deconstruct the conceptualization of gender and bodies as dichotomous variables. Linked to this are the critical issues raised concerning the "medicalization" of the transgender phenomenon and the concept of "transsexual" identities. The term "transsexual" is intended to define those who have undertaken certain surgical gender reassignment treatments in order to "transition" from one gender to the other (Mauriello, 2014). Within this critique, medicine is seen as a social institution that operates "control" over identities and bodies when the latter are considered "limited", in order to "transform" the subject to confirm a binary gender order (Mauriello, 2014). It is specified that this is not intended to deny the existence of transgender people's desire to belong to the opposite gender, but it is rather to consider the implications that such a view has on medical and psychological discourse, and on social relationships with these people. For example, there is a significant semantic difference between the terms "transition" and gender "affirmation." The term "affirmation" conveys a more respectful attitude towards those who do not intend to transition from one gender to another, but instead intend to affirm the gender identity to which they feel they belong (Crapanzano et al., 2021). Not all transgender people wish to undergo hormonal and/or surgical procedures, and there are a wide range of scenarios through which gender affirmation manifests itself. Similarly, not all transgender people espouse a gender identity in binary terms, i.e., male or female. Thus, it is possible that transgender people embody infinite identities between the two binary extremes, or "another gender" that has nothing to do with either masculinity or femininity (Dalle Luche & Rosin, 2017, p. 15).

Currently, gender affirmation in Italy is rooted within a complex medical-psychiatric system in which the psychological and psychiatric nosography is intertwined with legal procedures. Relevant debates dwell on the following point: despite being granted the apparent freedom to change one's body and name according to the gender perceived as one's own by means of the Law 164/1982, which stipulates the "Norms of rectification of sex attribution," this freedom is related to forms of pathologizing the phenomenon. More specifically, access to certain desired medical interventions is granted only when the subject "obtains" or "fulfills" the clinical diagnostic criteria of Gender Dysphoria (APA, 2013, pp. 527-537; Flights, 2018). The mental health professional therefore takes on the role of a "gatekeeper, filter or obstacle" in diagnosing these criteria, and in enabling the subject to initiate the medical pathway of gender affirmation (Schulz, 2018). It is inevitable that this substantially affects the psychotherapeutic setting for both the psychotherapist and the transgender person (Brooker & Loshak, 2020; Fiorilli & Rocco, 2019; Di Gregorio, 2019, p. 113; Mizock & Lundquist, 2016; Schulz, 2018). Critics argue that current diagnostic frameworks tend to place excessive focus on an individual's personal discomfort, rather than acknowledging the social factors that contribute to the experiences of transgender individuals (Schulz, 2018). The impact of stigmatization and discrimination in social and health contexts is therefore overlooked, and so more generally, is the influence of socio-cultural processes that contribute to the process of self-discovery and self-definition.

The questions to be investigated here are: What do people experience who define themselves as transgender? How is it possible to support them while minimizing the limiting impact of binary, pathologizing, and/or medicalizing views on gender identity?

The authors assert that one possible way to approach these questions is to address the complexity of the phenomenon by overcoming dichotomous beliefs about the human experience itself. This involves reconsidering perspectives on what is meant by sex (anatomical structure) versus gender (linguistic and performative structure), or, in other words, on what is meant by body versus mind, and by nature versus culture. It is assumed that only an integrative model that aims to unify these polarities (Denton, 2019), and is built on a com-

prehensive and flexible conceptual framework that integrates the notions of self, body, gender, and sex (Engdahl, 2014), would allow an articulate and in-depth understanding of the lived experience of transgender people. In this regard, the present work seeks to offer a view of the lived experience of a transgender person according to the neo-functional psychology model, which aims to transcend a dichotomous model of culture versus nature and of mind and body (Rispoli, 2004, 2014, 2016).

The Neo-Functional Psychology Model

Neo-Functionalism, also referred to as Modern Functionalism, originated in the 1980s with the research of Luciano Rispoli at the School of Naples and the European School of Functional Psychotherapy (Rispoli, 2014). At a theoretical level, the main roots of Modern Functionalism lie in the work of James (1890) and Dewey (1896) in early American Functionalism, as well as in the Chicago School of Angell (1907) and Carr (1925), in Wilhelm Reich's studies of the relationship between mind and body, and in more recent contributions to new research frontiers, such as psycho-neuro-endocrine-immunology (PNEI). The Neo-Functional Psychology model developed gradually with the attempt to frame the complex relationship between mind and body in a scientifically new way (Bastianelli et al., 2021; Rispoli, 2016, p. 14). In this regard, the *paradigm of complexity* led to a new theory of the Self that stipulates an integrated and unitary view of the living organism (Montouri, 2018; Rispoli, 1997). More specifically, there was a need to adopt a *multidimensional* perspective that included both partial and global aspects of the self simultaneously (Morin, 1985 in Rispoli, 2016, p. 14). In this sense, a structuralist view that focused on parts separately was replaced by a vision that looked at the *organization* of constituent processes, without becoming trapped in dichotomous differentiation of body and psyche, but moving on towards a *holistic* view (Bastianelli et al., 2021; Rispoli, 1997, 2016; Röhricht, 2009). As we will see, this vision would allow us to embrace the complex organism not only on an individual level, but also on a social level (Rispoli, 2016, p. 14). Thus, the relationships between psychic and bodily *systems* (perceptual, sensory, motor, postural, neurovegetative, and respiratory), as well as the emotional system, were investigated in order to fully understand the overall function of the organism (Bastianelli et al., 2021; Rispoli, 2016, p. 143; Röhricht, 2009). This meant moving away from concepts such as "conflicts" between parts, toward an approach that studies the functional organization of the whole system and its possible *alterations* (Rispoli, 2004, p. 28).

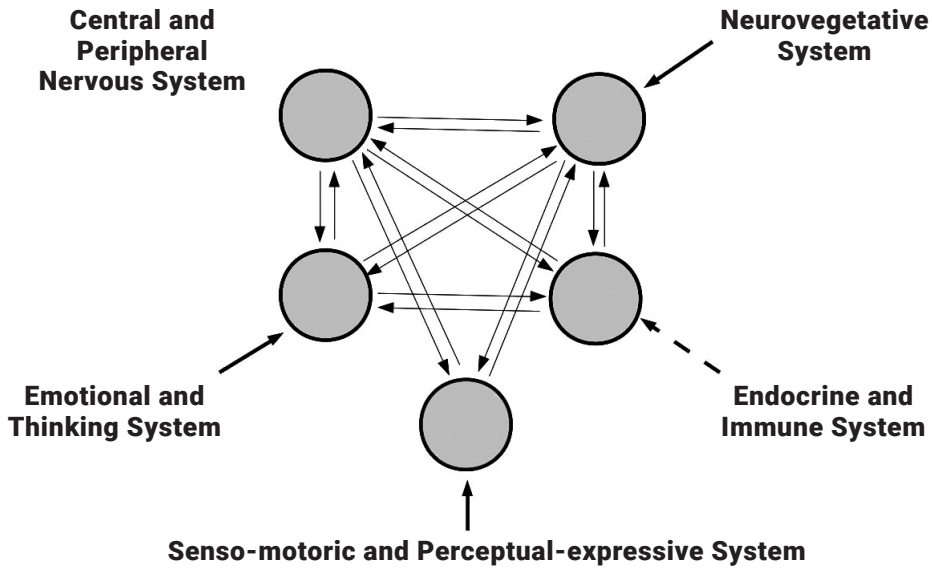


Figure 1. *Integrated Systems, their interrelations, as well as the way they can be influenced directly, partially or indirectly by external factors, such as precise functional interventions (Rispoli, 2016, p. 58).*

Figure 1 shows the systems that in turn constitute an overall system, which is the Self. The neurovegetative, endocrine-immune, and nervous systems refer to regulatory processes of internal physiological systems. The sensory-motor and perceptual-expressive system includes movement, posture, facial expression, gesture, voice, internal body and kinesthetic sensations, and sensory perceptions. The emotional-thinking system includes emotions, feelings, sense of self, rational thinking, awareness, symbolic thinking, memories, imaginations, fantasies and control, and so on (Rispoli, 2016, p. 57). An inseparable circular relationship among systems means that a modification at the level of one system will inevitably produce modifications in all the others, as well as a transformation of the whole Self. The phrase "integrated systems," according to Rispoli (2016), describes how humans function at several levels that are deeply interrelated since birth, and probably since conception. In this sense, *functional integrated therapy* affects multiple systems, and alters the whole (Rispoli, 2016, p. 147). For example, a precise touch technique in which a muscle is grasped with strength and pressure will lead to release in muscular tone and hypertonia (Gagne & Toye, 1994; Rispoli, 2016, p. 154). In addition, the peripheral receptors of the nervous system will produce psychophysical feelings of relaxation. At the endocrine level, there will be an increase in endorphins, as well as a sense of pleasure, vagotonia, calmness, and spontaneous breathing. Also, calm emotions and thoughts will be established. In modern functionalism, this technique is assumed to recall the developmental experience of being held lovingly, and protectively by an adult figure – an experience that may not have been fully and satisfactorily integrated.

Once the mind-body dichotomy was transcended and an integrated model of the interrelationship among systems was provided, the terms mind and body had to be abandoned, and it was necessary to identify a concrete operational modality within the psychotherapeutic context (Rispoli, 2004, p. 38, 2017b, p. 23). Thus, within the neo-functional area of thought, the concepts of *Functions* and *Basic Functionings* (*Basic Experiences of the Self* in developmental age) evolved (Rispoli, 2004, p. 38, 2016, p. 149).

Functions belong to the various systems of the Self, and manifest along a precise range of possibility. They can be conceived as divided into four levels of Functioning[1]:

- *cognitive-symbolic* – memories, thoughts, control, rationality, dreams, symbolism, fantasies, etc.
- *emotional* – understood as the "coloring" through which a person perceives the world
- *postural-motoric* – postures, movements, gestures, strength, etc.
- *physiological* – respiratory, cardiovascular, digestive, nervous, neuroendocrine, neurovegetative and immune system, sensations, muscle tone, etc. (Rispoli, 2004, pp. 39-43, 2016, pp. 20-22)

Without losing sight of the whole, each Function is intended to represent the entire Self (Rispoli, 2016, p. 20). The more the Functions are integrated, rather than opposing each other, the more the organism will experience well-being. Within the psychotherapeutic context, the general trend of these Functions is evaluated (e.g., the Function of "movement") (Rispoli, 2014). This does not mean that every single element of the Function "movement" is considered, such as each individual gesture or each particular posture, but is rather a more general sense of how a person moves – for example, softly, abruptly, quickly, slowly (Rispoli, 2004, p. 212, 2017b, p. 25). These general trends of Functions are studied in terms of their specific characteristics:

- *amplitude* – range of possible expressions on a continuum between two polarities[2], e.g., slow-fast movement
- *mobility* – the subject's ability to switch to the other polarity according to internal or external needs

1. This subdivision expresses a didactical necessity for the study of Functions rather than an epistemological assumption.
2. *Polarities*, within the Neo-Functional Psychology model, are not understood in negative or positive terms, and this is why they are also referred to as *false antitheses* (Rispoli, 2016, p. 51). *"Life is not to remain in the middle, it is not a balance or compromise between two extremes, but rather it is characterized by being able to move fully on one polarity, and then at other times (when necessary) assume the opposite polarity just as fully."* (Rispoli, 2004, p. 59, 2016, p. 51).

- *modularity* – the subject's ability to stay long enough in each polarity) (Rispoli, 2004, pp. 59-61, 2017b, p. 25)

A Function is considered altered to the extent to which it presents itself in a stereotyped and repetitive manner, incongruently with external or internal changes on other levels of the Self (Rispoli, 2004, pp. 53-61, 2017b, p. 27).

All Functions are deeply interrelated since birth and allow the individual to live a series of so-called Basic Experiences of the Self (BES) in order to consolidate a specific set of skills (Rispoli, 2004, pp. 48-50, 2017b, p. 28). To emphasize the epistemological significance of the Basic Experiences of the Self in developmental stages, they are written with capitalized letters (Dalle Luche & Rosin, 2017, p. 8). During development, a person's "roots of action" are thus configured, and with time a stable set of capacities (Basic Functionings) are established that will allow the individual to relate to their personal needs and external circumstances (Rispoli, 2004, p. 69, 2016, p. 25; Bastianelli et al., 2021). As all Functions manifest along a continuum between two polarities and constitute the individual's Basic Functionings, the latter will also manifest in terms of amplitude, mobility, and modularity (Dalle Luche & Rosin, 2017; Rispoli, 2004, 2017b). Yet it is important to specify that from a Neo-Functional perspective, the Functions are not directly altered in relation to non-facilitating external circumstances, but are rather the experience of the BES and the subsequent development of Basic Functionings (Rispoli, 2004, p. 214, 2016, p. 53). The BES of Calmness, for example, may be experienced in an altered way if an individual during childhood was pushed to Vigilance, was not sufficiently Protected, and/or was guided to exaggerate the use of Anger. All this may then have compromised the full and satisfying experience of Calmness, which instead may be expressed in terms of altered Functions (e.g., stiffened postures, ineffective movements, fear, aggression, restrained breathing, high muscle tone, insomnia, intrusive fantasies, negative memories) (Rispoli, 2016, p. 53).

In sum, Functional Integrated Therapy affects the Basic Functions of the individual, which during the course of their development became impaired or altered (Rispoli, 2004, pp. 208-213; 2016, pp. 149-150). In this way the therapy, aligning with the paradigm of complexity, affects various systems and all functional levels of the Self. By using specific assessment instruments, it is possible to create a specific Functional Diagnosis that provides a clear picture of the person's functional mobility and possible alterations, which in turn enable evaluation of Basic Functions (skills and abilities), linked to the Basic Experiences of the Self at developmental stages (Rispoli, 2004, p. 263). Finally, a precise functional therapeutic plan can be created that aims to restore, reexperience and reopen specific basic experiences of the self in order to regain a state of well-being (Dalle Luche & Rosin, 2017, p. 10; Rispoli, 2004, pp. 248-254). In this sense, the psychotherapeutic context can be thought of as a secure space where a person can experiment with new experiences and new actions, within and beyond the treatment relationship (Bastianelli et al., 2021).

A Neo-Functional Reading of Gender Incongruence

According to Salamon (2010), a non-pathologizing therapy approach that aims to comprehend the reality of transgender people and seeks to challenge the binary view of gender can be facilitated by an underlying theory that, similarly, moves beyond a binary notion of mind and body. Neo-Functionalism approaches the lived experiences of transgender people by sustaining a perspective in which neither exclusively the body, nor exclusively the way in which one has been taught to understand it, is the source of distress. According to the Neo-Functional model, the body of the transgender person represents "only" a Function of the Self within which the distress is embodied, while each Function equally expresses the whole Self (Dalle Luche & Rosin, 2017). The "problem" therefore does not lie in the body, but in the discomfort experienced concerning the possibility of being and expressing oneself. Also, Functional Therapy does not aim to identify certain psychic structures as related to the process of defining one's gender identity, but rather looks at the multidimensional functioning of the whole person. Furthermore, the complex system of the Self is intended to be intrinsically related to the complex system that is the world. Consequently, the possible discomfort experienced by transgender people is considered to relate to both – an inner crisis of self-realization and the relationship with the world. Figure 2 illustrates a functional diagram created by Rosin (2019), functional psychother-

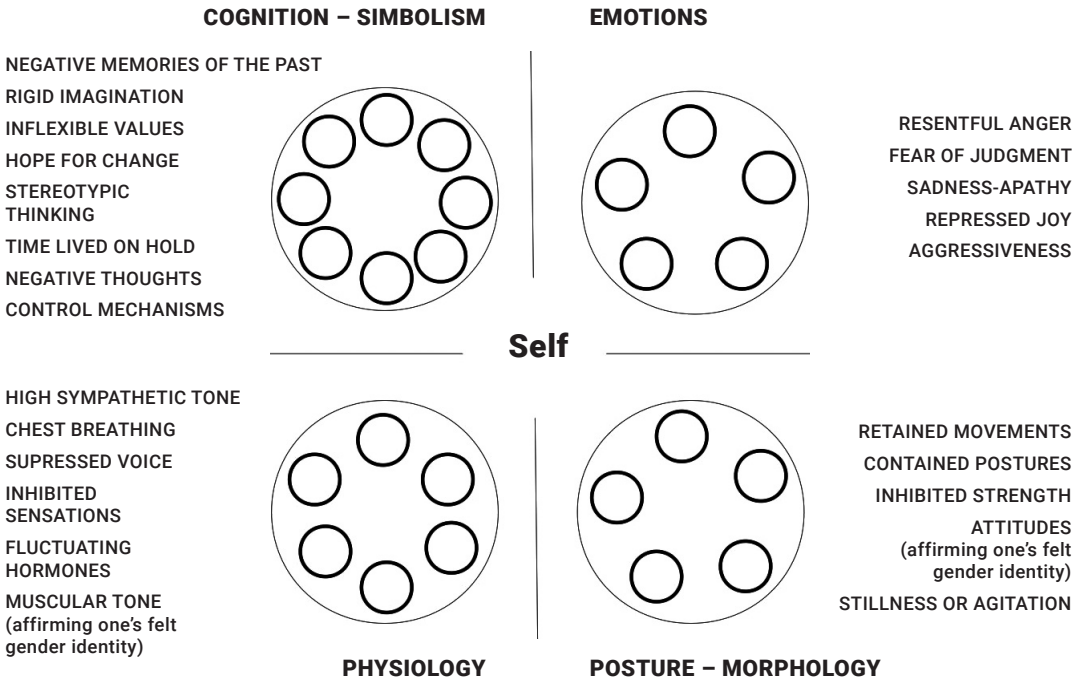


Figure 2. *A Functional Diagram of Gender Incongruence developed by R. Rosin (2019).*

apist and cooperator in this study, based on her psychotherapeutic experience with transgender people. This diagram aims to illustrate a possible manifestation of Functions, on all four functional levels, of the lived experience of transgender people during the initial phase of gender affirmation.

The Research Project

Research Aim

The aim of this study is to offer a Neo-Functional reading of the lived experience of one transgender person referred to as Marco (AFAB[3]). Marco began Neo-Functional Psychotherapy during his path through gender affirmation, i.e., before and during medical interventions. Here, the focus was on the period before any hormonal and/or surgical intervention programs. Regretfully, this "phase" of gender affirmation is often experienced by subjects as obligatory and stigmatizing, and, by professionals, as a moment to locate the person within a psychological and psychiatric classification (Brooker & Loshak, 2020; Fiorilli & Rocco, 2019; Di Gregorio, 2019, p. 113; Mizock & Lundquist, 2016; Schulz, 2018). This is why the modalities through which the person is approached become fundamental, that is, overcoming the limits of gender binarism, pathologizing and medicalizing views, and offering reassuring support through which transgender individuals can become integrated versions of themselves. In this sense and as outlined above, it is assumed that the Neo-Functional Psychology model can enable these modalities by approaching the transgender experience through a fluid theoretical framework between the sense of self and the body, and, thus, by addressing the complexity of the person's experience. More specifically, the initial and anamnestic phase of psychotherapy was investigated to illustrate the subject's lived expe-

3. When speaking of "gender assigned at birth", the abbreviations AFAB (*Assigned Female At Birth*) and AMAB (*Assigned Male At Birth*) are used to refer to those who have been assigned to the female or male sex at birth. Gender assignment is commonly, but misleadingly, understood to correspond to sex in terms of visible sexual organs. Yet by definition, the concept of gender encompasses social and personal factors, rather than biological ones.

rience in terms of a series of BES that shaped the psychotherapeutic process. The latter were identified through a Functional Diagnosis by the psychotherapist, and guided the data analytic procedure.

Finally, with regard to the still-marginal body of literature on this topic, this work may also contribute to the field of research that aims to illustrate the application of the Neo-Functional model to the field of transgenderism.

Clinical Case

This research project examined a Neo-Functional psychotherapy program where the Con-Te-Stare Association, Transgender Desk, and ONIG Center of Padua provided care for a transgender individual. Marco, an 18-year old transgender person assigned female at birth (AFAB), was accompanied during his path through gender affirmation by the Neo-Functional psychotherapist Roberta Rosin, a collaborator in this research project. The psychotherapy sessions typically lasted 50 minutes, and took place weekly, on average. The selection of the clinical case was motivated by the particular richness of Marco's stories, narratives, introspection, and reflections concerning his identity and feelings. The subject gave informed consent with respect to the processing of personal data for professional aims in terms of research in the field of body psychology.

Methodology

Data Collection

The psychotherapeutic sessions were audio-recorded and subsequently transcribed. Although no specific format was used for transcribing the data, a rigorous and thorough orthographic transcription was assured, i.e., a detailed account of all verbal (and sometimes nonverbal, e.g., silences, sighs) expressions was included. The first ten sessions were examined, as they were assumed to constitute the initial phase *of* the psychotherapeutic process (Hill, 2005). Generally, Functional Diagnosis is performed during the first one to three psychotherapy sessions (Rispoli, 2017b). Thus, the first ten sessions were selected to illustrate an articulated Neo-Functional reading of the subject's lived experience in terms of the BES that shaped the psychotherapeutic process. In other words, detailed descriptions of these BES were provided based on Marco's verbal statements about his current experience and personal history.

Thematic Analysis

As methodology, the thematic analysis of Braun and Clarke (2006) was chosen to illustrate a Neo-Functional reading of the subject's lived experience. As a qualitative methodology, recurring themes and contents within a specific data set are identified and analyzed (Braun & Clarke, 2006). A theme is defined as something that captures a significant entity within data in relation to the research question, and represents a certain type of schematic expression (Braun & Clarke, 2006). The latter is not understood as "emerging" from the text or as "found" in it; rather, the researcher is intended to play an active role in identifying themes (Taylor & Ussher, 2001). In this study, a specific set of themes was analyzed through a primarily *deductive* strategy, i.e., in relation to specific research areas. In other words, the analytical process included the description of semantic entities identified within data (meaning units), and their grouping (themes) and interpretation in relation to the areas of investigation (BES) (Patton, 1990). Semantic entities refer to the explicit rather than implicit meaning (such as underlying ideologies or assumptions) of the subject's verbal statements. In approaching the clinical case according to the Neo-Functional model, thus considering the human being in its entirety (Bastianelli et al., 2021), the epistemological approach of the data analysis was neither exclusively essentialist and realist nor exclusively constructivist:

> "One of the causes of … contrasts between different scientific approaches can be attributed to the dichotomy between subjectivism and objectivism. Some currents of science, and particularly of psychology, have all tended to differentiate themselves from the 'medical-organic' model by focusing exclusively on individual sensations, experiences, and subjectivism. Some branches of neuroscience and psychiatry, on the other hand, have continued to advocate a strong objectivism. … More and more scholars are in favor of the need for a complex vision that integrates subjective and objective levels … while taking into account the uniqueness of experiences and emotions of each individual subject." (Rispoli, 2004, p. 26)

Although there are subtle conceptual differences, the subjective dimension postulated by Rispoli (2004, 2016) seems to correspond with sociocultural processes of meaning construction and the subjective codification of reality (a socio-constructivist approach). On the other hand, the objective dimension would seem to be attributable to a realist approach that intends to sculpt the real and material nature of phenomena (a bio-essentialist approach) (Harrison, 2014). As previously stated, Neo-Functionalism adopts the paradigm of complexity by incorporating the *subjective* viewpoint (reality interpreted by the subject) with the *objective* perspective (pre-constituted reality independent of the subject's interpretation) into its vision of reality and the therapeutic process. Specifically, Rispoli's vision aspires to integrate the uniqueness of subjective experiences (of the subject and of the functional psychotherapist) with objectively visible and shareable elements (e.g., postures, breath, cold or sweaty hands) even outside the therapeutic environment. Thus, the results of the present study can both be understood in relation to a subjective perspective of the phenomenon (from the perspective of the subject, the psychotherapist, and the researcher) and in relation to an objective perspective. The latter included the subject's "observable" experiences within the therapeutic context reported mainly through a functional diagram of the self (see below). Now, while the epistemological question may seem problematic, as Joffe writes (2011), a systematic and transparent outline of the procedure will allow other researchers to trace the process by which the results were achieved, and, if necessary, challenge it. In this regard, the steps of the methodology adopted here are explained in detail in the following paragraph.

Procedure

1. **Familiarizing with data**. Before beginning to code the data, it was essential to gain an overview of it. This was possible through multiple readings, listenings, and transcriptions of the material. During this phase, an initial list of labels and coding schemes was created.

2. **Creating initial *units of meaning***. After becoming familiar with the data, initial meaning units were created. These, however, do not coincide with the thematic units, which are more extensive in terms of content, and which are elaborated within the subsequent steps. The meaning units instead represent thematic entities, i.e., meaningful entities related to the areas of investigation (Boyatzis, 1998, cited in Braun & Clarke, 2006). Using a deductive strategy, significant verbalizations of the subject that indicated his functionings were identified. In addition, significant experiences were registered that related to Basic Experiences of the Self. In other words, the data was approached in reference to specific research questions that guided the analytic process, such as: "How is the alteration of the BES of Opening Up expressed in Marco's stories, and in the way he speaks about himself?" More specifically, specific passages were taken directly from the text or summarized in one or two sentences to represent the subject's own language. Next, a table was created that contained all meaning units identified in each psychotherapy session.

3. **Defining the themes**. During this phase, meaning units were sorted and brought together to define initial thematic units. Specifically, thematic maps were created to represent each of the basic experiences of the self. More specifically, the thematic units represent the altered manifestation of each BES respectively, in relation to self and others. Where deemed appropriate, sub-themes were defined. To minimize interference, themes were formulated by using the subjects' own language as much as possible.

4. **Reviewing and refining the themes**. This was done using the criteria of internal and external heterogeneity (Patton, 1990). Meaning units that constituted a theme or sub-theme were reviewed in terms of internal semantic coherence. The second level validation aimed to ensure that the meanings of different themes were distinguishable from each other to avoid excessive overlap. Finally, the data were revised in light of the themes and sub-themes that were created.

5. **Final definition of the themes**. The themes were then finalized, with a detailed description provided, including their essence and role in relation to the entire data set, to other themes, and to the Basic Experiences of the Self.

6. **Producing the Report**. This phase is described below. Graphic illustrations are used to visually represent a thematic map for each BES.

Data Analysis

The BES that shaped the psychotherapeutic process and were diagnosed to have altered Marco's lived experience were: Being Considered, Opening up, Actively Connecting with Others, Pleasing the Other, and Being Held.

Being Considered (Being Seen and Valued)

From a Neo-Functional perspective, the experience of Being Considered (Being Seen, Listened to, Understood, Helped, Valued) by others leads individuals to develop a sense of themselves and how they are perceived by the world (Rispoli, 2004, pp. 122-125, 2016, p. 49). Marco did not have a satisfactory experience of being seen, listened to, understood, and valued in his life. One of the main reasons for this unsatisfactory experience could be Marco's difficulty in gaining acceptance from family members as a transgender person who wants to affirm their gender identity. Marco claims that his parents are "not ready" to value him for who he is and for who he feels himself to be. At home, they would address him by the female name assigned to him at birth. His mother found it especially difficult to accept him. At Christmas, Marco manages to convince his parents to open up to his extended family, grandparents, uncles, cousins, and family friends. However, they tend to be closed-minded and unwilling to welcome his requests. Although his father appears more willing to welcome his son's needs and requests, he also struggles to address him using male pronouns and his chosen name. Marco tends to feel "misunderstood" by people, including his parents. He speaks about a period of high school, during which he felt sad and was trying to figure out the meaning of life. During this time, he was unable to receive support and validating responses from his parents. He therefore turned to one of his high school teachers, seeking support and affection. Yet even this request was disappointing (see next section on Actively Connecting with Others). Marco began engaging in self-harming behavior, which he said allowed him to attract attention and express his suffering. This behavior lasted for two months. Finally, Marco experiences difficulties and discomfort in the university setting, because he would "not pass," i.e., others would not see and perceive him as male, although he would introduce himself with his chosen male name.

Here are some themes and examples of how they relate to significant life experiences regarding the BES of Being Considered:

- "They are not ready"

  "They [my parents] were not ready, and they are not ready now." (Session 1)

  "She [my mother] is not ready … to tell others … that is, to call me 'her son' in front of others and accept … that I will socially and physically become a boy." (Session 9)

- "They try to use male pronouns, yet they don't always succeed."

  Therapist: *"What do your parents call you at home?"*

  Marco: *"They are trying to use male pronouns; they don't always succeed."* (Session 1)

- "Generally, people misunderstand me."

  "It often happens that we argue [my parents and I] because generally … they don't understand me" (Session 2)

  "I notice that I am often misunderstood when I speak, and I often don't understand what people say to me …" (Session 2)

  "I gave up … on wanting to understand everything." (Session 2)

- "I was looking for answers that my parents didn't give me."

  "Then in the second year, I started to have, I don't know what to call it, depressive episodes … a period of sadness due, I think, to adolescence … in short, I had this period of confusion, and I was trying to find answers that my parents weren't giving me, so I asked him [my teacher]." (Session 3)

  "I started cutting myself because I missed [Andrea (my teacher)] … that is, at the beginning … I was trying to get attention, but I wasn't really well; I was looking for someone to help me out." (Session 3)

- "I was doubting that he was keeping me there a little bit."

  "His [the teacher's] behavior and other actions at that time made me doubt a little bit that he was keeping me there, because it must be nice to have an 18-year-old creature running after you." (Session 3)

  "He [the teacher] still didn't understand anything, even though I was talking to him about how I felt

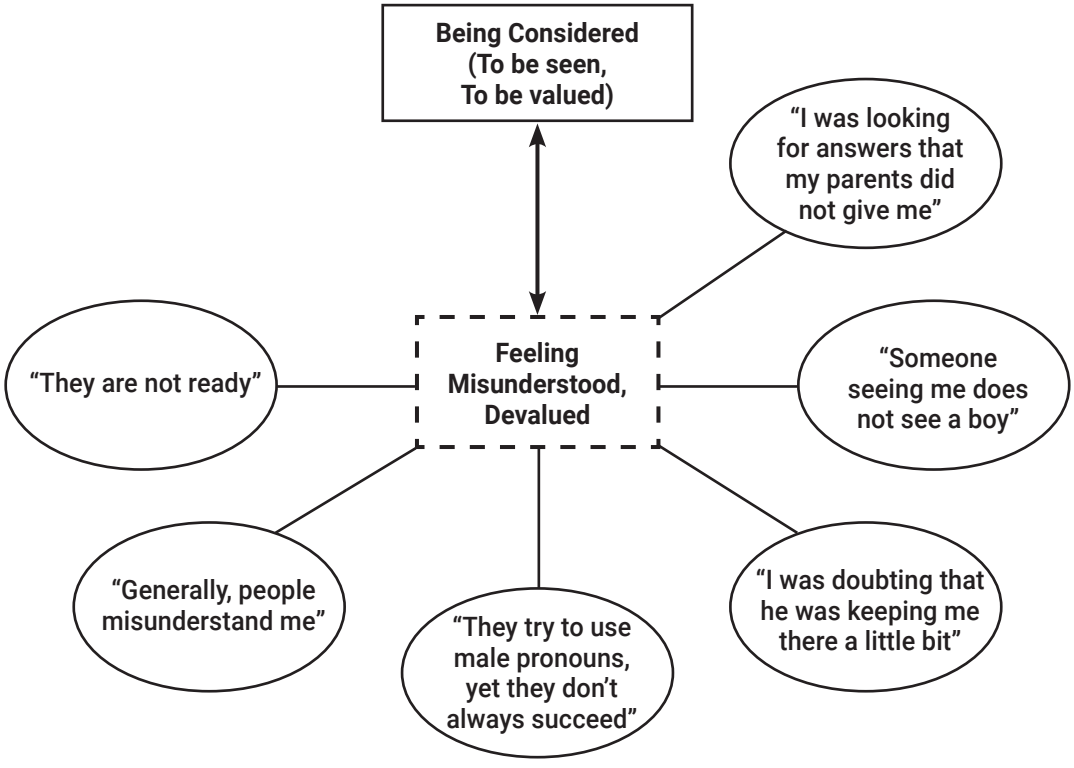


Figure 3. *Thematic map of the BES Being Considered and the alteration: feeling misunderstood and devalued. Dominant themes connected to the alteration are indicated.*

... waking up in the morning a bit dazed, and asking myself "Where's my willy?" "Ah, I never had it." But he still didn't understand anything." (Session 3)

- "Someone who sees me does not see a boy."

  "At the university, [I introduced myself as Marco] because I wouldn't want them to know that I am a trans man." although I do not pass ... that is, someone seeing me does not see a boy." (Session 1)

  "I asked someone where the toilet was, and he pointed me to the one for women, so that means that someone seeing me doesn't say this is a guy, but since I don't look like one, I try to force it." (Session 1)

Opening Up (Speaking About Oneself)

This Basic Experience of the Self belongs to the group of BES that involves Sharing oneself with others (Rispoli, 2016, p. 49). It is assumed that people are never alone, but always perceive themselves in relation to others, i.e., in interaction (Rispoli, 2004, p. 112). Moreover, Sharing one's experiences with others is possible thanks to the individual's ability to Open Up to others, telling them about personal thoughts and feelings (Rispoli, 2004, pp. 112-113). Moreover, the BES of Opening Up represents the polar experience of Being Considered (see previous paragraph; Rispoli, 2016, p. 49). In other words, each individual will have different life experiences on the continuum between Opening Up to the world and Being Considered, Understood, and Valued by it. Marco's ability to Open Up seems impaired, stifled and rather tending towards Closure. A related function that Marco expresses in an underdeveloped manner is the quality and sound of his voice, which is nearly inaudible. Also, Marco speaks about himself in a monotonous tone, using short and often incomplete phrases. These alterations perhaps developed in response to the difficulties he encountered in Being Considered, Un-

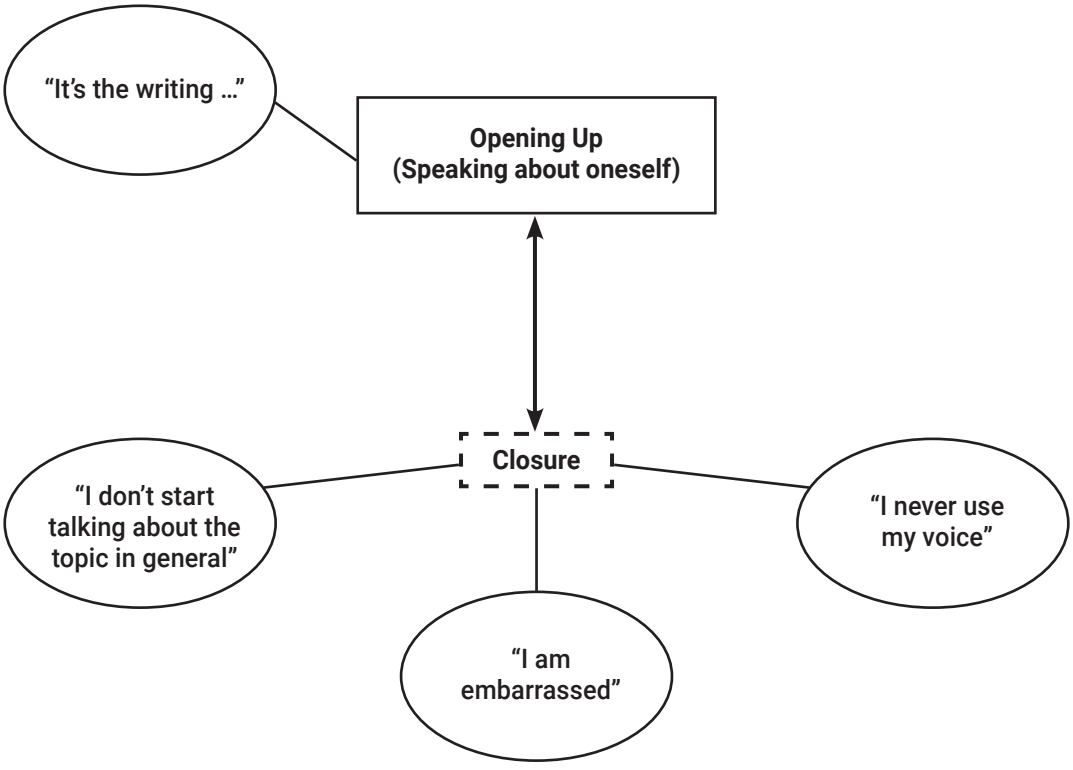


Figure 4. *Thematic map of the BES Opening Up and the alteration: Closure, showing links to the dominant themes.*

derstood, and Helped by significant others. Marco further claims it is useless to share his experiences with others, and he finds it difficult to talk about certain topics. He reports that the way he finds most useful to solve his problems is to manage them alone. Another aspect that Marco describes as being related to his difficulty using his voice is his current "transgender condition," and the wait for hormonal therapy to begin, which will eventually transform his voice. Marco also describes feeling embarrassed on several occasions, both within and outside the psychotherapeutic context. One way he has been able to develop over the past years, which allows him to share his deepest feelings with others, is through writing. He claims that he has always been passionate about writing, reading, and languages in general.

The following themes indicate some significant experiences that have shaped Marco's life, and can be understood to represent his altered ability to Open Up:

- "It's the writing ..."

  "I left them [my parents] a piece of paper saying: I am trans ... I need to start this journey." (Session 1)

  "I wrote a letter for my parents, but I didn't have the courage to do anything ... just in case I decided to ... attempt suicide ... [then] at one point I had an epiphany ... I became well again for no apparent reason ... it was just the writing that made me ..." (Session 3)

- "I never use my voice."

  "I don't make noise ... I never use my voice ... if I don't make efforts, I never use the... I don't, it just comes naturally to me." (Session 8)

  "I am waiting for my voice to change." (Session 8)

- "I am embarrassed."

  "I still feel a bit awkward when I'm in class; there are a lot of people I don't know." (Session 2)

- "I don't start talking about the topic in general."

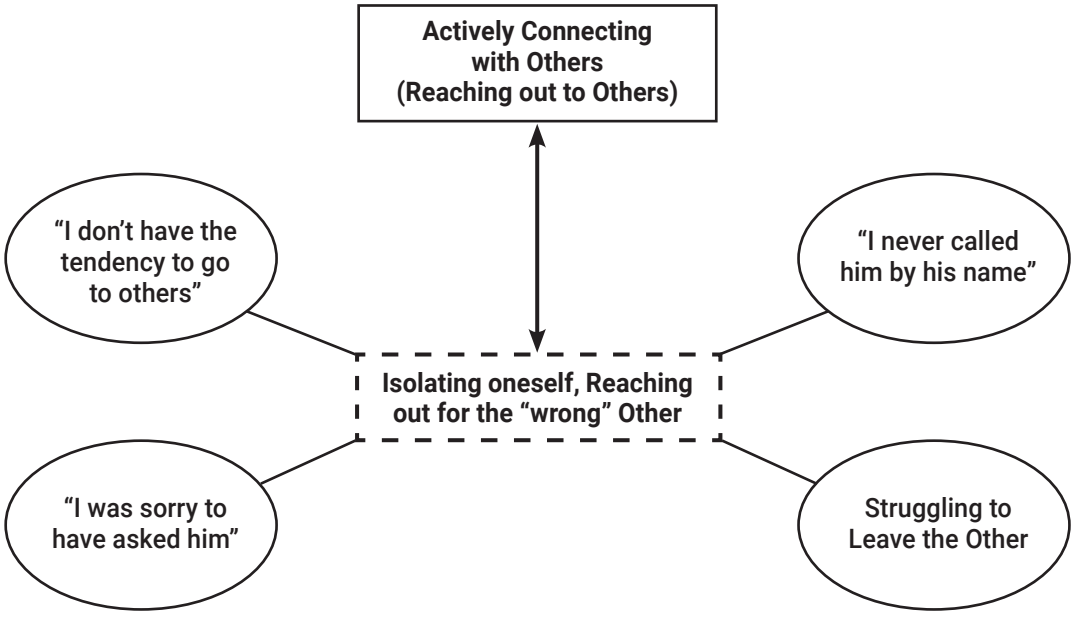


Figure 5. *Thematic map of the BES Actively Connecting with Others and the alteration: Isolating oneself and Reaching out for the 'wrong' others. Linked to these, dominant themes are represented.*

> *"If I have a problem, I generally give up … I don't find relief [in talking to someone about it]. Generally, when I have a problem, one of the ways I have always found useful to solve it was to take my time [and] be alone."* (Session 1)
>
> *"Every now and then we [my parents and I] talked about it (gender affirmation), but [my parents] always seemed very embarrassed, so I do not bring up the topic in general."* (Session 4)

Actively Connecting with Others (Reaching out to others)

Actively Connecting with Others represents another primal skill that enables people to interact with the world (Rispoli, 2004, pp. 95-98). Related to this skill is the ability to Reach Out to Others (Rispoli, 2004, p. 98). This can be understood in terms of seduction, not in a negative sense, but rather in terms of leading someone to oneself. According to the Neo-Functional paradigm, a balanced manifestation of this experience would present itself as being able to move fluidly between both polarities: leading the other to oneself, and leaving the other when necessary (Rispoli, 2016, p. 51). Moreover, the BES of Actively Connecting with others relates to the experience of Being Considered by others. That is, the person's hardwired capacity of Reaching Out to others can become suppressed by an unwelcoming, rigid and rejecting environment. In Marco's case, the alteration of this BES takes many forms. On the one hand, as described in the previous paragraph on Opening Up, Marco tends towards Closing and Isolating himself from a world where he did not receive the support he needed to sustain his life path. He feels that he "*never had the tendency to go to others*," and that it is useless to share himself with others. This also appears to be expressed in his struggle to use his voice to ask people to engage with him, and to receive their support. On the other hand, the lack of Being Considered by significant others in moments of difficulty led him to turn to other adults, such as his teacher. During his first year of high school, at the age of 13, Marco got a

"crush" on his geography and literature teacher. He sought support and affection from the teacher, but his feelings were not reciprocated. Marco writes to him, gets him presents, and visits him regularly in the library. He states that he imagined the possibility of building a romantic relationship with him. It can be assumed that Marco's unmet need to be Considered, Loved and Helped by the "right" people would have prompted him to reach out to the "wrong" ones in an illusory way, while at the same time struggling to separate from them. He begins to self-harm in order to "attract attention" (see paragraph on Being Considered). His inability to Actively Connect with others in a balanced way is further expressed through his feelings of discomfort and guilt when asking for help.

The following list of themes and examples of significant experiences indicate Marco's altered ability to Actively Connect with others:

- "I don't tend to approach others."

  "At the moment … I don't have as much contact with those who were my friends before … and … it takes me a long time before I call someone a friend …" (Session 5)

  "I never had the tendency, even when I was a child, to approach others." (Session 7)

- "I never called him by his name."

  "I don't know if I told you about the creature." (Session 2)

  "We never call each other … I gave him nicknames … I never used to call people by their names …" (Session 2)

- Reaching out for the "wrong" other

  "I was 13 [years old], he was a teacher, so I got to know him … I tried to start interacting with him a little bit, I used to … talk to him at the end of class, and one time, I looked for his address on the internet … and I found it … Then I looked on Google maps and one day, by bike, I went to his house. He invited me in and talked with me for an hour and a half, then I left." (Session 3)

  "I came out because I couldn't bear it any longer, [and so I told him] 'I love you' … he (teacher) never gave me a clear answer … One day … I asked him 'Could you consider being with me or not?' and he never gave me an answer." (Session 3)

- Struggling to Leave the Other

  "I realized and accepted that I loved him, and that he would never feel the same. I decided to become friends with him slowly, step-by-step, by trying to overcome certain limits of confidence each time. At the end of the third year, we got along quite well and by the fourth we were getting along better and better, and even in the fifth year. And the various gifts I got him … he must have tried to return them to me, but I didn't allow it." (Session 3)

  "Looking back, I can say that was the period when I was falling in love, and suddenly breaking away did me no good … I started to cut myself because I missed him." (Session 3)

- "I was sorry to have asked him."

  "I felt a bit shitty because … I had asked him to do something for me he wasn't prepared to do … that is, to act as a psychologist. For a teacher … it must not be an easy thing … I was looking for someone to help me out, and on the other hand I was sorry I had asked him to do something he couldn't do." (Session 3)

Pleasing the Other (Exhibiting Oneself)

Similar to the ability of Opening Up, the ability to Exhibit oneself in order to Please the other also falls into the group of Sharing Oneself with others (Rispoli, 2016, p. 49). Rispoli (2004, pp. 114-115). This refers to the basic human need to Exhibit Oneself to the world, and to receive approval from it. In other words, individuals display themselves to others with and throughout their body, and others represent a source of knowledge and information about themselves. In this way, individuals learn to feel themselves, and learn how what they feel inside affects the outside. An altered manifestation of Exhibiting Oneself manifests in an excessive way of displaying oneself to the world, or in contrast, in a feeling of shame in doing so (Rispoli, 2004, p. 115). These alterations can be influenced by old feelings of not Being Seen enough, Being Criticized or never Being Liked by others.

For transgender people, the experience of revealing themselves to the world for who they are, being socially recognized, and receiving approval from others, is particularly important. In Marco's case, the experience of showing himself to the world was not a satisfying experience. Marco strongly desires to show himself to the world with pleasure, and to be seen "in a body" where he feels he has always belonged. However, as mentioned previously, he

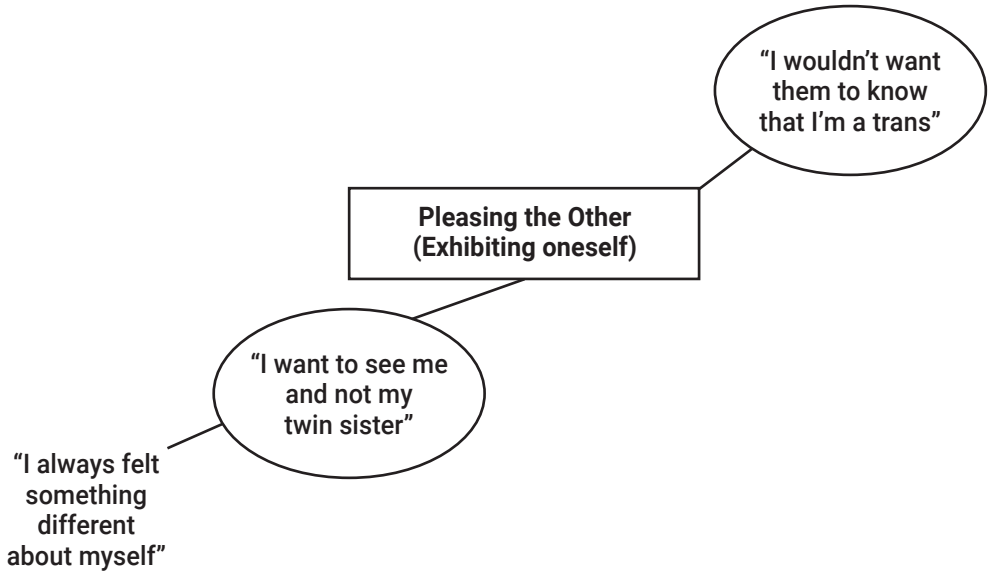


Figure 6. *Thematic map of the BES Exhibiting oneself, with linked themes and sub-themes.*

struggles to feel accepted and supported for who he feels himself to be, especially by people close to him, such as his parents and teacher. In addition, at the university, he becomes convinced that he does "not pass" as a boy because his phenotypic "appearance" would be "still too feminine." This experience leads to feelings of sadness and deep regret. Moreover, he expresses the need to hide himself as a transgender person, and to "force" a condition in which he will be seen as a boy.

Below are the themes (indicated with a black bullet point) and sub-themes (indicated in italics) that illustrate Marco's altered experience of Exhibiting himself.

- "I want to see myself, not my twin sister."

  "I am not yet born." (Session 7)

  "I want to see me and not my twin sister, who looks a lot like me but is not me; I am a boy." (Session 9)

- "I always felt there was something different about me."

  "I thought I would grow up and have a natural male puberty and develop a penis … it seemed impossible for me not to become a man." (Session 1)

  "I always felt there was something different about me." (Session 1)

  "Nobody uses my name yet, I don't know if I always knew, more or less, that I would be called like this, [Marco] … that I was born a boy." (Session 1)

- "I wouldn't want them to know that I'm a trans."

  "Someone seeing me wouldn't say that I'm is a boy, and since I don't look like one, I try to force it." (Session 1)

  "I wouldn't want them to know that I'm a trans person, even if I don't pass … so I make up that I have a hormonal disorder." (Session 1)

Being Held (Upheld, Stopped)

From a Neo-Functional perspective, the BES of Being Held manifests itself in two ways: Being Up-

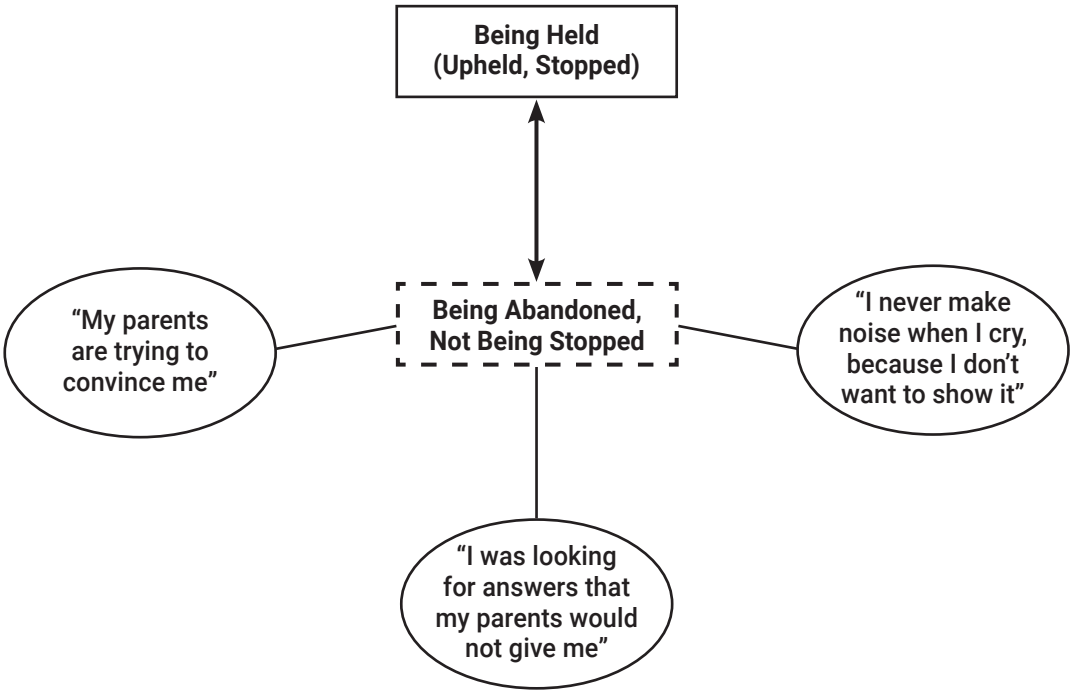


Figure 7. *Thematic map of the BES Being Held, the alteration Being Abandoned and Not Being Stopped, as well as dominant themes.*

held and Being Stopped (Rispoli, 2004, pp. 71-76, 2016, p. 49). It is assumed that the experience of Being Upheld with firm, reassuring, and protective hands generates a sense of tranquility and safety by releasing states of activation (Rispoli, 2004, pp. 72-75). The experience of Being Stopped is not intended as imposing, but rather in terms of an encounter with someone who is able to offer support with affection. In Marco's case, the experience of Being Upheld and Stopped with Love and Protection seems not to have been fully experienced. As mentioned above, Marco did not have the opportunity to receive valid answers from his parents during a period of his life filled with sadness and the search for meaning. It was during this time that he reached out to his teacher in need of attention and support – a request that was not fulfilled. Even earlier, during primary school, Marco reports that he became very attached to a teacher whom he then described as "a second mother." More generally, these experiences can be interpreted in relation to the lack of Being Held, supported, and protected by significant adults. Furthermore, another way this lack seems to express itself is in Marco's tendency to conceal his suffering: "I never make noise when I cry, because I don't want to show it." "My cuts, I tried to hide." One can assume this relates to the (partial or complete) lack of Being Stopped by someone lovingly to release suffering, pain, and/or states of agitation. Rather, it seems that the family environment is characterized by an imposing atmosphere.

The following list of significant experiences represent Marco's sense of not Being Held in a satisfactory manner:

- "I was looking for answers that my parents wouldn't give me."

  "[In primary school] I got very close to the Italian teacher, who became my second mother." (Session 4)

  "I had this period of confusion and I was trying to find answers that my parents were not giving me, so I asked him [Geography and Literature teacher]." (Session 3)

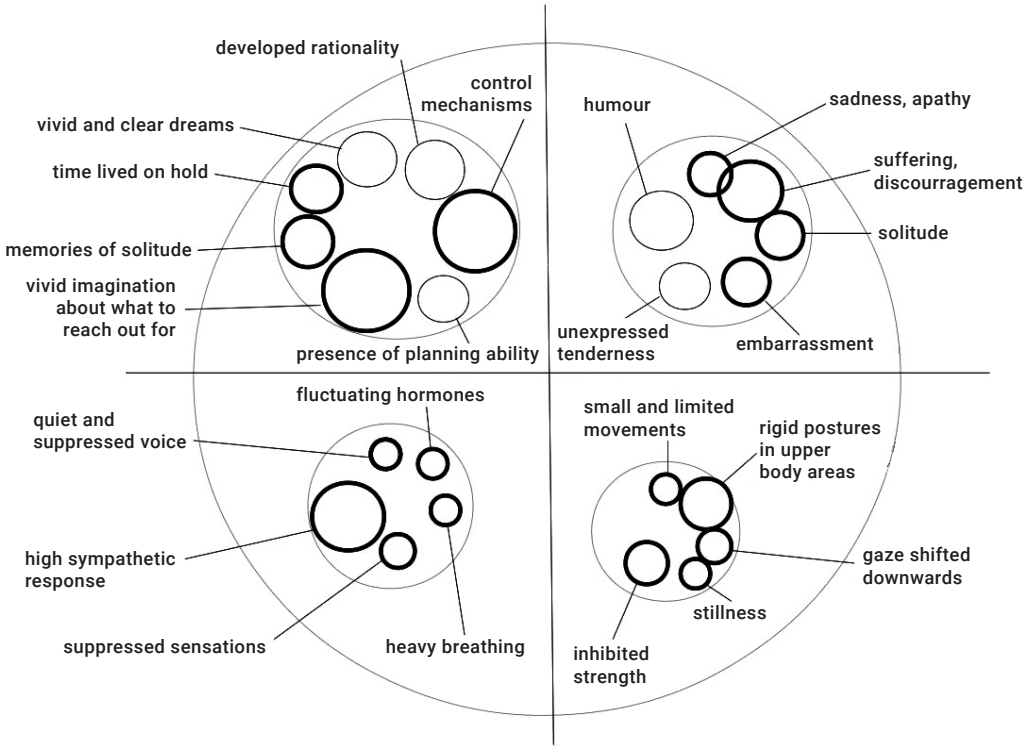


Figure 8. *Functional Diagram of Marco's lived experience during the initial phase of psychotherapy, developed by psychotherapist R. Rosin.*

- "I never make noise when I cry, because I don't want to show it."

  "I started to cut myself because I missed him … I was trying to hide [it] … I was trying to attract attention … I was looking for someone to help me out." (Session 3)

  "I never make noise when I cry … because I don't want to show it … my parents would worry about it too much … especially my mum." (Session 6)

- "My parents are trying to convince me"

  "My parents are trying to convince me to live here, but I'm fine not to." (Session 1)

  "They didn't want me to become overweight so they sometimes prevented me from eating." (Session 4)

- Not Being Stopped

  "Therapist: *Every week you wrote an email?*

  Marco: *Almost every day for a while … at some point I saw that he (Geography and Literature teacher) couldn't take it anymore, and I realized that I had gone too far and I stopped.*

  Therapist: *He didn't tell you?*

  Marco: *No, it's just that in hindsight I can say that that was when I was falling in love with him, and suddenly breaking away was very hard for me."* (Session 3)

Functional Diagram

Figure 8 illustrates a functional diagram of Marco's lived experience during the initial phase of the psychotherapy process. This diagram provides a detailed view of the alterations that shaped the overall functioning of the self, i.e., the precise manifestations of Functions on the cognitive-symbolic, emotional, postural-muscular, and physiological levels (Rispoli, 2004, 2016, 2017b). In reviewing the functional diagram, it is important to maintain a holistic view, as all functions are deeply interconnected (Rispoli, 2004, p. 54). On the one hand, the diagram illustrates the individual's functioning in terms of alterations, which are indirectly

described in the preceding paragraphs with respect to each BES. More specifically, the alterations are represented in terms of divisions (i.e., separations between circles that indicate imbalance between functions or functional levels: the more separate, the more disparity); hyper- and hypotrophies (the diameter of each circle indicates the extent to which a specific function is exaggeratedly present: hypertrophic, i.e., larger diameter, or almost absent: hypotrophic, i.e., smaller diameter); and rigidity (thickness of the lines of the circles, which indicate the extent to which the function can adapt to both, external and internal events. The thicker the line, the less adaptable the function) (Rispoli, 2004, pp. 53-57). On the other hand, this diagram also makes it possible to identify functions that can be considered as resources of the individual, such as Tenderness, Rationality, and Humor.

Discussion

This study aimed to offer a Neo-Functional reading of the lived experience of Marco, a transgender person (AFAB), during his path through gender affirmation prior to the initiation of hormonal and/or surgical interventions. We have chosen to focus on the period preceding medical interventions, as it constitutes a delicate and often debated stage during gender affirmation. Therefore, it seems particularly important to endorse a holistic view of transgender reality to support trans individuals to be received in an integrated version of themselves. The Neo-Functional Psychology model (or Modern Functionalism) has made it possible to address the complexity of the phenomenon without remaining trapped in a partial or too abstract view of it (Rispoli, 2004, 2014, 2016).

The Basic Experiences of the Self that were diagnosed as having altered Marco's lived experience were: Being Considered, Opening Up, Actively Connecting with Others, Pleasing the other and Being Held. Specifically, the lack of Being Considered, Seen, and Valued by the outside world for who one is and for who one feels to be, seems to have constituted a significant obstacle for Marco in living and realizing his authentic Self. In his experience, not Being Considered, and the belief of "not passing" as the gender perceived as his own, seems to have impaired his ability to Open Up and to Show himself to the world. Instead, he tended to isolate himself and develop a stereotyped function of shame and embarrassment. This also manifested in stiffened postural and motor functional processes, in physiological hypertension, and in control behaviors.

Additionally, there were uncertainties about whom to seek support from, as there was a risk of relying on the "wrong" individuals. In other words, Marco had to learn to differentiate between those who were truly able to meet his needs, and those who were not. These findings align with those reported by Cooper and colleagues (2020) about the phenomenology of the experience of embodying a gender "not in line with the norm." Specifically, the themes most frequently reported by participants with respect to social relationships were the worry of encountering misgendering experiences[4], a tendency to isolate as a consequence of not being seen in terms of their felt gender identity, and the internalization of social rejection, followed by hypervigilance, shame and fear. It is important to keep in mind that the experience of not Being Considered may not only refer to the "transgender condition,'" but rather to the experience of living itself – in other words, not being seen as an individual with personal life experiences and a desire to connect emotionally with others, seeking understanding and empathy. (Di Gregorio, 2019, p. 56).

Regarding the subject's lived experience of his bodily sensations and his body morphology, Marco reports a strong discomfort with his body image – particularly with the sexual characteristics of his body. This further manifested in closed body postures, especially in higher body areas (presumably to conceal his breasts), and, more generally, in stiffened and restrained posture and motor function. In addition, Marco claims to experience discomfort while waiting for his body to change through medical interventions. Here too we can relate to reports by Cooper and colleagues (2020) about the discomfort experienced by transgender individuals as a result of the dissonance between their felt gender identity and their physical appear-

4. When someone, more or less intentionally, refers to transgender subjects in terms of their biological sex, instead of the gender identity they feel themselves to be.

ance, leading to feelings of alienation and disgust towards one's body. More specifically, this would seem to relate to a bodily experience, especially prior to hormonal and/or surgical treatments, in which a feeling of *having* a body, instead of *living* it, prevails (Di Gregorio, 2019, p. 45). In this ambiguity, the body (with certain primary and secondary sexual characteristics) can be experienced as not representative of the subject who inhabits it.

A further aspect, not to be neglected, is the reporting of self-harming behavior. A study by Liu and Mustanski (2012) showed that self-harming and suicidal ideation are particularly prevalent in the LGBTQ+ [5] population, and motivated by factors such as victimization, hopelessness, and low social support. Furthermore, referring to Le Breton (2016), in a situation of suffering, the tendency to self-harm, seems, rather than a "blind and logic-free" act, a "sort of last chance to not disappear" motivated by a "will to live" (p. 9), and to realize oneself. We can assume that this is in line with what Marco experiences relative to his desire to define, realize, and transform himself not only psychologically, but also socially and physically.

Contrary to the diagnostic criteria of gender dysphoria (APA, 2013, pp. 527–537), Marco's lived experience was not limited to intra-individual processes of self-definition and self-perception, but was also significantly influenced by inter-individual processes (Cooper et al., 2020; Pulice-Farrow et al., 2020). Through personal narratives of gender non-confirming individuals about their lived experience of body dysphoria, these researchers investigated the extent to which those narratives overlapped with the diagnostic criteria of gender dysphoria. Similar to our study's findings, participants reported feelings of "alienation from their own body" and "distress" related to this experience. However, these feelings were not fixed or static, but were instead connected to personal and social experiences of gender affirmation. In addition, alterations in each Basic Experience of the Self, as illustrated in Figure 8, were observed to have manifested on all four functional levels of the self: the cognitive-mental, physiological, motoric-postural, and emotional. These manifestations related to the functional diagram of gender incongruence developed by Rosin (2019, Figure 2.). However, rather than confirming "transnormative" expectations that emphasize a specific view of what transgender people may experience (Riggs et al., 2019), the examined experience here should be understood as a personal history of life and ways of being. This does not mean that the experiences considered "typical" or "transnormative" do not exist – such as the feeling of living in the "wrong body," the demand and suffering associated with the wait for medical intervention, and defining oneself in terms of a binary gender order. Rather, it is a matter of going beyond this and getting to know the person on deeper levels, not only on the surface (Rispoli, 2017b, p. 14). As hypothesized, this seems possible only when addressing the complexity of human experience itself (Rispoli, 2004, pp. 52-53, 2014, 2016, pp. 14-15). This requires transcending cognitive boundaries between body and mind, gender identity and anatomical sex, and self and other, and reconsidering how these polarities are deeply interconnected.

Research Limits and Future Implications

Certain limitations and future implications of this research will next be illustrated. This work intended to offer an integrative view of the lived experience of a transgender person. However, due to the available source material (audio recordings of psychotherapy sessions), data analysis was primarily based on the psychological, cognitive, and symbolic dimensions of the subject's lived experience. Although every function is intended to represent the entire self, this did not allow for a holistic analysis of the phenomena under investigation. Despite the functional diagram provided, it seems important to deepen future study of transgender people's bodily lived experiences by including, for example, photos, video recordings, and/or registers of physiological processes.

Next, as the aim of this work was to illustrate the application of the Neo-Functional Psychology model, a deductive methodology was chosen to analyze the subject's reported significant experiences in relation to the BES. However, for future studies, an inductive methodology, such as an in-

5. An acronym for "lesbian, gay, bisexual, transgender, queer and other identities".

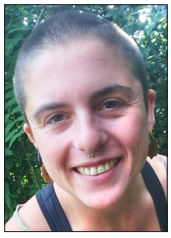
ductive interpretative phenomenological analysis [IPA] (Smith & Shinebourne, 2012), seems necessary to investigate the lived experiences even more thoroughly. This would allow us to study how an experience is lived first-hand, and thus inform and redirect the way that experience is understood (Neubauer et al., 2019). Here, despite this limitation, the subject's statements were used to form thematic experiential units in order to minimize, as much as possible, the impact of interpretative interferences.

Another factor is that the psychotherapy setting being studied is involved with legal proceedings on gender affirmation. As mentioned earlier, this has inevitably influenced the therapeutic process. Moreover, in relation to the current Italian medical-psychiatric model that legitimizes gender affirmation, the diagnosis included not only a Neo-Functional assessment, but also the administration of tests aimed to diagnose concomitant psychopathological conditions. The Minnesota Multiphasic Personality Inventory (MMPI-2), the Structured Clinical Interview (SCID-5-SPQ), the Cognitive Behavioral Assessment (CBA), the Utrecht Gender Dysphoria Scale (UGDS), and the Gender Identity/Gender Dysphoria Questionnaire for Adolescents and Adults (GIDYQ-AA) were implemented. The use of these tests and their specific effects on the therapeutic setting were not examined in this research project, since the study focused on the psychotherapeutic approach itself. However, in the future it would be useful to investigate how these tests, and more generally, the normative aspects of gender affirmation that framed the psychotherapy under investigation, influenced the functional psychotherapist's understanding of the transgender phenomenon. Also, this might not have affected only the Functional intervention itself, but also the transgender person's experience in psychotherapy.

A final limitation of this study could be noted regarding having investigated and described only one psychotherapeutic approach, and only its diagnostic portion. In future studies, it might be useful to compare different therapeutic approaches and techniques as applied to gender affirmation. This would make it possible to frame and compare the resources and limitations of each in approaching transgender reality.

Conclusion

Through applying the Neo-Functional Psychology model, the "transversality" and "multidimensionality" (psychological, social, relational, and bodily) of a transgender person's lived experience can be illustrated. As Giardina and Zabonati (2020) state: "As much as gender affirmation may pass through the body, it is by no means limited to it." We can also assume that gender affirmation is not limited to a mere act of self-definition at a cognitive level, nor is it disconnected from the sociocultural context. The domain of modern functionalism has been able to provide a framework from which to address the complex paradigm of human experience in enabling self-determination and free self-expression in a supportive and respectful manner (Rispoli, 2004, 2014, 2016). This is in line with Salomon's argument (2010, p. 13): a non-pathologizing approach to transgender reality that aims to challenge the binary view of gender can be facilitated when the underlying theory tries to overcome a binary notion of body and mind. More specifically, this approach has allowed us to offer a reading of a transgender person's lived experience through a series of Basic Experiences of the Self that developed in an atrophied and/or deficient manner throughout the lifespan – each of which, as we have seen, manifests itself through a specific functional configuration that includes all experiential levels of the self. We argue that by aiming to transcend the dichotomy of body and mind (Rispoli, 2004, 2014, 2016), the Neo-Functional area of thought can re-establish a valuable framework through which to approach transgender reality and the path of gender affirmation. Within this framework, as the limiting impacts of pathologizing and medicalizing views, as well as binary notions of gender, are minimized, the subject can be welcomed as a *person*.



Letizia Sturiale, Graduate of the University of Padua, Italy in Community Psychology, the promotion of well-being and social change.

Email: letizia.sturiale@studenti.unipd.it

Roberta Rosin, Functional Psychologist and Psychotherapist, Member of the Italian Functional Society of Naples (SIF) since 1994, Professor and Supervisor at the European School of Functional Body Psychotherapy (SEF), President of the Con-Te-Stare Association, i.e., transgender desk and center of the National Observatory of Gender Identity (ONIG) in Padua, Italy.

Email: roberta@robertarosin.com

Irene Leo, Functional Psychologist and Psychotherapist, Associate professor, Department of Developmental Psychology and Socialization (DPSS), University of Padua.

Email: irene.leo@unipd.it

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Somatic Experience of Microaggressions in Therapeutic Spaces

Understanding Rupture and Pathways to Repair

Shreya Vaishnav, Dareen Basma

ABSTRACT

This manuscript explores the somatic experiences of microaggressions, understanding rupture as a result, and ways to repair this rupture in therapeutic settings. The authors investigate the process of somatization in relation to microaggressions through a detailed case study. Furthermore, they emphasize the physical manifestations of this somatization, and propose somatic interventions that aim to restore harmony in an individual's relational embodied encounters.

Keywords: Microaggressions, rupture, repair, relational embodied encounters

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Microaggressions are subtle and often unintentional racial slights or indignities that convey hostile, negative, or derogatory attitudes towards individuals from marginalized populations (Sue et al., 2007). While microaggressions are more subtle, they are known to have a more profound impact on individuals than overt forms of isms (Sue et al., 2007). Microaggressions are known to feel like "death by a thousand cuts"(Johnson et al., 2018; Nadal et al., 2011). Microaggressions convey implicit messages to those on the receiving end, such as being a second-class citizen, ascription of intelligence, status as a perpetual foreigner, and many more (Sue et al., 2007; Sue & Spanierman, 2020). While these experiences can impact an individual's mental health through self-doubt, questioning reality, frustration, anger, and many more (Sue et al., 2007; Sue & Spanierman, 2020), microaggressions can bring out a visceral somatic experience that can impact an individual in many ways. The somatic experience of hearing microaggressions is often the first response an individual encounters before sinking into their emotions and thoughts around those experiences. As a result, it is imperative to explore the impact of microaggressions through an individual's lived somatic experience of the interaction.

> ***Microaggressions can occur in clinical settings, even when therapists strive to be culturally competent.***

Victims of microaggressions often find themselves caught in a challenging situation, as described by Sue and his colleagues (Sue et al., 2007; Sue & Spanierman, 2020). They face a catch-22 dilemma when deciding how to respond to microaggressions. On the one hand, responding immediately to a microaggression may risk their experience being invalidated or dismissed by others who may not perceive the subtle nature of the aggression. On the other hand, if they choose to delay their response until a later time, the opportunity to address the microaggression effectively may have passed.

Researchers have noted somatization of microaggressions resulting in fatigue, exhaustion, migraines, diabetes, sleep disturbances, and more (Ong et al., 2013; Sue & Spanierman, 2020; Torres-Harding, 2020). In this manuscript, we explore the somatization of microaggressions through a detailed case study that describes a rupture in a clinical setting, and the process of healing the rupture through somatic healing.

Case Study

Joanne is a 35-year-old White therapist working with Maya, an 18-year-old immigrant woman of South Asian descent. Joanne, in her attempt to understand Maya's struggles with her family, unintentionally slips into a stereotype. She remarks, "That must be tough, given that Asian families are usually strict, aren't they?" Joanne's intent isn't malicious, but her words leave a mark.

Maya's stomach drops. She becomes silent. On an emotional level, Maya feels a sudden surge of surprise and confusion. These feelings quickly give way to a sense of hurt and indignation, a reaction to having her unique experiences and struggles reduced to a cultural stereotype. Her body tightens to become smaller, while she also feels an urge to fight back, but she holds this, and it's exhausting. This emotional response is accompanied by feelings of alienation and invalidation, as the space that was once therapeutic and understanding now seems to be tainted by bias and misunderstanding. She subtly looks at the door, then the floor; feels her body wanting to leave, but fighting to stay. This energy is spent trying to find safety. Cognitively, Maya wrestles with a sense of disbelief, questioning whether Joanne's comment was indeed a microaggression. This questioning stems from the subtlety of microaggressions, which often leave the recipient questioning their perceptions. However, as the sessions continue, Maya starts to trust her interpretation, recognizing the comment as a microaggression that has disrupted the therapeutic alliance. This is made worse given the therapist hasn't even acknowledged what she said, and Maya is left holding the bag, again. Immediately after Joanne's comment, Maya's body goes into a state of high alert, signaling distress. Her shoulders tense, her breath becomes shallow, and she unconsciously wraps her arms around herself – a physical manifestation of her need for comfort and protection. All of a sudden, she feels really exhausted. This immediate somatic response is a clear indication of the impact of Joanne's comment, despite its subtlety. She is left feeling unseen, invalidated, and reduced to a stereotype.

In the sessions that follow, Maya appears guarded and less open, affecting the therapeutic rapport they had built over weeks. Her acute somatic responses evolve into chronic ones. Maya begins to experience increased levels of anxiety, reflected in her continued shallow breathing and constant tension in her shoulders. Her sleep becomes disrupted, possibly due to the heightened state of arousal and the emotional distress triggered by the microaggression. Maya also becomes more guarded in her interactions with Joanne. This is seen in her nonverbal cues – reduced eye contact, crossing her arms over her chest, and maintaining a greater physical distance. These changes are indicative of the rupture in the therapeutic alliance, and Maya's attempt to protect herself from further hurt.

Joanne, eventually noticing this change, wonders if her generalized comment about Asian family dynamics may have led to this shift. In the next session, Joanne decides to address the issue directly. She expresses her observations about the change in Maya's behavior, and discloses her concerns about her previous comment, apologizing for the unintended hurt. Acknowledging the impact of her words is the first step towards repairing the rupture.

Joanne invites Maya to express her feelings, and Maya shares her hurt and anger about the comment, stating that she felt stereotyped and misunderstood. Here's how the conversation goes:

> J: *Maya, I've noticed you've been protecting yourself more in session lately, and it's made me reflect on what happened for you to need to do that. I remember saying something about Asian families usually being strict, and I sincerely regret making that over-generalizing statement. I did not meet my need, or your need, for respect in that moment. This rupture is my responsibility, and I've*

been grappling with shame about hurting you. I am sorry I hurt you, and I promise to endeavor not to make over-generalizing statements anymore. It will take some time for me to repair this rupture; I want you to know your needs and feelings matter to me, and I want to earn your trust by showing you that through my words and actions. I also want you to know that I am working on my assumptions in personal therapy, and am open to hear anything you need to say, when you feel ready to share. I also understand if you feel I am not a sensitive enough match for you. I intend to grow to be reliable support for you.

M: [looks down and fiddles with her fingers, takes a deep breath] *I have been struggling with our sessions ever since that comment about Asian families being strict. I have been exhausted before, during, and after sessions. I was very confused and taken aback by that statement, given I had just described my family as being extremely laid back a few sessions before.*

J: *And of course, you would feel exhausted after being on the receiving end of a stereotypical microaggression from someone you hoped to trust. I'm really sorry.*

M: [Silence]

J: *When you are ready, could you tell me about how you felt in your body?*

Maya reveals her somatic reactions; how her body had tensed and her heart rate increased. She admits that these sessions have been causing her stress and sleepless nights since the incident. Joanne listens attentively, validating Maya's feelings, and apologizes sincerely. She affirms that such stereotypes are inappropriate, acknowledging that her comment was a misstep. She reassures Maya that her individual experience is what matters in their sessions, not preconceived cultural stereotypes.

They also explore the somatic reactions together. Joanne guides Maya through some grounding exercises to help her reconnect with her body and release some of the tension that had built up. Over time, they rebuild their therapeutic relationship, with Joanne consistently demonstrating her commitment to understanding Maya's unique experiences and avoiding cultural assumptions. She further invests in educating herself about the diverse cultural backgrounds of her clients to avoid similar incidents in the future.

Joanne takes a thoughtful and multifaceted approach to addressing the microaggression with Maya, starting with self-reflection and leading to direct conversation, validation, apology, and an ongoing commitment to change.

1. ***Self-reflection***. After noticing a shift in Maya's behavior during their sessions, Joanne starts reflecting on her own actions. She thinks back on their recent sessions, trying to identify any potential missteps. It is during this process of self-reflection that Joanne recognizes the potential harm of her comment about Asian families being strict.
2. ***Direct conversation***. Once Joanne realizes her mistake, she decides to address it directly in their next session. She initiates a conversation about the change in Maya's behavior, and brings up her comment, acknowledging that it was inappropriate and could have been hurtful.
3. ***Validation***. Joanne invites Maya to share her feelings and experiences, and when Maya expresses her hurt and anger, Joanne validates these feelings. She doesn't dismiss or minimize Maya's emotions, but instead acknowledges that they are a legitimate and understandable response to the microaggression.
4. ***Apology***. Joanne apologizes sincerely for her comment, recognizing the harm it caused. Her apology is not conditional or defensive; instead, it centers on Maya's experience and the impact of her words. This apology is a crucial part of the repair process, demonstrating Joanne's understanding of her mistake and her commitment to rectifying it.
5. ***Somatic healing***. Joanne acknowledges the physical impact of the microaggression on Maya. She introduces grounding techniques, helping Maya reconnect with her body, and providing tools to manage stress and anxiety. This focus on somatic healing not only helps address the immediate somatic responses but also validates the importance of bodily experiences in therapy.
6. ***Ongoing commitment***. Joanne communicates her ongoing commitment to understanding Maya's unique experiences and avoiding cultural assumptions. She reassures Maya that her individual experience is what matters in their sessions, not preconceived cultural stereotypes. Joanne also commits to educating herself

further about diverse cultural backgrounds to avoid similar incidents in the future.

Microaggressions can occur in clinical settings, even when therapists strive to be culturally competent. Therefore, to move towards a culturally affirming stance, it is important for therapists to acknowledge the potential for microaggressions, and actively work to create a safe and inclusive environment for all clients, regardless of their cultural identities. Therapists should be aware of the potential for somatic ruptures in therapeutic relationships as a result of microaggressions, and work to proactively repair those ruptures. Somatic ruptures can occur when a client experiences a disconnection between their mind and body, often as a result of trauma or other adverse experiences. Microaggressions can trigger these ruptures, leading to feelings of disconnection, mistrust, and even retraumatization. To repair these ruptures, therapists can work to create a safe and validating environment where clients feel heard, seen, and understood. This can involve validating the client's experiences, apologizing for any unintentional harm caused, and working collaboratively with the client to rebuild trust and connection. It is also important for therapists to continue to educate themselves on the impact of microaggressions and other forms of oppression on mental health and well-being.

Shreya Vaishnav, **PhD**, **APCC**, is an Assistant Professor in the Counseling Department at Palo Alto University. She identifies as an immigrant from Mumbai, India. Her expertise lies in working with immigrant populations on cross-cultural issues, specifically South Asian immigrants and first-generation Asian Americans. Her research focuses on the impact of microaggressions on students from marginalized identities, and she has facilitated workshops on navigating and responding to microaggressions in academia. She has also led research projects on effective mentoring practices for students and faculty, strengths-based approaches in working with students from marginalized backgrounds, and social justice advocacy.

Dareen Basma, **PhD**, **LPC**, is the Associate Dean of Diversity, Inclusion, Climate and Equity (DICE) at Heinz College at Carnegie Mellon University. Dr. Basma is an educator, researcher, and clinician whose work is grounded in social advocacy, community engagement, and the dismantling of oppressive systems. She firmly believes that in order for social and racial justice to prevail, they must be addressed within institutional and cultural contexts, rather than solely as issues to be resolved through individual enlightenment. As a result, much of Dr. Basma's career has focused on the development of research, teaching, training curricula, and clinical practice that aims to do so.

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Fanon's Vision of Embodied Racism for Psychoanalytic Theory and Practice

Kenyona Young

ABSTRACT

Fanon's *Vision of Embodied Racism for Psychoanalytic Theory and Practice* is a self-exploration of appeasement as a body defense that moves beyond the binary into the subconscious and preconscious states, going further still into the fabric of American caste. Scholars like Fanon, Hardy, and Knoblauch boldly explored how hierarchal structures of race and racism live in our interstitium. In this way, we must all examine ourselves and how we have been complicit in systems of oppression, and are subjects of a white ideology. This self-examination begins with interrupting the patterns of appeasement and enactment.

Keywords: Fanon, appeasement, body defense, annihilation, social self, race, racism, phantasies, Other

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> ***Slavery officially ended in 1865 but the structure of caste remained intact not only surviving but hardening...***
>
> —Isabel Wilkerson

In exploring Fanon's *Vision of Embodied Racism for Psychoanalytic Theory and Practice*, author Steven H. Knoblauch discusses his limitation in supporting his Black client, Waverley, described as "... an encounter consisting of my phantasies as rescuer in interaction with my patient's victimization, located in a space constructed out of the oppressive economic and political arrangement shaped in great part by racist assumptions and practices" (Knoblauch, 2020, p. 299). Stephen Hartman further expounds upon Knoblauch's vision of Fanon's sociogenic concept, inserting the importance of going beyond body-to-body understanding, and into the systems that make up our society. Hartman suggests that "our theories are stained with racial projections that we cannot collectively overlook (Carter, 2018; Christensen, 2019) just as our institutes sit on redlined real estate" (2020, p. 318). As the micro- and mezzo-systems are situated within a continuous feedback loop, Fanon's concepts of the *phobogenic* (*causing fear/phobia*) object and *lactification* (*to make white/to whiten the Black race*), explores and makes clear the loss of human connection as Black folx were made the Other. In the creation of the Other, all bodies formed, fractured, and became rigid composites that operate within *enactments* – the process of acting out conscious

As clinicians engage in therapeutic work, further exploration into the body as preverbal and preconscious states that sit just outside of our awareness is warranted in exploring the ways in which Black, White, and all Othered bodies are deeply affected.

and preconscious states of being, from the body defense of *appeasement* – a profound biosocial response to relieve anxiety and protect us from the intersubjective spaces and the preconscious spaces of "traumatic sociohistorical events" (Knoblauch, 2020, p. 307) Both Knoblauch and Hartman are henchmen in the same boat, with Fanon at the helm, in exploring the deep anxieties that live contextually throughout our lives and hold foundation to how we make meaning. As clinicians engage in therapeutic work, further exploration into the body as preverbal and preconscious states that sit just outside of our awareness is warranted in exploring the ways in which Black, White, and all Othered bodies are deeply affected.

In Stephen Hartman's article, *Binded by the White: A Discussion of "Fanon's Vision of Embodied Racism for Psychoanalytic Theory and Practice"* (Hartman, 2020), he discusses the failures of psychoanalytic thought and theory, and emphasizes the importance of avoiding the "bonds of Whiteness" when working with clients, asserting, "White analysts pursue acts of self-analysis that confirm risk differently than we commonly understood "destruction and survival" in a "good-enough psychoanalysis," and furthers this point in stating, "White analysis cannot understand the violence that slavery and its aftermath wrought from any other position than a position of Whiteness, so the position of the empathic ally who survives destructiveness is ever suspect" (Hartman, 2020, p. 319). White anxiety around approval lives within the body, preconscious, and is a part of the glue that bonds the work of the white analyst. Consequently, [White people] can't see the *white-constructed invisible fences*, barriers, walls, and *ways of being* that aggressively encroach on the lives of Black and Brown people over the course of a lifetime (Hardy, 2022, p. 9)." White anxiety around approval lives within the body, preconscious; it is "the internalized myth of White superiority that tells White people they are good, beautiful, just, moral, knowledgeable, deserving, and rightful heads of the human table" (McGoldrick & Hardy, Eds., 2019, p. 202).

This position must be at the very least acknowledged, with some steps taken towards dismantling, before allyship is broached.

Considerations

In approaching the emotionally charged work of appeasement through a somatic lens as a body defense that exists within hierarchal societies, some foundational concepts and understandings are necessary. This work is situated within a framework that understands America as a settler colonial nation, which is to acknowledge the ways in which the history of America and its acute indoctrination of Otherness lives intergenerationally, as well as permeates the day-to-day lives of Black, Indigenous, and other People of Color who are pressed to the margins of society.

While body psychotherapy is a radical departure from the centering of the mind within psychodynamic discourse, it remains centered in whiteness, and has evolved within a staunch psychodynamic framework that limits its ability to fully explore the wholeness of humans. Furthermore, body psychotherapy has yet to effectively address the lack of human rights, which lives in the bodies of the marginalized. For this reason, it is imperative to voice the rage of the lived experience of Others, and to give it the dignity of being seen as fully human. This conceptual analysis will pull from the allied fields of sociology, psychology, psychiatry, social work, and education (e.g., Fanon, Hardy, DeGruy, Winnicott).

A final consideration and foundational point to make clear is how healing may often be considered within American discourse, leading one to believe that healing is a journey with the destination of "healed." On the contrary, healing is a constant process without a destination.

Appeasement as defense

Many of us live our lives in some performative state; caricatures, whose distortions live so deeply in the body that the enactment feels true. It is only when the pattern is disrupted that we can begin to contend with the lie. Jeffery Mangram writes, in *The Elephant is the Room* that the price that is paid for living our lives within these performative states is losing oneself to the caricature. Mangram reflects that there was a time when he could not separate himself from performance, and found that he lived in a state of "the performance of survival," within all corners of his life, professional to personal. This "performance of survival," is a form of appeasement, and speaks to the many ways we live with the betrayal of our defenses. This betrayal is usually only confronted at later points of reflection. This is in part due to the very nature of the body defenses, and the fact that they live within the interstitium, neurons, and heartbeats of our lives, and are not always conscious. Appeasement speaks to the deeper automatic responses of the body, often in response to keep ourselves safe. When speaking of the marginalized, however, due to the hierarchical nature of our societies, and survival being relative to situations, status, and the like, appeasement will look very different for a middle-aged, cisgendered white man with all the privileges of our society in comparison to a middle-aged, cisgendered white woman, or a middle-aged Black man/woman. Appeasement is a defense, much like fight, flight, freeze, flop, and fawn. However, appeasement, unlike fawn, "cannot be solved by the individual alone." It is specifically situated within hierarchal systems/structures, "a feature of social hierarchy of inequality," and is a function of situational survival, safety, and our drive to be socially received (Ndefo, 2021).

America is built on chattel slavery, and Black folx have been fighting for the right to be truly accepted as human from the day the first African was considered something less than. In this frame, Black is at the bottom of the hierarchy, and white is positioned atop in the pigmentocracy of a white body supremacist structure (Menakem, 2022) – which is why much of our discourse around race and race relations in America is often very black and white. This is also the reason so many of us yearn for nuance, and a period where scholars, writers, and thinkers will boldly, obtrusively, meddle with the greys (shout out to Black feminist scholar Brittany Cooper).

Appeasement and I

I have been thinking a lot about appeasement lately, and how the body moves into this body defense without thought. For myself, by the time I am aware of the enactment, I am trapped in it. Deeply engaged, most often nonverbally, makes me think of how the body is "the first responder to trauma," and how all the information within any given space is, "neurocepted through non-verbal cues." In a fleeting period, my body has scanned for danger and prepared to respond (Galdos & Warren, 2022, p. 85). At some point, I become aware of both my body's response and discomfort, the need to get free, and the need to survive this social situation, realizing that the right response could be beneficial and the wrong response detrimental.

While analyzing the literature on Fanon's perspective and the importance of introducing clinicians to Fanon's work, I reflected on innumerable exchanges with my white peers within the Somatics program at the California Institute of Integral Studies (CIIS). I wondered; when my white peers engage with me, are they truly getting to know this body? Or are they (my white peers) attempting to become competent in who I am, a sort of individualized cultural competency, that may better support their skills development and lead to their overall ability to engage, interact, and treat Black people? Further, how is appeasement taking form in this body, living in the preconscious state, and engaging in enactments where I leave feeling exhausted and overwhelmed? This Black, female, queer body finds itself cursing allyship, and looking for accomplices, or co-conspirators. I long for the self-proclaimed ally to move beyond being a

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bystander with "BLM" signs in the windows of their fancy homes, to owning accountability for their complacency and contributions to our racist society. That will show itself in willingness to align with the Black bodies in danger, assuming some of this danger in support of truly honoring that Black too equals human. Is it possible that appeasement allows for white complacency and contributions, and that allyship is the first step to co-conspirator? Does appeasement allow for my white peer to become stuck at this first step? Or is it that Black as less than human is so rooted in the DNA of America(ns) that it lives in our bodies, outside of consciousness? In my quest for co-conspirators, my awareness of appeasement in my body begs for the stillness within to shake and uproot me out of the day-to-day enactments.

The disconnection between my experience and that of my white peers leaves me to contend with my rage alone, leaving me to question if my rage is righteous, or if there is any dignity to be found. Rage, to the marginalized, is a foundational function of appeasement, automatic and slightly invisible (Nndefo, 2021). Rage that is swallowed so deep and for so long can be hard for Black folx to bear to touch. Ayana Young, host of *For the Wild* podcast, interviews Nkem Ndefo in an episode entitled "The Body as Compass." Ndefo explained that those of us who live at the lowest levels of the social hierarchy spend "a great part of our existence in appeasement" (2021). Often, the phobogenic object (the object to be feared), we are the "embodied registrations… frequently shaped by traumatic sociohistorical events emotionally experienced as too unbearable for re-presentation/remembering as symbol/image in intersubjective space" (Knoblauch, 2020, p. 307). If this body is to truly be known, then my peers and "white analysts" must move beyond the "bonds of whiteness" into a radically different frame in which "clinical practice… is able to endure disruption and consequently alter its manner of clinical practice" (Hartman, 2020, p. 319), or reckon with this body and other Black bodies movement out of the stillness of enactments and beyond appeasement, as the rupture has already begun.

Resilience and appeasement

Both Knoblauch's and Hartman's articles address the resilience factor of appeasement, and how Black bodies are called into these enactments where we must draw upon resources to support us in getting through days where psychological violence is constantly minimized. It helps to think of appeasement in the subconscious as "confusion, or even cowardice… far from pacifying and resolving conflict, often only serves to postpone the inevitable confrontation, and so aggregates tension" (Laqueur, 1978). Here, I am called to body memories of engaging socially at CIIS in states of stress – where this body, tense with a heart rate steadily above normal, must slow and deepen its breath to keep the heart from escalating. Yet sweat, thick with proteins and lipids, continuously collects under my arms and around my groin. This mind moves between rage and disillusionment, fear, and containment. A prayer from somewhere beyond this soul and the cosmic center of the Earth: *When this body dies, give the flesh no time to rot. Burn it. Leave no evidence of the Blackness. God, bring me back white.*

Fanon and I

The ruthlessness of the prayer above speaks to the turmoil that lives within Black bodies: the desire to move beyond this flesh that communicates subjugation, and the reality that only destruction and death of the current systems of colonization will allow for true freedom and liberation to live within an "expression of the true self" (Swartz, 2018, p. 525). Swartz writes that Winnicott, as Fanon, understood, "the 'yes to life' … is not self-conscious but must be received without being modified into something other than itself" (Swartz, 2018, p. 525). Due to the deep anxiety that lives in both the conscious and preconscious body, white projections are made to avoid/deemphasize the personal investment one has in oppressive systems. To this end, some white folx may be well suited to situating themselves within some oppressive systems, and find themselves allying with Blacks and Others, while continuing to struggle with their involvement in anti-Black oppressive systems. Winnicott asserts that "the alternative to being is reacting, and reacting interrupts being and annihilates. Being and annihilation are the two alternatives" (Winnicott, 1986, p. 244). Annihilation is the diminished space where the social selves meet.

If the only options our bodies have is "being or annihilating," as Winnicott suggested, then, I posit, America is filled with annihilation, a sort of trans-

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mutation, given that we are born into our authentic selves. We are socialized into the social self, leaving bodies disconnected from each other, Earth, and ultimately themselves. This lack of vitality is where appeasement lives, in the space of compliance where we dampen our true selves, and "the opposite of feeling alive is not feeling dead. The opposite of feeling alive is having to devote all one's attention, time, and energy to others' (originally mother's) moods and expectations. The opposite of feeling alive is being a totally social self, reactive, compliant, and lacking in spontaneity" (1990). This body is struggling to maintain within the disconnected and chronically uncomfortable spaces of the "social self" and longs for its destruction as an opening to being.

Fanon's work forces the reader to take a long hard look into our souls, and with little resistance, I found my heart heavy when confronting the ways in which internalized racism, sexism, and ableism live, and are stored deeply in my fascia. All my encounters are colored by white supremacy; often I am pulled into enactments, lulled into spaces where only my defenses live. The psychodynamic/psychosomatic worldview threatens to put me in my place of acceptance of the dominant group's perspectives on all things mind/body with little regard for the ways in which we are shaped as a national body through white supremacist frameworks that elevate the DOMS (dominant omnipresent mutilation of self/state), using the rest of us as stepstools.

Moving beyond silos into theory

Much of what we think of or believe to be white/whiteness is an ideology. Dr. Kenneth Hardy explores this concept of the enduring, invisible, and ubiquitous centrality of whiteness (2022). He and others explore how "white" lives deeply in our subconscious: to be white is to be good, and to be good is to be socially acceptable. In this vein, DOMS is a state of being that marginalized folx hope to attain. In attempts to position myself in proximity to whiteness, due to Blacks' inability to fully assimilate like others in history such as (previously non-white) Italians and Jewish folx, who eventually found acceptance and received their white cards. Black folx can only pray for the next best thing to assimilation: proximity. This adds to Black anxiety, and causes us to raise our children with the belief that if they are good enough, their lives may be spared. Black cannot rub off in the shower; thus, we find proximity, via colonized ideas of good, bad, right, wrong, scholarship, and respectability politics. Appeasement speaks to how much of this anxiety refers to how we have internalized these beliefs.

In my relentless chase to obtain some proximity to whiteness, I have engaged in respectability politics, hated my skin, attempted to keep it as light as possible, straightened my hair, attempted to perfect my tone and speech patterns, smiled on cue, denied my sexuality, played good wife, attended many churches, and hated Others. I contorted my soul to fit into the white box, while somehow knowing I would never be fully accepted. My internalized racism informed me I was not worthy of the white card, but to keep trying as hard as I could, for the warmth of the light of white was the next best thing.

The current human condition that we refer to as "normal" is actually this annihilation or transmutation, this " totally social self" that robs us of our vitality.

We are, in part, so easily pulled into enactments where appeasement takes over due to the pervasiveness of holding patterns within micro- and mezzo-systems. Knoblauch brings this in through Fanon's sociogenic concept, where he explains how the unconscious is situated within "categorization and hierarchical meaning" (Knoblauch, 2020, p. 307), and Ndefo (2021) situates appeasement within hierarchal social systems that surround our bodies in social engagements where we fall into enactments. Our subconscious body-to-body knowledge is informative, not only from a biological sense. When investigated in the slightest, we become aware of the knowledge our bodies collec-

tively hold. Schimdt discusses the family as a body: "We can say, for example, that the family as-a-unit has its own formative process, character, and armoring, which are both separate and different from the formative process, character, and armoring of each of its members" (Schimdt, n.d., p. 46). In efforts to continuously situate our bodies within micro- and mezzo-systems, this body believes not only in the "family body," but also in the community body, societal body, and national body, and in the appeasement that these bodies are "wrought" with. This is exemplified by Bronfenbrenner's bioecological model (1977), which systems therapists aim to serve from a socioculturally-attuned frame (McDowell et al., 2018).

Both Knoblauch and Heartman show an awareness of the preconscious dance of appeasement and our living through enactments, which many of my peers continue to struggle with, in part due to their "cognitive imperialism" (Battiste, 2017). Cognitive imperialism is a term that describes the mental, emotional, destructive, and traumatic effects of the experience of individuals and people forced to be educated and living under Eurocentric colonialism and imperialism (Fanon, 1965, 1967; Memmi, 1967, 2006). It is a form of cognitive manipulation used in social and educational systems to disclaim other knowledge systems and values, known as a banking model (Freire, 2004), cultural imperialism (Carnoy, 1974), mental colonization or colonization of the mind (Chinweze, 1987; Hotep, 2003), culturalism, cultural racism, epistemic violence, cultural genocide, or cognitive assimilation (Battiste, 2017, p. 183-188).

Battiste confirms the importance of holding deep reverence for Fanon's work, and the work of uprooting and interrogating the bonds of prejudice as it is built into history. Her work speaks to a holding pattern that lives in our physical bodies, familial bodies, societal bodies, and national bodies – all of which are situated within. They constantly communicate, learning and informing each other, all of which are informed by the body defense of appeasement. As Fanon stated in *Black Skin, White Mask* (1967), sociogeny, or the phenomenological occurrence of appeasement, which likens itself to code-switching or double consciousness, live alongside ontogeny and phylogeny (Fanon, 1967). We have evolved to appease, to show up as our "totally socio selves," to move with ease into enactments. While Fanon's work, along with that of other Black scholars, have focused on Black bodies, my experience at CIIS leaves me to wonder about the white experience of appeasement, and how it plays a role in tethering white folx to current societal standards of living and being, or, as Winnicott would say, annihilation. I assert that the vast majority of us live within the event horizon that is white supremacy – pure annihilation.

Onward with Fanon at the helm

The only way forward is to hold ourselves, our development, and our healing, with deep regard. In learning the Latin origins of the word respect or *respicere*, *re* (back) and *specere* (to look at), *respicere* means to look back at, to regard. How might regard be used in the service of assessing, intervening, learning from, and dismantling the "totally social self"? Or, to use Fanon's work, how might we reflect, "emphasize, and critique the significance of racial prejudice expressed as hierarchy of development based on comparison of embodied characteristics, particularly skin color and fantasies of innate difference in physiological capacities"? (Knoblauch 2020, p. 300)

■ ■ ■

Kenyona Young, daughter of the matrilineal lines of Gipson, Young, and Wesley, identifies within the collective of Black folx who have cared for her; we are Black, womanist, and queer. An East Oakland native and currently a graduate student at the California Institute of Integral Studies (CIIS), Kenyona's dream is to work within the communities that have natured her.

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BODY PSYCHOTHERAPY AROUND THE WORLD

Body Psychotherapy in Italy

Maurizio Stupiggia

The Birth

Interest in body psychotherapy in Italy dates back to the 1960s, following the publication of the first translations of Wilhelm Reich's books.

An initial group of scholars met in Rome to study Reichian themes, and in 1968 the Centro Studi Wilhelm Reich was founded in Naples. Its structure promoted therapeutic intervention but also study and research activities, with a focus on prevention in the social sphere. Initially, the Center did not have an easy life, especially in its relations with official scientific and clinical practice that had always dismissed (if not also removed) Reich and his theories. While using his important insights and concepts, it always gave a restrictive interpretation of his work. Even today, Reich's *Sexuality in the Cultural Revolution* is translated as *The Sexual Revolution*.

In 1973, interest in Reichian themes took off, thanks in part to the Center's publication of the journal *Quaderni Reichiani*, which bore witness to the ferment of ideas and initiatives in the late 70s. For the first time, Reich's students and successors were invited to the Center in Italy, and from there all subsequent initiatives in this country thrived. Other related centers sprang up in Padua, Treviso, Genoa and Rome, and body psychotherapy developed and established itself as multiple clinical approaches flourished. Beyond their inevitable differences, they were always united by the certainty that giving space to the body in therapy did not mean using a bodily technique to be added to the verbal ones. It focused theoretically and practically on a new and more complex paradigm, which included aspects of the relationship between the therapist and client, as well as consideration of the personalities at work, which had been overlooked by other psychotherapeutic approaches.

The framework of Italian body psychotherapy is made lively and complex by the interweaving and affirmation of various theories and schools of thought, such as Vegetotherapy, Bioenergetic Analysis, Functional Psychotherapy, Organismic Therapy, Orgonomics, Biosystemic Psychotherapy, and Bio-Psychosynthesis. No less important are the contributions of psychosomatic medicine, sexology and psychomotricity. These rich and dynamic offshoots are marked by the effort to understand, explain, and frame in an articulated theoretical system the many phenomena observable in the clinical setting that are not adequately integrated in exclusively verbal psychotherapy.

At the end of the 1980s, this movement became more vibrant and significant. In an attempt to establish reconnection between the various referenced theories and clinical practices, an important symposium, "Reich, History of a Removal," was held in Naples in 1987. It led to a series of important international and European conferences. Based on the results and conclusions of these meetings, and in conjunction with major international movements in the same field – the European Association for Body Psychotherapy (EABP) and Comité Scientifique Internationale de Thérapie Psychocorporelle (CSITP) – the first

National Conference of Body Psychotherapy took place in Naples in 1990. The goal was to define and officially establish in Italy a theoretical space not yet fully recognized by the official scientific and cultural world. It was so rich in content and perspectives that it made a fundamental contribution to research on human health and psychophysical well-being.

The National Association

In the context of this first conference, the National Committee for Body Psychotherapy was founded under the direction of Luciano Rispoli, gathering all the scholars in the field. Two years later, at the second National Conference in Catania, the Committee was transformed into the National Association for Body Psychotherapy.

In the years that followed, the activities of the Association continued with a series of meetings and debates. Yet it still lacked a true national aim. Moreover, at that time Italy was focused on new ordinances for regulating psychotherapeutic activity, as well as accreditation of its training schools. The contacts, entrusted mostly to individual representatives, along with the organizations that directly formulate the new law, remain active today. It is always individual representatives who are active in the international and European associations, particularly the EABP, and who also hold leadership positions. The international and European conferences became venues for exchange and confrontation, and have given new impetus to the Association. In 1999, all the Italian institutes and societies focused on psycho-corporeal work came together. The individual psychotherapists who had followed the evolution of the Association during its ten-year lifespan rewrote the statutes and officially established the Italian Association of Body Psychotherapy (AIPC) in 2000.

With its diverse representation, the AIPC constitutes the Italian section of the European Association for Body Psychotherapy. Its link with the EABP is defined in its statutes, and expressed by full adherence to the objectives, code of ethics, and standards of admission for members of the EABP. In fact, being an AIPC member confers the status of corresponding member (for the individual or the institution) of the EABP. As a body, the AIPC adheres to the Italian Federation of Psychotherapy Associations (FIAP), which is the Italian section of the European Association for Psychotherapy (EAP). All recognized psychotherapy training schools in Italy are members of the National Coordination of Schools of Psychotherapy (CNSP).

Body and culture

With regard to the position of body psychotherapy in the panorama of Italian culture, we can say that we are faced with a certain duplicity. On the one hand, we have a consonance with the Italian way of using the body emphatically for linguistic expression and communication in general. This makes the use of the body in psychotherapy a fairly accessible tool, and those who come to therapy are not so surprised by this methodology. On the other hand, it must be said that the philosophical and cultural tradition of the last century is deeply rooted in the work of two thinkers, Benedetto Croce and Giovanni Gentile, who influenced both culture in general and educational institutions in particular. They shaped the Italian spirit with the predominance of intellectual over personal or existential experience.

This double track comprises a large part of the Italian cultural construct. On the one hand, we find creativity and flexibility, typical characteristics of "getting by," as a sort of emergency pragmatism. On the other hand, we encounter a large tendency to serve

tradition, as well a strong propensity for intellectual abstraction. These can be blocks to innovation and evolution. This dichotomy of conservation and transgression are rather typical traits of the Italian mindset. In the field of psychotherapy, this produces a paradox: it is not shocking for a therapist to suggest movements with the body or even exercises to the client, but this is often not considered a form of treatment that is actually "real psychotherapy." In such a cultural landscape, the way that body psychotherapy landed in Italy turns out to be logical. It closely resembles the work of the mole, emerging suddenly, but after long underground digging.

In fact, after the first attempts at diffusion during the period of cultural and political protest in the 1960s, the movement seemed to die out. Or, perhaps we should say that it seemed to sink, only to re-emerge strongly between the 1980s and 1990s, until it built itself into a truly independent force in psychotherapy.

We can now say that body psychotherapy has managed to create its own autonomous space of reference and action in Italy. It is a relatively small space, but one that is now recognized by other models. It is no longer subject to misunderstanding or devaluation, as might have been the case some time ago.

As a consequence of what has been described so far, it must be said that this progressive integration of body psychotherapy into the larger psychotherapy community has also come at a certain price. Body psychotherapy has had to transform, adapt, and adjust to a certain style of work and thinking that modulates and reformulates all the strongly expressive, cathartic, or, as Baudelaire would say, "expérience limite" that predominantly characterized the practice during its first few decades. Metaphorically, we could say that a certain youthful extremism had to give way to mature moderation. I say this with a dual emotional involvement: there is an awareness of the need to adapt to changing conditions, and at the same time there is a longing for the intensity of continued experimentation.

Another important aspect that characterizes the position of corporeality in the thinking of Italians is the powerful presence of Catholic institutions in the country. The fact that Rome is the seat of the Vatican is not irrelevant, because this proximity to a "spiritual power" creates a strong impact on the conscience of its citizens. We could say that Italians may feel both watched but also protected by the Vatican. Thus, we can again observe a dual reaction to the use of the body. Catholicism (and Christianity as a whole) produces a two-faced vision of the body, with pleasure remaining on the dark and hidden side. This causes a split that favors a general attitude of dismissing corporeal and sexual pleasure, and producing an exaltation of the purifying and redeeming power of all pain experienced in life.

We can thus understand how complex it is for such individuals influenced by a particular strand of Catholicism to elaborate the relevance of the body in the psychotherapeutic setting, where deep, forbidden desires and guilt urges appear. It can be inferred from these considerations that the stereotypical "Italian hedonism" is often an attempt to avoid pain rather than an active pursuit of pleasure. It is more akin to fear of punishment than excitement about reward.

With these considerations, we can hope to explain the attitude of the rather ghastly curiosity with which orthodox psychoanalysts ask body psychotherapists if they really dare to touch the client's body, and if it is really true that reactions such as trembling, shortness of breath, and even convulsions are stimulated by touch – which reminds them of the hysterical phenomena described by Freud. The perplexities of the psychotherapeutic scientific community are first and foremost ethical, and secondarily epistemologi-

cal. They sink their reason into the sociocultural unconscious rather than the dictates of scientific methodology. For this reason, paradoxically, it then becomes easier to make these opposing universes communicate, partly because the Catholic message is far more complex than the simplification of common thought.

In fact, I want to quote a well-known Psalm (39; Hebrews 10:4-10) that summarizes all the richness and the complexity of this theme: "Entering into the world, Christ says: 'You wanted neither sacrifice nor offering, a body instead you prepared for me. You did not please either burnt offerings or sacrifices for sin. A body you offered me, to follow your will.'"

Dance movement therapy

At this point, the history and evolution of body psychotherapy, understood as the development of Reichian and post-Reichian thought and practice, calls for a separate discussion of the history of yet another strand of body-mediated clinical work. I'm referring to dance movement therapy, which arrived in Italy in the early 1980s, thanks to two U.S.-trained therapists, Debra McCall and Rosa Maria Govoni.

The probing cultural research of these two dance therapists produced a gradual aggregation of all the experiences revolving around expressive dance, Psychomotricity, and Authentic Movement. It created a theoretical and clinical container that allowed them over time to constitute a pole of attraction for everyone who sought to bring together movement with sensory and emotional work.

It is strange, however, that body psychotherapy and dance movement therapy have traveled parallel yet distinct paths. Without significantly meeting, and separately building their own paths of cultural and scientific recognition, they remained in dialogue and built alliances from different clinical perspectives. While body psychotherapy has always drawn deep nourishment from the influence of humanistic psychology, dance movement therapy has looked almost exclusively to the territory occupied by psychoanalytic models. This is probably due to the formative history of the respective founders in Italy of the various schools of psychotherapy. It is perhaps also partly related to that cultural split involving corporeality, discussed above.

There is a note of peculiarity in all of this because we have very similar clinical practices, while using very different models.

Indeed, dance movement therapy, according to the model of Italian Art Therapy – an association founded in 1982 – makes particular reference to psychoanalytic theories that have deepened the observation and study of the affective processes that occur between the child and their environment during development. It also places emphasis on the symbolic value of bodily representations, and the developmental significance of the creative process. The dance therapist makes use of their own bodily and imaginative experience to get in touch with the developmental needs of the client. This therapy provides a favorable environment for the individual to discover and elaborate expressive modes and symbolic forms representative of their experiences, thus promoting a creative, transformative, and maturing process.

It is within this theoretical framework that dance movement therapy developed its clinical practice, but above all, it builds the essential meaning of its model. It becomes a bridge between artistic practices of all kinds, and clinical models. It is an attempt to explain and interpret, in an innovative way, the role of creativity with the body of the individual.

The current situation

Until the late 1980s, body psychotherapy and dance movement therapy continued to expand and spread in a somewhat random manner, without constant points of reference. But since the early 1990s, the fate of psychotherapy schools in Italy has been marked by an important event that changed the cultural and scientific landscape. A law regulating the professional practice of psychologists and psychotherapists was passed in 1989. The result of lengthy parliamentary debate, it finally defined the field of psychology in Italy, and created its boundaries. It did so by differentiating it from medical and psychiatric practice, and elevating it from a vast sea of empirical therapeutic practices based on cultural syncretism or randomness. The law ennobles clinical psychology, but at the same time characterizes it in a highly restrictive way. In fact, the law allows only physicians and psychologists access to the schools of psychotherapy, thus eliminating all those with degrees in the humanities and/or in social sciences. The approval of this law is a kind of drastic consequence for all schools of psychotherapy with various previous approaches, since it forces all institutes to apply for government recognition in order to have cultural visibility, and especially presence in the market.

In 1989, a ministerial commission, composed mostly of academics, was established to judge the scientific validity of the clinical model, and its organizational and didactic capacity. The criteria adopted by the commission was obviously related to academic practice and vision, and it is therefore a difficult and complex task for body psychotherapy schools to obtain legal acceptance from the commission. Here a watershed with the past was created: only those who are approved can hope to continue to survive, since only recognized schools of psychotherapy will be able to issue valid certificates for professional licensing.

It is clear that future students will tend to choose only those schools that can provide them with legally valid certificates, so all other schools will be doomed to a gradual loss of interest.

It must be said that in the 1970s and 1980s, the Italian scene consisted essentially of two groupings. On one side, the neo-Reichian schools that clearly drew on the Reichian tradition, and on the other, the so-called post-Reichian schools that were based on the thought and work of personalities who took their cue from Reich, but later elaborated and even profoundly transformed his thought, such as Alexander Lowen, Luciano Rispoli, David Boadella, Jerome Liss, Malcom Brown, and George Downing.

After the law was passed, the schools submitted their scientific model to the ministerial commission, but not all of them received recognition. At present there are four recognized body psychotherapy institutes that can issue diplomas recognized by the Ministry of Universities, and thus also by the Ministry of Health: Società Italiana Analisi Bioenergetica (SIAB), Società Italiana Analisi Reichiana (SIAR), Scuola Europea Psicoterapia Funzionale (SEF), and Società Italiana Biosistemica (SIB).

Similarly, dance movement therapy schools have also applied for recognition, but presently only one obtained it: the Institute of Expressive Psychotherapy, which draws on the work of Arthur Robbins.

I believe the current situation is good enough, although we are in danger of losing some worthy schools and traditions along the way. At the same time that we gained scientific credibility, organizational reliability, and media visibility, as with all historical change, we have, as Morin would say, both gained and lost. We witnessed an emergence as well as a constraint, an enrichment but also an impoverishment.

Maurizio Stupiggia, **PhD**, is Professor at the Department of Clinical Sciences – Faculty of Medicine and Surgery, University of Milano, and has worked for many years as a body psychotherapist with individuals and groups. For several years, he worked at the Italian Ministry of Health, where he assisted the integration of immigrants. For the past ten years, he has supervised therapists and educators working with immigrant women from Africa who are victims of various traumatic abuse in war. With Jerome Liss, he is cofounder of the International School of Biosystemics. He has worked for 20 years in Japan with survivors of major earthquakes. With Rubens Kignel, he cofounded the Bio-Integral Institute of Body Psychotherapy in Tokyo. He has worked as a trainer in European countries, as well as in Japan and Latin America.

PERSONAL VIEWPOINT

A Report from the Trenches

Ann Bradney

If you have come to help me, you are wasting your time.
But if you have come because your liberation is bound up with mine,
then let us walk together...

—Lila Watson
Australian Aboriginal Woman

This is a report from the trenches.

I am going to start with the journey of *Radical Aliveness*, and then bring in the work we are now doing in Israel and Palestine with *Together Beyond Words*.

The birth and evolution of Radical Aliveness

Radical Aliveness was born 22 years ago. I left the Institute of Core Energetics, where I had studied and been on the faculty, to answer a calling from my spirit to create a way of working in a group setting that would use the powerful tools I had learned. I wanted to work relationally rather than focus on the individual. I wanted to develop a process that would honor the wisdom that emerges from the fluidity of a group that's discovering and evolving and experiencing itself – a process that would necessarily include working with systemic issues, which are crucial to who we are.

We are not separate from the world; we are part of it. We are shaped by the systems (religion, socio-economic origins, family, tribe, gender, ethnicity, language, etc.) we are born into. And for every systemic influence, there is healing for us to do. We are in this together, and this is true in every country in the world, in every group I have ever worked with.

I am a process person, I am an experimenter. I am in the field using a laboratory method to develop, invite, collaborate, research, and learn.

I was very interested in how to create a working space where all perspectives, all ways of expression, and all voices would be welcome. And I saw that I could use our differences as a medium itself, a tool to pry open self-awareness, feelings, and knowing each other more deeply.

Importantly, I wanted all the voices and energy and perspectives to lead groups to where we needed to go, rather than being bound by a theory from the outside that would impose a preconceived agenda of what healing means. From my perspective, there is not one way, one leader, one model that can get us to a new story in this world. When we engage in this kind of process, we are all required to be both leaders and participants.

It has been an illuminating, challenging, powerful, life-changing, awareness-growing time.

The Radical Aliveness Institute was a place of experimentation, chaos, intensity, and creation. There were plenty of failures and mistakes, and there was also a sense of joy and excitement for many who had never found a forum where they were able to bring everything they wanted to bring without being told where to go, what they should feel, or what healing for them was.

As the years went on, voices and perspectives spoke loudly to me. "You say you welcome everything, but I am not feeling welcome here." I listened. It required my being willing to be changed, being willing to find a frame that would be expansive enough to invite in everything that wanted to come, and also have enough structure that people were supported to grow, transform, and become more aware. It required me to learn deeply about my own assumptions, perceptual filter, and worldview. It required me to enter into the unknown. It required, as a leader, being willing to be challenged over and over again, and to learn from these challenges. The more I learned, the less I knew for certain. And this was an invigorating process for me personally, because it mirrored the flux and uncertainty I invited my group participants to embrace. I became more interested in having people from thoroughly different perspectives in the room together.

My belief then and now is that this is the way forward. Differences. When people of wildly divergent backgrounds are thrust together in a learning forum, intense emotions and interactions happen organically. As the "leader," it is my job to conduct the energy of groups, not suppress or control it, and to harness the surprising gifts this unleashed energy always yields.

I was profoundly blessed to meet an incredible woman (who asks to remain unnamed) who saw my vision and the spirit of what I was doing, but also saw what was missing. I spent six years working with her in Nairobi, Kenya, with diverse groups comprising people from different tribes, different countries, and different positions in the societies in which they lived. There were over a dozen languages. We developed a way to learn about each of our own perceptual filters and frames. We used the differences and conflicts among these participants to recognize ways we had been socialized to perceive the world. We read, we did organic research (a qualitative research method), we processed. The more we learned to see our own filters, the more curious and open we could be to what was in front of us. Tools and techniques were examined to see who created them and the implicit assumptions they held – assumptions about bodies and feelings and healing. What worldview were these coming from? We studied individualism and collectivism and the spectrum of what a self is from these different worldviews. We studied power on personal, interpersonal, and systemic levels. We looked at who a socialized human being is. We made space for the deep feelings that are often at the base of our intense misunderstandings and conflicts in the world. We worked with values and value judgments. And of course, we worked with feelings, sensations, and emotions.

At this time, Radical Aliveness moved from being an expert model (one in which we have a clear frame with tools and techniques that we use universally with everyone and which has an agenda of where we need to go) to a non-expert/expert model. A non-expert model means to me that I have a lot of knowledge and tools and techniques, but I use them flexibly and with creativity in service of "What is healing for you?" and with an awareness that I have my own perceptual filter, and I need to be open to what is true for you, what your body needs, how feelings are expressed in you, even what words mean. You are the expert on yourself.

The familiar ground each of us stands on as a leader is pulled out from under us. And it's both scary and exhilarating.

During this period, I developed the principles of Radical Aliveness as a foundation for the work we do:

- Knowing I don't know
- Being willing to be changed by our encounters
- Saying yes to everything within us with an intention toward consciousness (including our no!)
- Cultivating a non-shaming heart and attitude (toward ourselves and others)
- Honoring multiple perspectives
- Doing no harm (knowing we WILL do harm, but we will stay to the best of our ability when we are confronted with the harm we have done)

And we added one more after working in Israel:

- DO YOUR PART

This work is not about self-transformation alone. It is about being part of the world and connected to the world, so we always accentuate that we are change agents who need to bring this difficult and important work back out into our families, communities, the world.

We also use guidelines to support the work. These include self-focus (with the understanding that the self and how it develops and what it means varies culturally). Self-focus allows us to slow down the moments when the process gets very hot, and to check in around intention and impact. What is your intention right now? What is your impact? We have to be willing to know we all have impact on others, and to really hear it to the best of our ability when we are being told what our impact is. We work with curiosity as a foundational value. We also have a value of staying through difficult interactions, though of course there are times when it is right for people to leave. We embrace discomfort as part of the process. We work with complexity – seeing the ways in which each of us is not a single story.

Something that has been foundational to our work is the understanding that we all have work to do. The healing for a person in a mostly normative position is different from the healing for someone in a marginalized position (with the understanding again that we are not a single story, and that normative and non-normative live in all of us).

All of us need support to see, feel, and change so we can live together in new ways. The quote at the beginning of the article is perfectly aligned with our philosophy. Our liberation is tied together. The dynamics of social stratification – better than/less than – occur all over the world. It is only the jackets that change. We hold space in *Radical Aliveness* for everyone. Being in relationship with differences is at the heart of one's willingness to change. When we can hold a space where there is enough understanding of complexity and socialization, where we move beyond categories and labels that stop the conversation, opportunity arises for the deeper feelings and stories to be shared in every direction. When the space becomes more complex, we are also able to ask, "Where do I do to others what is being done to me?"

This is not easy work, and I don't mean to imply that we skip over the harsh realities of the world and what people are experiencing. In fact, there is something about this process that allows for all this information to emerge, to be integrated. The polarization that seems to be a hallmark of our interactions these days actually has pathways here to move somewhere deeper. It requires the willingness to be with intense feelings and awareness. It requires an ability to ultimately support people in mostly normative positions to feel cognitive dissonance (as opposed to feelings of guilt or "I am here to help you"). At the

same time, people who are having experiences of marginalization and being non-normative in society need support to find their sovereignty, rather than staying in the dynamic of reaction to the normative frame.

My experience is that people are hungry to have a space like this. It brings hope, it brings relief, and it brings the opportunity for something different from what people are used to. It invites a kind of leadership in the room. When there is not a leader with "the way" telling people what to do, people step up and bring their wisdom. Those many perspectives and voices take us far beyond where we would go with a single leader.

Radical Aliveness developed three hard and fast rules – our only rules: don't hurt yourself physically, don't hurt another physically (though feelings WILL get hurt) and don't hurt the room. Everything else is welcome.

This supports a process that becomes very organic. We hold a space for mystery to guide us – never knowing what will emerge. Life leads the way. It requires standing in a profound "not knowing" and being comfortable with chaos. It requires trust that human beings have lived a life before they met us, and come to us with wisdom, ways they have learned to survive with dignity and power. It helps us know deeply that we are not broken, that there is nothing to fix.

Because the group process welcomes all expression and energy and the willingness to allow chaos, many powerful feelings, judgments, and beliefs emerge that might normally remain underground in a more controlled atmosphere. We welcome that. There is nothing that comes out of us that is not part of being a socialized human. Once in the open and received in non-shaming ways, we have an opportunity to see things we have been afraid to see. We have an opportunity to understand where these attitudes, beliefs, and feelings come from. Faced with more information, we have the space to "heal," and many times to change our hearts and minds.

Of course, Radical Aliveness is not for everyone. There are people for whom this way of working is not helpful, so we work hard to make sure that people understand what they are walking into. However, as intense as this work is, there is a sense of safety and trust, and profound relief that there is a place where all these feelings can be held and allowed. Our goal has been to support human beings to navigate life from the here and now and with CHOICE.

This brings me to the work we are doing in Israel and Palestine today.

Applying the work in Israel and Palestine

In 2006 I was at the Esalen Institute to lead a workshop. At the cocktail party for workshop leaders, I met an amazing woman from Israel talking about the work she did with Jews and Palestinians. Her name was Nitsan Joy Gordon. She had been doing this work for many years, and when she spoke, I was called. I had been developing *Radical Aliveness* for four years at that time. A powerful voice told me to tell her I wanted to work with her.

Nancy Lunney Wheeler, the head of programming, invited her to bring a group of Palestinians and Jews to Esalen the following year. When Nitsan asked whom she should work with from the leaders who worked at Esalen, Nancy, in her incredible intuition, suggested me.

Nitsan and I met in 2007 to work together for the first time. I had no idea what I was doing, and I knew that what these women had experienced was something that I had never experienced. What I did know was that I was not afraid of powerful feelings or conflict. The women had been with other leaders before me at Esalen who were wonderful, but

the full force of their rage, grief, and fear had not been allowed to emerge. By the time I arrived they were ready to explode – and they did! It was the beginning of a long and beautiful collaboration between me, Nitsan, and our Palestinian partner Silvia Margeyah.

Together Beyond Words is the organization Nitsan runs. She had found ways to bring Jewish (Ashkenazi and Sephardic) and Palestinian (Christian, Bedouin, Druze, and Muslim) women together through dance, touch, and listening partnerships for the past number of years. Our work was a perfect fit. In the years since then we have grown and developed together, influencing each other's work with this population. By 2014 we started including men in the groups. We worked together at Esalen a number of times, at the Omega Institute, and in Israel and Palestine. During this time, we experimented, grew, and worked with many people.

Three years into the work in Nairobi, I stopped my collaboration with *Together Beyond Words* because as I was learning more, I became aware that as much as people loved the work, I didn't know enough to be doing it responsibly and without imposing my filter on their bodies, spirits, and beings. I needed more information and awareness. After I had been in Nairobi for six years, I felt informed enough to return.

Since that time our work has matured and spread in Israel/Palestine. Right now, we are doing a two and a half-year *Radical Aliveness training* program for leadership, training

Left to right: Ann Bradney, Silvia Margeyah, Nitsan Joy Gordon

We believe pain that is not transformed is transmitted, and have been creating safe havens where participants learn to transform their inner pain related to the conflict into understanding and empathy toward the "other."

Palestinians and Jews in this way of working. We use three languages – Arabic, Hebrew, and English. We translate everything because language is a conduit for power. We also do workshops for people in Israel and the West Bank. Many times, people are in the room with others they have only heard about through the media, sometimes harboring a historic hatred or fear. This process allows us to move beyond the categories and simple stories people have about each other, and invite the complexity that exists in each of us. It does not lead to a cozy "we are all the same" place, but instead to a mature place that asks us to listen to different perspectives, come to deeper understanding of each other, and often to a feeling that even with our differences, we are connected and need each other for our very survival. Rage and tears flow, hearts open, people walk out changed. This is the goal.

Pain that is not transformed is transmitted

Radical Aliveness and Together Beyond Words are doing powerful, bold, outside-the-box work that we don't believe anyone else is doing with these challenging and motivated populations. We are not afraid to engage the deep feelings and chaos that have led to generational patterns of violence. We believe pain that is not transformed is transmitted, and have been creating safe havens where participants learn to transform their inner pain related to the conflict into understanding and empathy toward the "other." We are three women – an American, Ann Bradney; a Palestinian Israeli, Silvia Margeyah; and an Israeli Jew, Nitsan Joy Gordon.

Finally, I leave you with two voices and reflections, one Palestinian from the West Bank, and one Jewish, from our last training module. As rockets fell outside and sirens sounded, this committed group stayed and did the work of "heart justice."

> *As a Palestinian born under occupation, and living in Ramallah under Israeli military rule, "apartheid," I was subjected to many violent situations, which I carried in my heart. That is until I got to know the group (Radical Aliveness), and worked with them for a full week – Arabs and Jews, women and men, hand in hand, supporting each other to overcome crisis. We are not distinguished by religion or nationality; we support each other and preserve our humanity. I didn't imagine that it was possible to change to this extent. I now see the world from another perspective; this gathering and these people, they are the only ones who gave me hope in life.*
>
> —S., Palestinian, West Bank

Want a surreal experience? Here you go.

While outside there is war, and rockets are falling on both sides, a group of Israelis and Palestinians spend a whole week together – and agreed to meet whatever comes up. Could you imagine that?

It's not such a beautiful and polite meeting. It's a stormy, noisy meeting full of everything. And when the news about the rockets begins to filter in, during the middle of the week, we sit in pairs, back-to-back, and just support one another. Leaning on each other. Physically. Emotionally. Mentally.

Oh my god, how much pain is there.

And pain is pain. No matter who's it is.

Is that not clear?

And we agree to stay. And deal with all that comes up.

Because if we don't succeed, with all the love we have between us, what chance do we have at living here together?

And if we are able to create a safe space for the feelings, then solving the problem of borders is really a small task. Because the solution isn't that complicated, even if we don't know what it is yet.

The history of our Earth is full of conflicts that raged for years, conflicts that people believed would never end. Then at some point, the conditions matured and peace broke out.

This weekend I am thankful for the insight I received into what the world could look like when people choose to feel what is theirs to feel, rather than act it out, fight, or flee.

We have endless opportunities to practice this in our everyday lives. Shall we give it a try?

—H., Israeli Jew

Let us walk together.

Ann Bradney founded and directed the Radical Aliveness Institute, a four-year professional program based in Los Angeles, from 2008 until 2021. In the 1990s, she studied under Core Energetics pioneer John Pierrakos, and served on the faculty at the Core Energetics Institute in New York until 2002. She co-directed the International Radical Aliveness Practitioner Program based in Nairobi, Kenya, for six years, and now leads a two and a half-year Radical Aliveness Peace Leadership Program for Jews and Palestinians in Israel and Palestine. Ann developed the original concepts and practices of Radical Aliveness over the past 20 years. Her innovative approach to working with individuals and groups expands beyond the realm of psychology and personal issues to address community healing and systemic issues, with the goal of creating a more just world.

info@radicalaliveness.org
www.radicalaliveness.org

PERSONAL VIEWPOINT

Why War?

Corrections and Additions

Courtenay Young

In the last issue of this journal (Vol. 21, No. 2, 13-22), I commented on warfare in the human species, *Homo sapiens*, as follows:

> *"... The human animal is possibly the only animal on the planet that conducts sustained aggression (warfare) against others of its own species."*

I have since discovered that this statement is factually incorrect; I present my apologies. There is at least one other species that regularly conducts a form of warfare: one of our nearest relatives, the chimpanzee, *Pan troglodytes*.[1]

I recently watched a four-part Netflix series, *Chimp Empire*, about troops of chimpanzees in the Ngogo forest in Uganda's Kibale National Park (which contains the largest known group of chimpanzees in the world). This group has been studied for 20 years.[2] The makers of the film spent years filming facets of chimp life that have never before been seen on film – including the first film about Ngogo chimpanzees, *Rise of the Warrior Apes*, by the same filmmaker, James Reed, in 2017.

While aggression between rival groups of chimpanzees was fairly well-known, what was exceptional and captured in these films was that the original central group had split into two or three other groups occupying neighboring territory.

Chimpanzees are extremely territorial, and so there arose a great rivalry between the larger central group and the more closely-bonded western factions of these chimpanzee groups. They have an incredibly complex society, and can form very strong and sophisticated social politics and familial relationships – forming alliances, building trust, caring for one another, and often going head-to-head in never-ending fights for power.

These films, made over a 20-year period, give new insights about the violence, brutal power struggles, rivalry, enmity, friendship, and diplomacy within the strictly hierarchical primate group, and also about the territorial rivalry between neighboring groups. There exists actual warfare against other chimpanzee groups, and severe aggression towards conspecifics (members of the same species) on a regular basis.

Chimpanzees are very dependent on their food sources – mainly fruit trees. Since different types of fruits come in season at different times, there is a territorial imperative to access these trees. Competition is rife, and there is no sharing outside the resident

1. Chimpanzees share about 98% of their DNA with humans.
2. For more information about the Ngogo Chimpanzee Project, see campuspress.yale.edu/ngogochimp/project/

group. The most important source is the giant fig tree, *Ficus mucuso*, which does not fruit seasonally, and which produces enormous fruit crops, some of which are available most of the time. The brutal group hunting of other monkey species is common. Monkeys (especially the red colobus) who also eat this fruit are regularly chased away, and are often caught, killed, and eaten.

An emergent property of between-group competition is evolutionary group dominance, which increases the size of the chimps' territory and reduces neighbor pressure in wild chimpanzees (Lemoine *et al.*, 2020; Amsler, 2009). Increases in the number of males in a group lead to territorial increases, suggesting the dominant role of males in territory acquisition. Males regularly go out in groups on patrol to maintain – and extend – the boundaries of their territory. If they meet a single chimpanzee from another group, they will kill. Patrolling chimpanzees cover long distances, and patrols are likely to involve energetic costs for participants, as well as considerable dangers.

Meeting up with a smaller number from another group results in warlike behavior (with the use of weapons – stick and stones – and individuals will be hurt and killed until the smaller group flees, which results in territorial extension for the larger group. However, cohesion within a group is also significant, as a closely-knit group will work together better than a group with inherent rivalries, even if that group is larger.

These sorts of anthropological observations have stimulated numerous comparisons between chimpanzee violence and human warfare over neighboring groups. Male chimpanzees compete with males in other groups over territory, food, and females, and base their decisions to attack strangers on assessments of numerical strength. They strive for dominance over neighboring groups (Wilson & Wrangham, 2003). This is, in effect, a form of warfare:

> *Humans inherited a propensity for violence from our primate ancestors, a new study says, making it easy to think, "Ah, see – we really are just animals." But that doesn't give animals enough credit. The first humans were about as violent as could be expected based on their family tree, researchers report* (http://nature.com/articles/doi:10.1038/nature19758) *September 28 in the journal Nature. The scientists pored through examples of lethal violence – not animals killing other species, such as predators and prey, but killings within a species, whether by cannibalism, infanticide, or aggression.*
>
> *More often, though, people think animals are more violent than they really are, says animal behavior expert Marc Bekoff, an emeritus professor at the University of Colorado Boulder. "Violence might be deep in the human lineage, but I think people should be very cautious in saying that when humans are violent, they're behaving like nonhuman animals," Bekoff says.*
>
> *Bekoff has long contended that nonhumans are predominantly peaceful, and he points out that just as some roots of violence can be found in our animal past, so can roots of altruism and cooperation. He cites the work of the late anthropologist Robert Sussman, who found that even primates, some of the most aggressive mammals, spend less than one percent of their day fighting or otherwise competing.*
>
> *These differences among primates matter, says Richard Wrangham, a biological anthropologist at Harvard known for his study of the evolution of human warfare. In chimpanzees and other primates that kill each other, infanticide is the most common form of killing. But humans are different – they frequently kill each other as adults. "That 'adult-killing club' is very small," he says. "It includes a few social and territorial carnivores such as wolves,*

> *lions, and spotted hyenas." While humans may be expected to have some level of lethal violence based on their family tree, it would be wrong to conclude that there's nothing surprising about human violence, Wrangham says. When it comes to murderous tendencies, he says, "humans really are exceptional."* (Engelhaupt, 2016)

Wrangham's book (1996) explores, in a meticulous manner, some of the controversial issues about human aggression when examined anthropologically. It unfolds a compelling argument that the secrets of a peaceful society may well be, first of all, power-sharing between males and females, and second, a high level and variety of sexual activity (both homosexual and heterosexual). The authors "*... present evidence that most dominant human civilizations have always been likewise behaviorally patriarchal, and that male humans share male chimpanzees' innate propensity for dominance, gratuitous violence, war, rape, and murder. They [also] claim that the brain's prefrontal cortex is also a factor, as humans have been shown experimentally to make decisions based both on logic and prefrontal cortex-mediated emotion.*"

They quote an example of primate behavior in bonobos (*pan paniscus*), sometimes called pygmy chimpanzees, who live in a predominantly matriarchal system and are unique for their female-biased dispersal relationships, which encourage resolution and peacemaking tactics among the group, and discourage violence and war. Bonobo social structures reject aggression, and focus on the power of cooperation, and how it benefits the group's overall survival. Since male violence is, by most counts, evolutionary undesirable (as well as being morally reprehensible), and – given modern weapons – it threatens the existence of the whole species. While they quote some figures that suggest that violence has been decreasing in some human societies, they also make the case that human males are genetically predisposed to violence, but that the human species also has the intellectual capacity to override this flaw – if society recognizes it's in the interest of our survival to do so.

Given this background and the evolution of humans from a chimpanzee-like ancestor five million years ago, we can begin to look at human aggression in a different light. James DeMeo, an author from a Reichian tradition, has written a fairly massive tome "proving" a geographical basis to human aggression. He seems to ignore its biological and evolutionary basis, and his conclusions are thus somewhat debatable.

The basis of his theory is that the much harsher environment to be found around the world's major desert area, which he calls *Saharasia*, the title of his 500+-page book) seems to provoke a much more violent and misogynistic culture. That may well be true, but it is not the whole picture. I am not questioning his detailed research, but, when combined with the evolutionary perspective dating back over the past five million years or more, the conclusion he reaches about the cultural developments of the last 6,000 years is perhaps incomplete.

Given the territorial imperative that we have almost certainly inherited from our common ancestors, and ably shown in this film series about chimpanzees, it is more than likely that when environmental conditions are harsh and food supplies short, as in desert and near-desert environments, our inherited aggressive potential becomes exaggerated.

In my own article on the theory of evolution (Young, 2010), I try to look at the significant physiological developments that distinguish us from all other primates – not just hairlessness, but also subcutaneous fat, salt tears, the ability to control our breathing, etc. – and weave them into an environment that can create and account for all these distinguishing features, as well as for the variety of other hominids that evolved and then

disappeared over the last five million years. Latent aggression may even account for the occasional interbreeding between Cro-Magnons and Neanderthals and Denisovans, and yet their inevitable extinction.

Again, my apologies for the informational mistake, and my thanks to the IBPJ editors for the opportunity to correct and add to my previous article.

Courtenay Young
courtenay@courtenay-young.com

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BOOK PREVIEW

The Science of Embodiment

Trauma, Body, and Relationship

Herbert Grassmann, Maurizio Stupiggia, Stephen W. Porges

Herbert Grassmann, together with Maurizio Stupiggia and Stephen Porges, are the editors of a new book, ***The Science of Embodiment: Trauma, Body, and Relationship****, to be released by Norton in 2024. Here, they give us the rationale behind their extraordinary undertaking, and a preview of the contents of the book, which aims to update the theory and principles of our field of somatic psychology. The expanding inclusion of embodied experience, a process increasingly shared across therapeutic and coaching approaches, represents a paradigm shift. To quote the editors: "…[O]ne cannot casually attach bodily techniques to exclusively verbal therapies without radically changing their theoretical and practical structure. In other words, introduction of the body transforms psychotherapy into a somatic psychotherapy."*

It is with great anticipation that we await the release of this seminal volume, and until then, we hope you enjoy this glimpse into the book as it takes form.

Keywords: Embodied science, somatic psychotherapy, trauma, polyvagal perspectives

During the past decade, there has been a dramatic shift in psychotherapy as the impact of the body and nervous system on mental health has been acknowledged. Many forms of psychotherapy, explicitly or implicitly, now integrate an understanding of the nervous system and bodily state into their treatment models. Through both clinical trials and case reports, the body of research on psychotherapy is increasingly documenting impressive evidence of the central role that the client's body, and especially their nervous system, play in the treatment of all psychological disorders, regardless of severity (Lanius, Vermetten, & Pain, 2010; Lanius, Paulsen, & Corrigan, 2014; Cozolino, 2017; Payne, Koch, & Tantia, 2019). Complementing the empirical literature are several clinically relevant theoretical models (Nijenhuis, Spinhoven, Van der Hart, & Vanderlinden, 1996; Martens, Schweitzer, & Herholz, 2023; Rosendahl, Sattel, & Lahmann, 2021) linking mental processes to bodily states, including strong links that are frequently witnessed as comorbidities between mental and physical diagnoses.

Current theoretical mind-body and brain-body conceptualizations have resulted in the psychotherapy community rethinking mental health disorders and treatments. An increasing number of psychotherapists are recognizing the connection between mental processes and bodily function, and no longer treat them as separate entities. In fact, Allan Schore proposed (Schore, 2009) that the inclusion of embodied experience in clinical practice, a process shared across several therapeutic approaches, represented a new paradigm.

The processes involved in the regulation or disruption of physiological states, which underlie thoughts and behaviors, are dynamically adjusting and adapting during each moment of life. Whether we focus our therapies on thoughts or behaviors, our physiological substrate is constantly adjusting to optimize our survival. This is true not only from the perspective of the individual, but also with respect to relationships. Thus, the co-regulation that occurs between individuals reflects an embodied relationship – a crucial dimension for several psychological theories and for most forms of psychotherapy. We can especially see this in cases of trauma. From a neuroscientific perspective, trauma functionally permeates into the survivor's nervous system, retuning it from a dynamic state that supports sociality and homeostatic functions (i.e., health, growth, and restoration) to a chronic state that supports defense (e.g., fight, flight, shutdown). Thus, we witness how trauma becomes physiologically embedded, altering the optimal trajectory of a flexible and resilient nervous system, and profoundly disrupting the development of the experience of self and others.

Reframing trauma from an event to a biological behavioral response transforms our understanding of the consequences of "traumatic" events. From this perspective, the traumatic event is viewed as being capable of overwhelming the survivor's neuroregulatory capacity to support underlying physiological homeostasis and observable resilient and flexible behavior and thinking. The consequence is a general breakdown in the client's physiological and emotional regulatory capacity within themselves and also in relation to the world around them. Treatment becomes a gradual process of repairing these ruptures, involving a co-construction of a new form of functioning within a therapeutic framework that privileges and elevates a sense of safety as an essential condition for transformation and healing.

Complex trauma therapy can be challenging because attachment patterns, based on trust, develop within a neurobiological substrate occurring outside conscious awareness and expressed non-verbally via bodily reactions (Bessel van der Kolk et al., 2001). Mindfulness, somatic exercises, and touch-based interventions are powerful tools for revealing and studying unconscious patterns and facilitating healing. They provide an embodied experience of change within the context of a safe relationship without triggering an explanatory narrative, which would often recruit defensive memories and associations.

A brief description of the book's contents

In *The Science of Embodiment: Trauma, Body, and Relationship*, through the documentation of somatic-oriented practices and theoretical orientations, we attempt to fundamentally transcend the separation between body therapy and psychotherapy. Collectively, the volume supports a transformative view that somatic and psychological problems cannot be treated as disparate domains. Rather, the premise of treating somatic and psychological problems via different therapeutic strategies is challenged by a perspective integrating biological behavioral and neurobiological sciences and clinical observations. Thus, a central message of the book is that no therapy will be effective unless the individual's physiology welcomes and supports it. By accepting such a perspective, the therapist's knowledge, awareness of the physiological state of both self and client, and their capacity to self- and co-regulate, become essential tools for therapy. As therapists, we are engaged in a deep process whose effectiveness is related to our ability to engage.

We will explore several somatic interventions for working with relationship issues through a combination of participant experience and case presentation. Each section of the book is organized to open up new directions in treatment. Identifying competencies is an essential part of defining the somatic psychotherapy profession, and increases its

credibility among other psychotherapy modalities. By establishing clear parameters for therapists, it also contributes to the development of a more robust framework for future research in the field. We aim to highlight a few qualitative and quantitative measures of interoceptive awareness (IA), and build on the conversation for when reactions can be adaptive and lead to further embodiment – especially in realm of self-agency or autonomy, which are arguably most important in the clinical healing process. SPECS, the Somatic Post-Encounter Clinical Summary (Freedman, Silow et al., 2022), a newly designed instrument, will be highlighted for its innovative role in helping clinicians and researchers measure clients' physiological states relative to task and treatment efficacy. A wide variety of different clinical approaches within somatic therapy will be presented, including chapters on touch work, the relationship between fascia and emotion, deep brain reorienting, post-traumatic growth, the treatment of trauma and addiction, the impact of yoga in treating sexual trauma, and the benefits of creating a sense of safety during birth.

Several chapters provide guidance for healthcare practitioners seeking to incorporate interoceptive practices, which we believe will lead to better choices in caring for both themselves and others. The book emphasizes a common theme: when healthcare providers are informed by the wisdom of the body and practice self-care, they tend to pass this value on to their clients, which leads to more effective care of others. By cultivating interoceptive practices, healthcare providers can enhance their resilience in high-stress professional contexts, benefiting both themselves and their clients.

Each chapter will be organized by following these six guidelines:

1. Tools for somatic assessment, including the ability to monitor both the client‘s and therapist's own physiologic al states. There are several tools that can be used to assess somatic features and to infer physiological state. Below are a few examples, although the chapter's authors will not be constrained by this list. These tools can be combined to provide a more comprehensive assessment of the client's somatic state, and guide interventions that address both emotional and physiological needs.
   - Observations of the client's body language, facial expressions, and nonverbal cues. These observable features can provide valuable information about the client's emotional and physiological state. For example, a client who is slouching, fidgeting, or avoiding eye contact might be experiencing anxiety or discomfort.
   - Monitoring the client's heart rate, blood pressure, and respiration rate can provide important information about their physiological state. These measurements can be taken using inexpensive instruments such as a blood pressure cuff, smartphone app, or pulse oximeter.
   - Through biofeedback techniques, a client can learn to become more aware of and more efficient in controlling physiological variables, such as muscle tension, skin temperature, and heart rate variability.
   - Therapeutic techniques such as Somatic Experiencing® can provide the client with greater awareness of bodily sensations and physiological reactions, which enhances their ability to regulate physiological responses. Polyvagal Theory, as a model of the nervous system's reactions to challenges, enables the therapist to provide the client with an intuitive and understandable narrative of bodily reactions, along a continuum from safety to life threat. By understanding the theory, therapists can become more proficient in reading their client's physiological state and tailoring interventions to their specific needs.
2. Develop a structured diagnostic framework to evaluate the client‘s physiological state. Each author has the freedom to creatively propose a structured diagnostic framework that can be used to evaluate a client's physiological state. This can be implemented

through well-defined protocols, including specific challenges and tasks. By using a structured diagnostic framework, a client's physiological state can be evaluated and a therapeutic strategy can be developed to address their vulnerabilities and challenges.

- ***Interoception***. Interoception refers to the ability to perceive and interpret internal bodily sensations, such as hunger, thirst, pain, and emotional arousal. To evaluate a client's interceptive abilities, the therapist could:
  - ask the client to describe bodily sensations they are currently experiencing, and the emotions associated with them.
  - use biofeedback to measure the client's physiological responses to different stimuli and help them learn to regulate their bodily sensations.
  - observe the client's nonverbal cues, such as facial expressions, body language, and breathing patterns, so as to infer their emotional state.
- ***Proprioception***. Proprioception refers to the ability to perceive the position, movement, and orientation of one's own body in space. To evaluate a client's proprioceptive abilities, the therapist could:
  - ask the client to close their eyes and move their limbs in different directions, and describe the position of their limbs as they move voluntarily.
  - use physical tests, such as balancing on one leg or walking heel to toe.
  - observe the client's movements and posture, and make note of any irregularities or asymmetries.
- ***Kinesthesia***. Kinesthesia refers to the ability to sense the force, effort, and tension required for different movements. To evaluate a client's kinesthetic abilities, the therapist could:
  - ask the client to perform simple movements, such as lifting a light object or pushing against resistance, and then ask them to describe the force and effort required.
  - use instruments such as dynamometers or grip strength meters to measure the client's strength and force.
  - observe the client's movements and make note of any irregularities or difficulties.
- ***Balance***. Balance refers to the ability to maintain stability and control while standing or moving. To evaluate a client's balance abilities, the therapist could:
  - ask the client to perform different standing or walking tasks, such as standing on one leg or walking on a balance beam, and observe their control.
  - use instruments such as force plates or computerized balance assessments to measure the client's balance control and sway.
  - make note of any balance limitations or difficulties, and observe how the client compensates for them.

3. Describe how neural regulation, expressed in self- and co-regulation, is embedded in the proposed somatic approach. In this context, neural regulation refers to the process by which the nervous system modulates and regulates the body's physiological responses. In somatic applications, neural regulation can be used to help individuals self-regulate their bodily sensations, physiological reactivity, and emotions, or to co-regulate with others in social and therapeutic contexts.
   - ***Self-regulation***. Self-regulation refers to the ability to monitor and modulate one's own physiological responses to different stimuli. This can be achieved through techniques such as mindfulness, deep breathing, and relaxation exercises, which activate the parasympathetic nervous system and help reduce stress and arousal. By practicing self-regulation techniques, individuals can become more aware of their bodily sensations and emotions, and learn to regulate them more effectively.
   - ***Co-regulation***. Co-regulation refers to the process of regulating one's physiological responses in response to another person's cues and signals. This can occur

in social interactions, where individuals may unconsciously synchronize their breathing, heart rate, and other physiological responses with those of others around them. In therapeutic contexts, co-regulation can be used to help clients regulate their emotions and bodily sensations in the presence of a supportive therapist or group.

The principles of self- and co-regulation are often applied in somatic therapies, such as Somatic Experiencing® and Sensorimotor Psychotherapy. These therapies aim to help clients regulate their bodily sensations and emotions through techniques such as breath work, movement, and touch. By practicing self- and co-regulation, clients can learn to regulate their physiological responses more effectively, leading to improved emotional regulation, stress reduction, and overall well-being.

4. Demonstrate the hierarchy of autonomic nervous system (ANS) states, and how to work with them therapeutically. The following description of the hierarchy of ANS states illustrates how to work with them within a therapeutic context. By understanding these states, therapists can tailor their interventions to help clients regulate their physiological responses, and achieve states of optimal arousal and well-being. Therapies such as Somatic Experiencing® and Sensorimotor Psychotherapy, and others informed by Polyvagal Theory, are based on the principles of ANS regulation, and can be effective in helping individuals heal from trauma, reduce stress and anxiety, and improve their overall functioning.
   - ***Hypoarousal***. This state is characterized by low levels of physiological arousal, such as low heart rate, blood pressure, and breathing rate. Individuals in a hypoaroused state might feel sluggish, numb, or disconnected from their bodies and surroundings. Therapeutic work with individuals in this state can involve gentle physical touch, movement, or sensory stimulation to help them become more aware of their bodily sensations, and increase physiological arousal.
   - ***Resting state***. This state is characterized by a baseline level of physiological arousal in which the body is relaxed and at ease. Individuals in this state may feel calm, centered, and grounded. Therapeutic work with individuals in the resting state can involve mindfulness, meditation, or relaxation exercises to help them remain calm and reduce stress and anxiety.
   - ***Sympathetic activation***. This state is characterized by high levels of physiological arousal, such as increased heart rate, blood pressure, and breathing. Individuals in this state may feel anxious, fearful, or agitated. Therapeutic work with individuals in a sympathetic state may involve techniques such as deep breathing, progressive muscle relaxation, or cognitive restructuring to help them regulate their physiological responses and reduce anxiety and arousal.
   - ***Hyperarousal***. This state is characterized as a consequence of experiencing an extreme level of physiological arousal, such as panic, terror, or rage. Individuals in this state may feel overwhelmed, out of control, or disconnected from reality. Hyperarousal has metabolic causality, and the body cannot sustain it for extended periods without eventually shifting to hypoarousal as a result of feedback circuits that regulate the autonomic nervous system. In the therapeutic context, working with individuals in this state can involve techniques such as grounding, sensory modulation, or trauma processing to help them regulate their physiological responses and stabilize their emotional states.
5. Describe how traumatic experiences influence the ability to build strong co-regulatory relationships within the therapeutic context. Therapists should be aware of the potential impact of trauma on co-regulation and adapt their approaches accordingly. This may involve creating a safe and supportive environment, using trauma-informed

approaches to build trust and establish a sense of safety, and working collaboratively with clients to help them regulate their physiological responses and develop more secure attachment patterns. Therapeutic approaches such as Somatic Experiencing®, attachment-focused therapy, and trauma-focused cognitive behavioral therapy can be particularly effective in helping individuals who have experienced trauma to build stronger co-regulatory relationships within the therapeutic context.

- Traumatic experiences can have a significant impact on an individual's ability to build strong co-regulatory relationships within the therapeutic context. Trauma can be defined as an event or series of events that overwhelm an individual's ability to cope, resulting in a sense of helplessness, terror, or horror. Trauma can have lasting effects on an individual's nervous system, leading to difficulties with emotional regulation, attachment, and social interaction.
- One of the key ways that trauma can impact co-regulation within the therapeutic context is through disruptions to attachment patterns, which may have enduring influences on subsequent relationships. Attachment refers to the emotional bond that forms between an infant and caregiver, and it plays a critical role in the development of social and emotional skills. Traumatic experiences can disrupt attachment patterns, leading to difficulties with trust, intimacy, and emotional connection. Individuals who have experienced trauma may struggle to form secure attachments with others, and may have difficulty building strong co-regulatory relationships within the therapeutic context.
- Additionally, trauma can impact an individual's ability to regulate their own physiological responses, which can in turn make it more difficult to engage in co-regulation with others. Individuals who have experienced trauma may be hyperaroused or hypoaroused, making it challenging to engage in social interactions and connect with others on an emotional level. They may also experience dissociation, which can result in a sense of detachment from themselves and their surroundings, which further hinders their ability to form meaningful connections with others.

6. Describe the concept of relational well-being and how it relates to context, choice, and connection.
   - Relational well-being refers to the quality of an individual's relationships and their overall sense of connectedness and satisfaction with their social environment. It encompasses a range of factors, including emotional intimacy, social support, sense of belonging, and trust.
   - Context is an important aspect of relational well-being, as it shapes the nature and quality of social connections. Context refers to the social and cultural environment in which an individual lives, including factors such as family, community, and broader societal norms and values. Different contexts can provide different opportunities for connection and choice, and can impact an individual's sense of well-being in different ways.
   - Choice is also a key aspect of relational well-being, as it reflects an individual's ability to make meaningful decisions about their social connections and interactions. Having agency and autonomy in choosing relationships can lead to a greater sense of fulfillment and satisfaction, while a lack of choice or control can lead to feelings of disconnection and disengagement.
   - Connection is at the heart of relational well-being, as it reflects the quality and depth of an individual's relationships with others. Strong connections are characterized by mutual trust, respect, and empathy, while weak connections can lead to feelings of isolation and loneliness.

Overall, the concept of relational well-being highlights the importance of social connection and support in promoting overall well-being. It underscores the need for individuals to have agency and choice in their relationships, and to be mindful of the context in which those relationships develop. By fostering strong connections and prioritizing relational well-being, individuals can lead happier and more fulfilling lives.

A science of correlation or an embodied science

Beneath the exploration of embodied practices embedded in existing psychotherapeutic practices, there is a need to examine scientific rationales for addressing embodiment in both quantitative and qualitative research paradigms to help provide a platform for future research programs. This volume will focus on reframing psychotherapy to expand beyond dialogue, memory retrieval, and behavior to include an objective appreciation of both the client's and therapist's bodily states through reliable metrics, which would include monitoring autonomic function (e.g., heart rate variability) and structured questionnaires assessing bodily feelings (e.g., Body Perception Questionnaire, 1993; Neuroception of Psychological Safety Scale, 2022).

Introducing the body into treatment requires changing aspects of the clinical treatment model, including diagnostic and prognostic criteria. This would lead to conceptualizing healing processes within a relational dimension, which might include touch, as frequently employed in forms of somatic-oriented therapies (SOT). A central message is that therapy can be efficiently delivered only if the therapist is trained to detect the cues of safety and threat that are broadcast by clients. Therapists gain this skill by learning to infer autonomic state from facial expressions, vocal intonation, muscle tension, and gestures, because these overt markers are linked to the neural regulation of our viscera, including our neural calming system that involves vagal regulation of the heart. Moreover, therapists need to be trained to discern their own bodily reactions (i.e., interoception) to their clients, and to appreciate that clients are responding to their physiological states.

This book does not advocate any particular therapeutic approach or training orientation. It does, however, recognize influences from other disciplines, including occupational and physical therapy as well as dance therapy and sensory integration, as important contributions. It is structured to examine and explore the embodied scientific foundation of several therapeutic methods. In this context, the embodied phenomenology of diagnostics are critically contrasted with symptom-driven diagnostic systems (i.e., DSM-V, ICD-10).

The novelty of this book is centered on the relational perspective of treatment. Prior to this publication, most strategies to either study or treat trauma have focused on the client's range of function and identifiable features of malfunction. This volume, by starting from the realm of body interaction and mutual co-regulation, emphasizes the importance of relational complexity in transforming the client's physiological and emotional regulation. In treating trauma, and especially complex trauma, the environmental and relational context is crucial, and influences both the client's and therapist's biobehavioral state and the dynamic relational atmosphere created in the therapeutic setting.

This book is designed for a professional audience interested in learning about the field of clinical somatic-oriented therapies (SOT) as an applied science of embodiment research and treatment. It is timely and consistent with contemporary neuroscience research (e.g., Porges, 2021, 2022), which has informed trauma treatment by illuminating the importance of bodily experience for self-regulation and interaction with others in a social context. Human behavior, especially in traumatic situations, is understood as a complex and fully embodied biobehavioral process expressed in thoughts, feelings, and behaviors that

are driven through neurophysiological sensors detecting features in both our body and external environment. This integrated sensory-motor system dynamically adjusts aspects of physiology, perception, behavior, and motivation to enhance our ability to cope with a full range of dynamic challenges, ranging from cues of safety to those of threat.

Weaving long-established somatic approaches into treatment models that have formerly ignored the body

Currently, the consideration of physiology is not prominent in many forms of psychotherapy. Because some clients do not benefit from highly cognitive verbal methods like talk therapies, the integration of more physiologically-oriented approaches would expand the toolbox of therapists working with dysregulated nervous systems.

During the past few decades, there has been a trend in trauma treatment where several "talk"-focused psychotherapies have attempted to incorporate techniques and methods that were developed in somatic-oriented therapies. As therapists cope with the challenges of treating trauma, there has been increased interest in integrating somatic-oriented perspectives and techniques within traditionally verbal approaches. Clinical evidence documents that the clinical course of trauma patients is enhanced by incorporating body-oriented techniques (Gene-Cos, N., Fisher, J., Ogden, P., and Cantrel, A., 2016). By including a body perspective, many more traumatized patients can be effectively treated. Therapy is conceptualized as a process of mutual co-construction where the therapist influences the client's physiology, nervous system, and self-regulatory capacity. In complex trauma, the subject loses both the ability to regulate biobehavioral state and the capacity to process regulatory stimuli from the other. For this reason, relational techniques that influence and normalize bodily functions are proliferating, including those listed below:

- Treating disorders of embodied self-awareness
- Using sensory processing as a layer of experience in human development
- Improving the capacity for embodied emotional attunement
- ntegrating autonomic regulation into therapy
- Strengthening self-regulation through dyadic co-regulation

The success of these techniques depend upon the theoretical basis on which somatic-oriented therapies are founded. The body-mind unity, which is dependent upon bi-directional neural communication between brain and body, is the basic assumption upon which various forms of SOT have evolved. Thus, the current status of contemporary neuroscience provides a theoretical basis for treatments and investigations of SOT strategies within an integrated mind-body-brain theoretical model. Embodied methods could be useful in understanding difficult-to-treat conditions, such as autism, chronic pain, and medically unexplained symptoms – or in the diagnosis and therapy of neurodiversity.

An important point is that introducing the body into treatment means changing other aspects of the clinical treatment model, including diagnostic and prognostic criteria. This would lead to conceptualizing the healing processes within a relational dimension, including the role of touch, which is frequently employed in forms of SOT.

This means that one cannot casually attach bodily techniques to exclusively verbal therapies without radically changing their theoretical and practical structure. In other words, introduction of the body transforms psychotherapy into somatic psychotherapy.

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Herbert Grassmann, **PhD**, is Chair of the Science and Research Committee of the European Association for Body Psychotherapy. He is Professor of Psychosocial Studies and Bodymind Healing; Fellow, Parkmore Institute, South Africa, Johannesburg, and teaches at Maltepe University in Istanbul. Scientific Advisory Board "Polyvagal Gesellschaft e.V." He is the founder of the SKT Institute and Director of the European Institute for Somatic Trauma Therapy. He is currently training osteopaths and physical therapists in a method he developed called Polyvagal Embodiment Training (PET). His extensive research has focused on both the development and evaluation of interpersonal neurobiological models, and on bridging the gap between attachment and dissociation theories within a somatically-focused model of trauma therapy. As a trauma specialist, he has conducted trainings in South America (Brazil, Colombia, Mexico) on the treatment of trauma, with a particular focus on the phenomena of domestic violence and chronic pain

Maurizio Stupiggia, **PhD**, is Professor at the Department of Clinical Sciences – Faculty of Medicine and Surgery, University of Milano, and has worked for many years as a body psychotherapist with individuals and groups. For several years, he worked at the Italian Ministry of Health, where he assisted the integration of immigrants. For the past ten years, he has supervised therapists and educators responsible for immigrant women from Africa who are victims of various traumatic abuse in war. With Jerome Liss, he is co-founder of the International School of Biosystemics. He has worked for 20 years in Japan with survivors of major earthquakes. With Rubens Kignel, he co-founded the Bio-Integral Institute of Body Psychotherapy in Tokyo. He has worked as a trainer in European countries, as well as Japan and Latin America.

Stephen W. Porges, **PhD**, is a Distinguished University Scientist at Indiana University, where he is the founding director of the Traumatic Stress Research Consortium. He is professor of psychiatry at the University of North Carolina, and professor emeritus at the University of Illinois at Chicago and the University of Maryland. Dr. Porges served as president of both the Society for Psychophysiological Research and the Federation of Associations in Behavioral & Brain Sciences, and has received a Research Scientist Development Award from the National Institute of Mental Health and the Pioneer Award from the United States Association of Body Psychotherapy. He has published more than 400 peer-reviewed scientific papers that have been cited in more than 50,000 peer-reviewed publications.

In 1994 Dr. Porges proposed the Polyvagal Theory, which links the evolution of the mammalian autonomic nervous system to social behavior, and emphasizes the importance of physiological state in the expression of behavioral problems and psychiatric disorders. He is the creator of a music-based intervention, the *Safe and Sound Protocol*™, currently used by approximately 3,000 therapists to reduce hearing sensitivities, improve language processing, and increase spontaneous social engagement. He is the author of *The Polyvagal Theory: Neurophysiological Foundations of Emotions, Attachment, Communication, and Self-Regulation*, *The Pocket Guide to the Polyvagal Theory: The Transformative Power of Feeling Safe*, and *Polyvagal Safety*, as well as co-author with Seth Porges of *Our Polyvagal World: How Safety and Trauma Change Us*, and co-editor with Deb Dana of *Clinical Applications of the Polyvagal Theory: The Emergence of Polyvagal-Informed Therapies*. Dr. Porges is a founder of the Polyvagal Institute.

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BOOK REVIEW

The New Collected Papers of Biodynamic Psychology, Massage and Psychotherapy: 2022

E-book edited by Courtenay Young

Mark Ludwig

Scholars and students of somatic psychology and psychology have just received an enormous legacy gift. With the e-publication of *The New Collected Papers of Biodynamic Psychology, Massage & Psychotherapy: 2022* we are presented a uniquely valuable, large, and accessible archive of writings from the beginning of the modern body psychotherapy movement. I believe it is safe to say that not many readers of this review, outside the Biodynamic communities, have ever seen or read any of these 150 articles, which were written and published between 1970 and 2022. Their voices tell the story of a vibrant professional community engaged in serious collegial exchange on essential questions still under discussion today within our larger community: the essential processes of regulation; models of organismic integration; the qualities of bio-energy; the science underlying clinical practice, work with the self-righting capacity of clients; the role of emotional expression in psychological health; the relationship between psychodynamics and biodynamics; vegetative resonance in therapy; and the impact of instrumental touch on psychological states, among others.

Perhaps because we somatic psychotherapists sometimes identify ourselves as a branch of *psycho*therapy, it's somewhat controversial today in our field to place the emphasis on "somatic" vs "psychological" when discussing our work. I believe and hope that we represent a kind of new health enterprise, a whole-person model of integrated functional life processes. Clearly the detailing of these foundations remains a vast horizon, but Boyesen's position was very clear: the body itself must share the central focus of clinical theory and practice.

> "Gerda Boyesen, a pioneer before her time, never tired of advocating that the body "has a mind of its own" and that the gut-feelings have their own 'intelligence'! She – and all the people she trained – have applied this knowledge in their therapeutic work and have been bridging an essential gap in the understanding of a person's integral psyche-and-soma: these are indivisible. This is a unifying principle of all the different Body Psychotherapies that have descended from Wilhelm Reich's pioneering work."
>
> "The technique of 'dynamic relaxation' consists of a special form of massage, which aims the whole time to furthering abdominal respiratory release and, in this way, towards giving a relaxation so deep that underlying, repressed emotional patterns are awakened and especially those containing traumatic autonomic responses. In this way, we can influence both the repressed emotions and the associated psychological material."
>
> —From the 2nd Preface by Ebba and Mona-Lisa Boyesen

This timely work was imagined, organized, and edited by Courtenay Young, himself a student of Gerda Boyesen and Biodynamic psychology in London in the 1970s. This compilation was built through the cooperation of the international Biodynamic professional community, its various professional publications, and the somatic psychology journal *Energy and Character*, founded by David Boadella. Several important one-off articles from additional sources are included by benefit of Courtenay Young's extensive connections and his own editorial acumen.

These works flow from the foundational theory and practice of Gerda Boyesen (1922-2005) and the deep Norwegian body psychotherapy tradition. Boyesen was a Norwegian psychologist and physiotherapist, and a participant in the fertile community around Aadel Bulow Hansen, the woman who, with psychiatrist and psychoanalyst Trygve Braatøy, co-developed the Norwegian school of Psychomotoric Physiotherapy. Within that community, Hansen explored the connection between occupational and war-related stress, muscle tension, changes in respiration, and mental distress. Essentially, these are among the early pioneers in the understanding of autonomic nervous system regulation, a project which continues today as a central focus of our field. Braatøy recruited Hansen to his psychiatric clinic, where she joined a professionally integrated team in the treatment of a spectrum of mental health issues from neurosis through trauma and psychosis. This is a community with a strong grounding in the organismic model of health and wellness, wherein psychodynamics are held as inseparable from biodynamics.

For readers not familiar with the generative contributions of Scandinavian holistic psychotherapists, I would refer you to Michel Heller's informative 2007 two-part article, "The Golden Age of Body psychotherapy in Oslo" in the UK journal *Body, Movement and Dance in Psychotherapy*. The region remains a thriving center for mind-body psychological inquiry and somatic practice. Michel Heller writes:

> "Today, Norway is one of the only European countries in which science and body techniques can associate in a way that can be exploited by health and academic institutions."

Later, Boyesen was also influenced by the work of Wilhelm Reich through her therapy with Norwegian Reichian traditions grounded in Ola Ranknes's Characteranalytic Vegetotherapy. She and the Biodynamic community remained conversant with trends and new ideas in international body psychotherapy as the scene developed, but they remain deeply, and you could even say uniquely, rooted in the organismic/whole person-in-context model. This commitment across many decades is what makes this collection so instructive, and such a welcome exposition of a truly somatic approach to psychotherapy.

It's necessary and relevant to acknowledge again that most of these 150 articles by 50 clinicians have never before been seen by North American body psychotherapists, although the works were all originally published in English in UK professional journals. This may be due to the fact that American neo-Reichian entrepreneurs, almost exclusively male, capitalized on the western European enthusiasm for body-centered psychological approaches, and exported their mindscape through numerous trans-Atlantic training programs, giving Europeans back a, sometimes muddied, version of their own creations. I worked as a European trainer in one such enterprise!

By contrast, the vast majority of papers in this volume are written by European women. The integrative Norwegian tradition evolves from a female line, which includes Nic Wal, Bulow Hansen, Gerda Boyesen, Lillimore Johnson, and, more recently Berit Bunken. Whatever putative gender qualities are operating in this lineage, it seems clear that the tradition and its therapy express a good deal of compassion for human problems-of-living and faith in the somatic intelligence and self-healing capacity of our embodied selves.

Interestingly, some European-trained women like Marion Rosen (Rosen bodywork) and Charlotte Selver (Sensory Awareness), influenced by Elsa Gindler, brought back to the US a feeling for these less-directive, more resonant approaches.

Kate Codrington makes several excellent points in this direction in Article 9.6:

"The body of work Gerda created, Biodynamic Psychology, was different to that of her contemporaries. She brought a female, cyclical sensitivity to her clients and teachings that was entirely absent previously. While her male counterparts tried to 'break' body armor with physical stress, she described herself as a midwife, holding space, waiting and encouraging the body to find its own way to unfold towards expression and regulation while the armoring that was ripe was encouraged to melt away... There was a great deal of importance attached to the therapists' relationship to their own body and the somatic resonance arising from clients' process. Again, something that has become a widespread tool across the board in psychotherapy, somatic movement and therapeutic circles... Biodynamic is a generous, spiritual modality, holding that all humans have the capacity for healing and well-being. She inspired absolute trust in the wisdom of the body and its energy to find its own way... It's a client centered and client led approach, that was established right at the beginning of the client centered, humanistic psychotherapy movement. This trust in energy and our essential 'goodness' is now a common-held, unremarkable tenet from trauma therapy, somatic practices, yoga, through meditation and beyond, yet it was a radical shift at the time before interoception was a thing."

Boyesen learned a relaxation-based model from Bulow Hansen's work, and continued to employ more these "soft techniques" (George Downing), emphasizing presence, attentiveness to the slower rhythms of unfolding tension patterns, and massage interventions to support deep relaxation. It is in attending to these periods of deepening relaxation that Boyesen began to notice how increased sounds of peristaltic activity accompanied moments of both relaxation and integrative insight and understanding. She theorized that the human organism could discharge its tension in two directions: upward and out through the head and extremities, accompanied by the sound and fury of Reich's model, and also downward, and inward, as decreased muscular tension, facilitated by massage and breath work, allowed release and "digestion" of trapped fluids and the body's stress chemistry. Her investigations led her to develop the use of medical stethoscopes to improve her listening. She called her technique "Psycho-peristaltic Massage," and Young's volume contains copious examples of the application of this revolutionary somatic psychology clinical tool.

At 1,552 pages, *The New Collected Papers of Biodynamic Psychology, Massage & Psychotherapy: 2022* is a veritable tome. The material (44.2 MB (44,213,377 bytes) is available for purchase and use by agreement with Courtenay Young through his publication center, Body Psychotherapy Publications (http://www.bodypsychotherapypublications.com). Like psychoanalysis, our field has seldom been of one mind about its foundational theories, and periodically engages in *"split-offs and break aways."* Psychology and psychotherapy are rife with multiple perspectives and, at times, bloody political feuds. In his preface, Courtenay demonstrates his insider knowledge of this community and the history he lived as the Biodynamic community formed and developed in multiple directions. Those who are interested in such histories will find much of interest here.

Courtenay's motivations for this effort are multiple, but always imbedded in his personal development and clinical experience. In the preface he chooses a lovely quote from an Ebba Boyesen article, and continues to reflect on his own process in connection with Somatic Psychotherapy:

> *"To listen to its signals and to become familiar with its plasmatic expressions brings one in touch with a very subtle core of being where instinct and consciousness function in unity. By*

> *following these impulses, one is eventually led to a way of existence in which the life-force can function without undue compromise and can guide the body in a self-regulating harmony. One can almost ask – is this discovery a hitherto unknown law of nature?"*

He continues:

> "I have found this to be very true in relation to the practice of a reasonably steady continuum of 'body awareness' and modern Mindfulness practices: this sort of awareness, this sort of re-"centering" and "grounding" (David Boadella) helps to sustain – and is in harmony with – a moment-to-moment form of inner awareness and emotional self-regulation that provides a much more peaceful, harmonized, dynamic state of ▪ absorption, ▪ inner processing, ▪ affect and ▪ appropriate action. This is not an airy-fairy form of spirituality, nor one sustained by regular prayer or practice, nor one mediated by priests and scriptures, it is more of a medium in which I swim, constantly dipping my awareness both inside and outside: what is within me and what is around me."

If we are to develop our field of somatic psychotherapy and psychology, we will need many and more such volumes of this quality and quantity from which to investigate the development of the essential concepts and practices underlying our clinical paradigm. This publication, edited by Courtenay Young, is an important step in that direction. Somatic psychology scholars and practitioners could rejoice if this intra-modality level of internal discussion and writing became widely accessible. These intra-modality publications offer a level of access to the actions and experience of the practitioner that are of another order from important resources like Marlock et al.'s *The Handbook of Body Psychotherapy*. If the mainstream and sectarian publications of neo-Reichian journals became visible, we could see ourselves more clearly and find a fruitful direction for our development conceptually and clinically. We have this journal, the *International Body Psychotherapy Journal*, and we have *Body, Movement and Dance in Psychotherapy*, and we had, until it ceased publication, nearly five decades of multi-year volumes of *Energy and Character*. More riches like this Biodynamic e-anthology await to resurface into public domains. I am thinking here from my own professional reading over 40 years: *Bioenergetic Analysis • The Clinical Journal of the IIBA*, *The Radix Journal*, *The Hakomi Forum Professional Journal*, *Somatic Psychotherapy Today*, *The Rosen Method International Journal*, Core Energetics' *Energy and Consciousness*, the numerous USABP Conference Proceedings, and the sectarian-moment publications like the multi-volume *Black Butte Conference Proceedings* from the US Bioenergetic community. When you graze in a field as large as *The New Collected Papers of Biodynamic Psychology, Massage & Psychotherapy: 2022* one is apt to lay back and dream from time to time. My dream-du-jour is a searchable archive of our shared thought and practice!

As we attempt today to articulate the underlying assumptions of our field, we will find some of those foundation stones expressed in Biodynamic literature. Many themes in this body of work will be familiar to students and practitioners of somatic psychotherapy. It would only be a distortion and be unfair to the writers to summarize or generalize about these 150 articles. In future issues, I hope to be able use the occasion of this publication to draw out some of the threads of fundamental theory and practice discussed herein.

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The New Collected Papers of Biodynamic Psychology, Massage and Psychotherapy: 2022 can be purchased online at http://www.bodypsychotherapypublications.com

Mark Ludwig, **LCSW**, **SEP**, is a clinical social worker, university lecturer, and somatic psychotherapist in private practice. He completed his Biosynthesis training in 1996. He has served as Program Director of the Somatic Psychology Masters programs at both John F. Kennedy University and the California Institute of Integral Studies. He is currently in clinical and consultation practice in Oakland, CA. A graduate of the Napa-Harvard Children's Hospital Infant-Parent Mental Health Fellowship, he is certificated in Somatic Experiencing, and has also studied extensively with Diana Fosha, PhD, Allen Schore, PhD, Stephen Porges, PhD, Kathy Kain, MA, SEP, and Bruce Perry, MD, PhD.

mludwiglcsw@gmail.com
www.somaticpsychologyassociates.com

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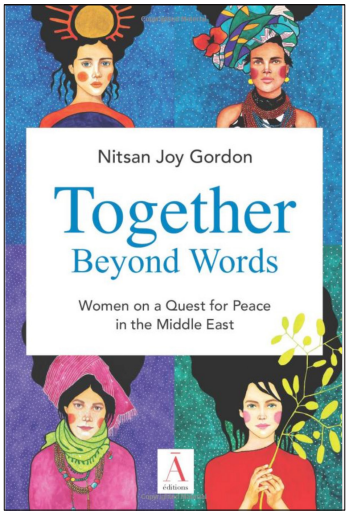
BOOK REVIEW

Together Beyond Words

Women on a Quest for Peace in the Middle East

by Nitsan Joy Gordon

Lisa Monagle



As a child, I was inextricably drawn to the Israeli-Palestinian conflict; it felt like the "mother of all conflicts" at the center of the world. Perhaps I was drawn to the hope that "adults with expertise" in the world would resolve the issues. And yet over time it felt so hopeless, like the never-ending violent conflict I experienced in my home, which affected my own feelings of safety, self-worth, and aliveness.

In her book, *Together Beyond Words; Women on a Quest for Peace in the Middle East*, Nitsan Joy Gordon shares her life's work not as an expert in conflict resolution, but as a mother sitting in a bomb shelter with her children. She envisioned creating peace and a better world for all the children. There and then she made the decision to trust her skills, feel all her feelings, and to try to know the "enemy." It was a conscious choice, a courageous one, and one to which she invites each of us to bring our skills and souls.

In this profound work, Nitsan shares her methods and wisdom tools, which are implemented together with co-facilitators in Israel and Palestine, as well as with colleagues Ann Bradney, Richard Schwartz, Pauline D'Arcy, and through Esalen and the Omega Institute, to name a few. Along with supporters and numerous peace groups, she truly creates a world village. Through movement, listening, touch therapy, and many other

empowering body-based modalities, we are invited to join in with the belief that human beings are powerful and have innate wisdom, and that all our voices and skills are needed in the world's collective healing.

I had the privilege of attending a Together Beyond Words/Radical Aliveness workshop with Nitsan Gordon and led by Ann Bradney. At the paradise of the Omega Institute, thousands of miles away from the conflict, a car backfired, and within a millisecond, half of the participants dove for the ground, and the other half hunched over in fear. I witnessed what is automatically carried in the body for these women daily, no matter how "safely far away" they are. In front of me, I could feel on a somatic level how we carry intergenerational trauma in our bodies and nervous systems. Nitsan quotes Father Richard Rohr, "Pain that is not transformed is transmitted." She goes on to describe in detail how the Together Beyond Words process has worked to create a world that felt like a safe place. What I experienced in that room was deep hatreds, trauma, and pain being held, hearts cracking wide open, and, ultimately and almost shockingly, our group *embodying* the shared desire for peace and the good of the world.

The work is no easy task. I was touched reading that at times the workshops/gatherings could only take place in Palestine (the Occupied Territories) because sometimes the Palestinian participants were not allowed entry into Israel. Three languages were involved, requiring translators so their "mother tongue" could be spoken. I tried to imagine how it was for the facilitators who found themselves in real time racing for the bomb shelter when an air raid began right before their scheduled workshop. Here is a world of courage, of heart, of a life-and-death commitment to peace, to never giving up. Nitsan writes: "When this transformation occurs, and it shall one day, we will truly be a holy spot on earth where an ancient hatred has become a present love. May it be so." Amen.

Reading this powerful book, I could see that every voice is invited and NEEDED. We have a choice to not wait for the "experts" to resolve the conflict, but to enter a place of "not knowing openness" and heart-based curiosity, so that we might bring our own deep desire for life-giving human connection. When we know we have our own "adult Self" innate leadership, there is never-ending hope. Thank you Nitsan for lighting the candle and sharing this empowering, life-changing, and life-giving work. YES!! to this energy.

■ ■ ■

Lisa Monagle has been long interested in "life's bridges" and bonding connections. She has worked as a nurse-midwife and hospice nurse in different countries, and completed her doctorate in cross-cultural aspects of women's health. Through her training at the Radical Aliveness Institute, and the International Radical Aliveness program, she felt empowered to work with her deep belief in the possibility of individual and community healing through the powerful Radical Aliveness process methods she learned. Using somatic techniques to access the body's fullest wisdom, Lisa invites deep and full expression of all of we are in the search to "know self" and connect with others authentically. She encourages each client to live from their deepest passion, and to bring their unique gifts as part of a world community. Lisa has a private practice in Santa Fe, New Mexico and is soon to be a Grandmother!

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Somatically, the lack of a shared understanding of our collective trauma history leads to macrodissociation from our collective human body.

—Karen Roller

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