INTERNATIONAL BODY PSYCHOTHERAPY JOURNAL

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The Art and Science of Somatic Practice

EMOTIONS

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RESEARCH

IN MEMORIAM

BOOK REVIEWS

Emotion

A 21st Century Integrative Understanding

Aline LaPierre
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In this issue, we explore the nature of emotional experience. Affects, emotions, feelings, sensations, though omnipresent in our experience, are hard to define, and seemingly even harder to understand. Words can lure us into a linear thinking that masks their multidimensionality, and imposes limits on our ability to work with them in the therapeutic context.

The articles in this issue present a 21st century integrative, interdisciplinary understanding of emotion. Drawing on the latest developments in embodied cognition, emotion, enactivism, and body psychotherapy, we offer a rich array of thoughtful directions that move the understanding of emotion beyond entrenched concepts towards new perspectives of the self as a developmental emergence, arising from the seamlessly integrated flow of emotional, cognitive, and behavioral processing systems.

In contemporary culture, emotions are often sensationalized and reduced to simplistic pop-scientific narratives, leaving a gap in our understanding of their true complexity. This gap is often further extended by another trait of today's culture – the notion that emotion and cognition are separate, and even mutually exclusive. The ensuing preference for cognitive reasoning over emotional experience at times borders on the renunciation of the emotional self. Our guest editor, Raja Selvam, aims to fill these gaps by bringing forward a timely, critical, and holistic exploration of emotion. This issue delves beyond the superficial portrayals of emotions to invite readers to engage from a body-informed perspective that acknowledges intricacy and depth.

Selvam's discussion with Giovanna Colombetti on the enactive approach to emotion provides a foundational understanding for this exploration. Challenging the traditional separation of emotion and cognition, Colombetti posits that cognition "is enacted or brought forth by the whole living organism in interaction with the environment" and that it is "inherently affective." She emphasizes that emotions are not separate psychological states, but are inherently intertwined with our cognitive and bodily processes. This dynamic view aligns with body psychotherapy's emphasis on emotions as processes

that unfold within the lived experience of the body, constantly interacting with cognitive and environmental factors.

The dialogue between Les Greenberg and Raja Selvam highlights the importance of integrating emotion into our understanding and treatment of the body. Selvam argues that emotions are deeply embodied experiences, stating that "if you don't embody emotions or if the emotion is blocked in the body, the brain is not efficient at processing cognitions, behaviors, and emotions." Greenberg in turn emphasizes the "primacy of emotion" and its role in driving not only cognition and behavior, but also in being the most effective pathway for change. He introduces a powerful metaphor, likening the affect system to the trunk of a tree, with categorical emotions such as anger and sadness as the main branches, and the more differentiated feelings as the leaves, thus illustrating the interconnectedness of our emotional experiences with their manifestation, meaning, and action potential.

The traditional view that emotion, cognition, and behavior are distinct and mutually exclusive is challenged by an integrative perspective that places them together within complex physiological and experiential networks. The denouncement of emotions in favor of cognitive reasoning, or the uncritical sidelining of cognitive reasoning that leads to succumbing to emotion, seem to arise from a failure to recognize their interconnectedness all aspects of our lived experience. Acknowledging that emotions are not only present but deeply intertwined with every part of ourselves can help both our clients and us engage with our emotional experiences more courageously and honestly. This acknowledgement allows us to create meaning by synthesizing all components of experience, making for a richly textured affective life. Patterns of interwoven emotions, beliefs, and purpose are repeatedly highlighted throughout the articles, revealing the dynamic, multifaceted nature of the fullness of emotional experience.

As you engage with the articles, we hope you will be inspired to reflect on how you conceptualize and work with emotions in your personal process and in your practice.

In This Issue…

We launch with a fascinating conversation between *Les Greenberg* and *Raja Selvam*. In **The Future of Emotions**, Greenberg focuses on the transformation of emotions through the introduction of new emotional states, while Selvam emphasizes a gradual process of increasing emotional tolerance by expanding the capacity to bear emotions within the body. Both approaches offer valuable insights and practical applications for therapists, underscoring the richness and complexity of emotional work in psychotherapy.

Science, Phenomenology, Body, and Emotion is a conversation between *Giovanna Colombetti* and *Raja Selvam* on the enactive approach to cognition and emotion. They advocate a perspective that sees emotions as integral to our sense-making processes. Colombetti's enactive approach challenges the conventional view of emotions as static states, proposing that they should instead be understood as "dynamical configurations that emerge over time." Additionally, this conversation touches upon the radically different understanding of the body in Western and Eastern phenomenology and psychology.

In **Creative Agency: Changing Life Trajectories**, *Larry J. Green* shares the wisdom of his five decades as a therapist, during which he realized that many therapeutic projects only "tweak" the default network. He reveals how he guides clients to connect with their capacity to make an originary move that first disrupts, then replaces, the settings that govern the trajectory of their lives. *Leah Benson*'s **Bioenergetic Psychoanalysis: Embodied Emotions as Seen Through a 21st-century Lens** is in alignment with the science of brain function and emotion presented by Greenberg, Selvam, and Colombetti, which posits that emotion and cognition are functionally indistinguishable, and arise from the brain's continuous process of interoception and categorization. In **Embracing Shame**, *Aline LaPierre* interviews *Bret Lyon* and *Sheila Rubin*, who share their work with the binding emotion of shame – work they have taught to thousands of therapists, coaches, and helping professionals worldwide. In **Somatic Shape and Emotions: Integrating Formative Psychology with Accelerated Experiential Dynamic Psychotherapy**, *John Cornelius* shows how the Formative Psychology of Stanley Kellerman and Diana Fosha's Accelerated Experiential Dynamic Psychotherapy can be brought together to improve clinical outcomes. *Katherine Young* in **Affecting Gestures** describes how gestures not only express emotional states but also generate them, illustrating an important dimension of somatic psychotherapy.

Closing the clinical section, *Marcel Duclos* underscores how emotional states are often best captured by poetry. He generously offers us personal poems that reflect his lived emotional experiences of advanced old age.

The RESEARCH section richly contributes to our somatic field's growing interest. *Courtenay Young* continues the essential work of delineating the role of psychotherapy and body psychotherapy and the science that informs them. Exploring what is appropriate research for the profession today, **A New Paradigm for Psychotherapy and Body Psychotherapy Research** completes Young's article on competencies published in our previous issue. In **Client Satisfaction in Somatic Experiencing: An Interpretive Phenomenological Analysis**, *Greg James* responds to the lack of client-centered research by looking at the lived experience of clients in SE therapy. He brings forth the factors that help and hinder therapeutic outcomes in order to reassess interventions, advance our understanding of therapeutic change, and gain insight into clients' hidden processes. Using confirmatory factor analysis (CFA), **Translation, Cultural Adaptation, and CFA of Nepali Version of Somatic Symptoms Scale (N-SSS-8)** by *Yubaraj Adhikari* and *Birgit Senft* examines their translation of the Somatic Symptoms Scale (SSS) to assess its cultural validity and its reliability. **Water As Affective Medium** is an innovative approach in which

Elenore ten Thij, *Moniek van Slagmaat*, and *Truus Scharstuhl* explore the clinical observations that suggest that haptotherapy (touch) in water improves clients' capacity to experience positive affect. Their study constructs a method of using water to increase bodily awareness and affective capacity. In line with the full body-mind integration required to address the range of physiological responses and symptoms caused by interpersonal violence, **Polyvagal-Informed Therapeutic Drumming for Victims of Interpersonal Violence: A Feasibility Study** by *Jessica Hoggle*, *Debra Nelson-Gardell*, *Nancy Rubin* speaks to the incorporation of rhythm and drumming, an emerging therapeutic tool that explores the different nervous system states through sound and rhythm.

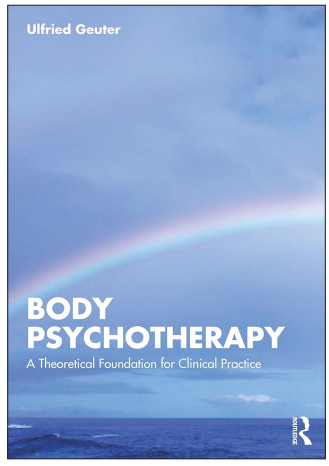
Our BOOK REVIEW section first takes us on a journey through EABP history. ***EABP–The First 35 Years*** by Jill van der Aa with Courtenay Young, reviewed by *Christina Bader Johansson*, richly illustrates with photos the origin, history, and structure of the European Association of Body Psychotherapy (EABP), the place of Body Psychotherapy among other forms of psychotherapy, as well as its place in the social debate in different countries. *Helena Vissing* reviews Peter Levine's latest book, ***An Autobiography of Trauma: A Healing Journey***. Levine, who has significantly influenced the understanding and treatment of trauma through his innovative Somatic Experiencing method, provides readers with a compelling narrative that intertwines an intimate exploration of his personal journey to heal his severe childhood trauma with the evolution of his therapeutic approach.

All communication, including speech, sign language, gestures, and writing, is mediated via the motor system. In other words, interconnectedness through movement is what makes us human. But what happen to our movements when we live with high levels of chronic stress, adverse experiences, or trauma – either developmental, relational, or shock? *Christina Bogdanova* reviews ***Unleashing Your Potential: Body Psychotherapy Exercises to Enhance Presence, Contact and Energy Regulation***, a long-awaited book by some of our more seasoned body psychotherapists, *Erik Jarlnaes*, *Joel Isaacs*, *Bo Bromberg*, *Ginger Clark*. Presented through photographs, this book on movement brings together a considerable body of work on the importance of movement in somatic work. It is a most welcome addition to our somatic library.

Following Clover Southwell's death, we received several testimonials from friends and colleagues who expressed the profound appreciation for the life-changing influence she had in their lives. **In Memoriam** gathers these testimonials, and together with extracts from Clover's writings, we pay homage to the importance of her legacy.

From Our Readers

Author's Response



I am very pleased with Christopher Walling's review and thank him for it. I had not expected to read that the book had been adopted for his graduate students at the California Institute of Integral Studies.

Aline LaPierre, as editor-in-chief of the *IBPJ*, invited me to respond to Christopher's review since he raised some critical points.

Firstly, he points out the use of the term Somatic Psychotherapy in North America, whereas I prefer Body Psychotherapy. My preference has to do with my background in the German language. In German, speaking of soma means to speak about the objectified body of a natural scientific medicine. *Somatische Medizin*, i.e., somatic medicine, means a medicine that, in contrast to a psychosomatic and holistic view of the human being, confines itself to applying medical tools such as surgery, pharmaceuticals, or physical methods. If I lived in the United States, I think I would adopt the term somatic psychotherapy, which indicates, as Christopher writes, an understanding of the body or soma as a "form of knowledge production."

This is exactly what I argue for in Chapter 5, where I base body psychotherapy fundamentally in an enactivist and phenomenological theory of the living subject in their lifeworld, and in a holistic view of the human being. In contrast to the widespread view of the body as an energy system in body psychotherapy, I place body experience at the center as a source for the generation of meaning. Thus, my view of the body is not only as being a means for therapy, but as the place where our subjective relationship to the world and to others is being felt. I refer to Legrand's notion that the interoceptive is the subjective. So when I speak of the body, I speak of the living, felt body as the ground for our subjective experiencing.

Secondly, Christopher misses my acknowledgement of "the many indigenous systems of somatic healing." Historically, body psychotherapy developed out of psychoanalysis, body pedagogical methods of enhancing body perception, fostering movement, and dance, and later the human potential and the humanistic psychotherapy movement, even if in the United States indigenous systems may have been included and integrated. My book was written from a central European and German perspective, and effectively, the history of body psychotherapy might be written differently from an American perspective. I regret that I am not familiar enough with the development in the U.S. when Christopher points to the fact that accredited degrees in somatic psychology at Pacifica Graduate Institute, Santa Barbara Graduate Institute, and John F. Kennedy University no longer exist. I understood the information about somatic studies specialization on the homepages of both institutions differently.

Thirdly, Christopher does not agree with my statement that the specific perspective of considering the body in body psychotherapy is generally lacking in other approaches. In his opinion, we share our perspective "with much of relational psychoanalysis today." In psychoanalysis, as well as in cognitive therapy and Acceptance and Commitment Therapy, there has recently been a turn towards the body. However, relational psychoanalysis primarily talks about the body in terms of mentalization of body experience. In principle, it does not work with an embodiment of the mental, nor with the breath, movement, or bodily methods of emotion regulation, or bodily interaction. I am not claiming that we are "the only psychotherapy that sees bodily experience as the foundation for self-experience." I refer to those humanistic traditions that have paved the way for this thinking, and are largely in agreement with it. But if we look into the history of the other approaches, we cannot help noticing that they largely have failed to include a deeper understanding of the significance of body experience or body communication, and of therapy as a resonant, embodied encounter.

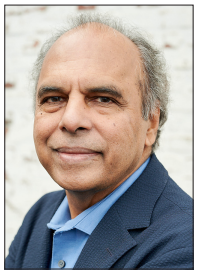
This does not mean that as a body psychotherapist I work exclusively with the methods of our field. According to the study Christopher mentions, in practice we have to be integral psychotherapists, as most body psychotherapists are. I myself have first been trained as a client-centered psychotherapist, and later I underwent a full psychoanalytic training. This colors my way of working. But, as Christopher writes, we have always been "experience near," near to body experience, near to what is bodily felt in the therapeutic process and in the therapy room encounter. There is a tendency towards a growing commonality with other approaches. But both psychoanalysis and cognitive therapy are still mainly working in the sphere of cognition. There is yet a long way to go to integrating them "into the embodied fold."

Ulfried Geuter
Author, *Body Psychotherapy*

Special Section

GUEST EDITORIAL

The Rise of Affectivism



Raja Selvam

In the last twenty-five years, there has been so much research on the neuroscience of cognition and emotion that leading researchers of emotion have declared that the *era of affectivism* has dawned at last. Simply explained, affectivism holds that it is emotion that determines every aspect of cognition and behavior in every moment of our lives – not the other way around, as the earlier eras of behaviorism and cognitivism would have us believe.

Much of this new knowledge on affectivism has yet to find its way into clinical practice, even in body psychotherapy settings. Therefore, the first aim of this issue on emotions is to bring some of the new findings and their clinical applications to the readers of this journal. A second overlapping aim is to highlight unique ways some body psychotherapists are working with emotions in an embodied manner.

As guest editor, I had the pleasure of meeting with Dr. Les Greenberg, a pioneer in the important work of applying the research on emotions to the process of psychotherapy. To kickstart this special issue, the *Journal* collaborated with Liam Blume, USABP program director, to organize a Forum titled *The Future of Emotions*. Dr. Greenberg and I discussed the recent neuroscientific findings, their clinical applications, and some possible directions for future research on emotions. Presented here as the opening article, our conversation was videotaped, and is available on the USABP website at www.usabp.org.

I also interviewed Dr. Giovanna Colombetti, Professor of Philosophy in the Department of Social and Political Sciences, Philosophy, and Anthropology at the University of Exeter, who works on emotion and affectivity from the perspective of so-called 4E cognition – embodied, embedded, enactive, and extended cognition. In our conversation, *Emotion, Body, and Western and Eastern Phenomenology*, we discuss the limitations of relying solely on the scientific method to study emotions. We touch on further insights from Western as well as Eastern phenomenologists on emotions, in particular stretching the standard definition of the body in body psychotherapy to include the existence of additional bodies that contribute to our emotions, and to the wide range of our psychological experiences.

It is my hope that the articles in this issue trigger a new wave of interest in the latest findings on emotions in science and phenomenology, and their applications to the field of body psychotherapy. In line with the current era of affectivism, the *Journal* invites the submission of articles on emotions and how to work effectively with them in the body.

Sincerely,

USABP/IBPJ FORUM

The Future of Emotions

Les Greenberg & Raja Selvam

Moderator Liam Blume

Les Greenberg

Raja Selvam

Our forum brings together two distinguished pioneers in the field of emotion: Dr. Leslie Greenberg, creator and co-developer of Emotion-Focused Therapy. and Dr. Raja Selvam, creator and developer of Integral Somatic Psychology.

Dr. Greenberg is the recipient of the APA Award of Distinguished Professional Contributions to Applied Research and the Carl Rogers Award. A pioneer in the important work of applying research on emotions to the process of psychotherapy, he is co-author of the major books on emotion-focused approaches to psychotherapy. His publications include 102 peer-reviewed papers, 89 book chapters, and 17 books, of which his most recent is Changing Emotion with Emotion: The Practitioner's Guide*.*

Dr Raja Selvam is the developer of Integral Somatic Psychology and author of The Practice of Embodying Emotions: A Guide for Improving Cognitive, Emotional, and Behavioral Outcomes*. He is also a senior trainer at Somatic Experiencing International and has trained professionals for 27 years in two dozen countries on six continents.*

Liam

Les and Raja, if you were to apply a retrospective lens, what drew you into the field of emotions?

Les

I was an engineer before I became a psychologist. I transitioned from engineering to psychology, and in that process, I took a course on perception. We wore inversion glasses that, after a few minutes, turned the world upside down. When I took the glasses off, the world was still upside down. It really hit me that our brain constructs the world, and that what we see out there is really not necessarily what is out there. It's what our brain makes of it. It confirmed my drug experiences in the 60s and 70s that you can alter perceptions of reality by some sort of different processes.

Raja

I come from another field as well. My first PhD is in the field of marketing from Northwestern University in Chicago. In retrospect, my emotional difficulties brought me to psychotherapy as a client, and from there it was a natural progression to become a licensed clinical psychologist.

Les

What drew me to this field was seeking greater social relevance. I come from South Africa, and even though I was an engineer who was not very politically oriented, I was involved in fighting against the apartheid government.

When I moved to Canada, I needed greater social relevance. I moved from studying outer space to studying inner space. What really motivated me was that in my final year of engineering, I solved a math problem that no one else in my class had solved, and I didn't know how I knew how to solve it. I became fascinated that I know more than I can say, a notion presented by Michael Polanyi in *Personal Knowledge* and *Tacit Knowledge*. I didn't know that pursuing the mechanism of knowing more than I can say would lead me to emotion and into psychology. I had more of an investigative motivation than a helping motivation, though I was also interested in working with people.

I have a funny story; I became an engineer because I liked working with people. That may sound like a contradiction, but I wanted to be a nuclear physicist. I went to a guidance counselor who told me that because I liked working with people, I should become a nuclear engineer, because engineers work with people more than background physicists.

Liam

With regard to the future of emotion in mental health, what are some ways you would like to see forward movement? Is there something that really stands out for you?

Raja

Given my orientation and knowledge of the recent literature on embodiment and embodied emotions, I would like to see as many modalities as possible work with the body. We now know – through research paradigms of embodied cognitions and embodied emotions – that cognition, emotion, and behavior depend on the body. I would like to see as many modalities as possible focus on embodiment, in that they would pay more attention to the body in whatever way possible. That's one of the reasons I joined the USABP Board – not to represent certain body-oriented modalities, but to bring the science to all modalities. I want all modalities to know, beyond USABP members and its Alliance of Somatic Educators, that they can be more efficient in their work if they include the body.

I would also like to see more modalities make emotion the central part of their work. When I was doing research for my book, I was so glad to run into Les' work because, in a sea of cognitivism and behaviorism, he'd already made emotion the focus! I'm quite grateful to you, Les, for that.

Science is now catching up, and the research on embodied emotion shows that if you don't embody emotions, or if the emotion is blocked in the body, the brain is not efficient at processing cognitions, behaviors, or emotions. So I would love to see more of the body, more of embodied emotion, in as many modalities as possible, so that we can all better serve our clients.

Les

My focus has been on emotion. I moved from being very cognitive, conceptual, and rational as an engineer towards the appreciation of emotion. Then, through the appreciation of emotion, I moved to appreciation of the bodily felt sense. There are different ways of conceiving of the body, but I'm always struck by how we live from our bodies, and that – even in tacit knowledge – we attend to the world from the body. There's always something going on in the body that is the basic source of information. So, I also hope to see the body more included.

I want to make the point that I think emotion and the body are more important than cognition, behavior, and interaction. The primacy of emotion is important, and emotion includes the body. I hope this perspective will become more and more acceptable.

Liam, you told me that the APA does not favor anything that has *somatic* in its title in terms of their support of Continuing Education (CEs). That is a deep tragedy! Emotion used to be in that role – emotion was regarded as an epiphenomenon. I hope to contribute to seeing emotion as a phenomenon in itself, as is the body. My hope is that it will be recognized!

"The world affects the body, and emotion is an assessment of the impact a world situation has on a person. Given that, I refer to all these terms – mood, affect, emotions, feelings, etc. – as emotions. I like to broaden the definition of emotion all the way to just feeling good or bad."

Liam

There are many here who are glad to hear you affirm this! There are a lot of different terms for emotions – "mood," "affect," "emotions," "sensorimotor emotions"... Would you talk about how you use these terms?

Raja

I'll jump into that. There are different ways to define emotions. The definition I like is along the lines of what Les just shared. The world affects the body, and emotion is an assessment of the impact a world situation has on a person. Given that, I refer to all these terms – mood, affect, emotions, feelings, etc – as emotions. I like to broaden the definition of emotion all the way to just feeling good or bad. How is a situation affecting my welfare? Is it bad? Or good? We can make emotions available all the time, as opposed to having a certain list of emotions – primary emotions, secondary emotions, etc. When people come to us and say, "I feel bad; help me," feeling bad is a good enough place to begin using emotion. That's an example of what I call *sensorimotor emotions* – terrible term, but I just came up with it and now I am stuck with it.

Les

I agree with your definition that emotion is evaluation or appraisal of a situation in relation to our needs. It's saying how the world is impacting us, whether our needs are being met or not. At a clinical level, I use the words interchangeably – emotions, feelings, affect, and sensation – depending on which seems to best fit the context.

I did a search years ago and found that over the years, more philosophers than psychologists used these words interchangeably. Some said, "Affect is this." And another said, "That's emotion, but affect is this." There's a fuzzy boundary and confusion. I use this analogy or metaphor from Damasio: a tree. Think of the tree – there's the roots and the main trunk of the tree, which is the affect system. The affect system refers to the physiology and to the fundamental evaluation, "Is it good or bad for me?" Then the main branches of the tree are the categorical emotions like anger, sadness, fear, shame. The tree's small branches and leaves are the way feelings are used in English in a more differentiated fashion – like, "I feel embarrassed," "I feel in awe" – that's what Damasio proposes. But

that leaves out the sensory feelings. So I've added the bark of the tree. The bark of the tree is rough or smooth, which incorporates sensation as one of the four elements. So, affect is generally the whole system; emotion is the categorical; feeling words are more social-cognitive; and sensory feelings are the bark. That's how I use these terms formally, but in clinical practice, I use the words as they best fit the context.

I don't want to hog the microphone, but I want to go back to the future. Raja talked about the hope of the body becoming central. I also want to add the idea that the best way to change emotion is with another emotion. I hope this will become empirically validated. Up until now, it's been, "You change emotion by changing cognition," or "You change emotion by changing motivation, or interaction, or physiology." I'm saying that one of the best ways to change an emotion is with another emotion. I really hope for that to become a more central understanding.

Raja

Here, we slightly differ. My experience is that the best way to change emotion is to develop more capacity for the emotion by expanding it in the body so that it becomes more bearable. The benefit is that it improves the brain's capacity to process the situation cognitively and behaviorally, which in turn helps change the emotion.

Les

That's interesting. I read your book recently, and I do think that increasing the capacity to tolerate emotion is important. But in the 60s and 70s, as you know there was a movement towards "come to accept your feelings" and "it's good to feel your feelings." My key development was recognizing that, yes, you have to increase the capacity to tolerate emotion, but some emotions are traumatically-based and maladaptive. Yes, you have to arrive at them before you can leave them. But, you also have to leave them, and that means transformation.

For example, we have to take people to their core shame. You have to feel shame to change shame. But then you also have to change it, and you change it by feeling other emotions – like feeling pride. Pride will change shame, or empowered anger will change shame. So it's not only a matter of increasing one's capacity – which is very important, and is the first step – but then, we also need to step into something new. Both acceptance and change are what I see as important.

Raja

In the 60s, and even today, the focus is not on developing a greater capacity for emotion. The focus has been on the cathartic expression of emotions, and that does not necessarily develop a greater capacity. The reason why I say we need to develop a capacity is not for the sake of developing the capacity, but for the change it can lead to. It improves the brain's ability to process the emotion and the situation – cognitively, emotionally, and behaviorally. This can lead to change, or at times to another emotion. For example, when I work with shame, it sometimes leads to pride. But sometimes, it leads to the resolution of the issue of shame itself. Sometimes it leads to change in behavior, sometimes to change in cognition, which in turn leads to change in emotion. There are quite a few ways to change emotions, not only by bringing in another emotion. But you are the pioneer in this field. You have made emotion the focus of therapy, and now, neuroscientists say it is emotion that determines cognition and behavior. You know the recent developments, and you know better than anyone all the ways to change emotions.

Les

This is really interesting. I really liked you saying that developing a greater capacity for emotion helps to process cognitively and behaviorally in a better way. I'm saying that another emotion has to arise. You're absolutely right about the distinction between catharsis and expanding capacity. But if you are afraid of being on a horse, you fear horses. From a behavioral perspective, you get up on the horse and have a successful experience, and then you can ride a horse. The issue is, if you get up on the horse and you're still afraid, you won't change your fear of horses. Getting up on the horse and feeling joy, or feeling excitement, that's what changes the emotion. It's not only that you have a greater capacity to think more broadly; you actually have to feel another emotion to change the original emotion.

Raja

I totally agree with that. I just wanted to say that the embodiment of emotions not only helps to better process the situation cognitively and behavio-

"There's evidence that when I'm angry, I think angry thoughts; when I'm sad, I have sad memories. This is the evidence that emotion influences cognition. When you have a new emotion, then you begin to make new meanings."

rally. but, most importantly, emotionally as well. For example, in your case, it could be that when they get on the horse, they feel a sense of safety. That's what we would expect. Depending on the clients, when embodied, some go there on their own, and sometimes you have to bring them to it.

Les

How do they go there on their own? Implicitly or explicitly, they have another feeling. We can agree to have a slightly different...

Raja

I'm in agreement. The question is, do they arrive at the emotion on their own, or do you focus on cultivating it in them? It depends on the client. Other than that, we are not in disagreement at all.

Les

When they arrive at it on their own, what they're arriving at is a new feeling that changes the old feeling. That's the point I'm trying to make.

Raja

That's the point – from shame to not feeling shame one way or the other. That's good enough for me.

Liam

Les, you have talked about processing all the way through arriving and leaving. A corrective emotional experience also means making meaning. Does that resonate with you in terms of process?

Les

I see making meaning and changing the narrative as the final consolidating step, not as the originating step. People in narrative therapy say change the story: reframe, and cognitively restructure. I say that you have a meaningful change in meaning only if you have a change in emotion. Certainly, changing emotion leads to making a new meaning. There's evidence that when I'm angry, I think angry thoughts; when I'm sad, I have sad memories. This is the evidence that emotion influences cognition. When you have a new emotion, then you begin to make new meanings.

Raja

What Les is saying is absolutely right. Neuroscience is saying it's emotion that determines every aspect of cognition and behavior in every moment. Les has been further on the psychological path than neu-

"The biggest shift for me was to understand that emotion is actually the action tendency – it's not the feeling. The action tendency is fundamental. If you feel shame, the action tendency is to shrink into the ground…"

roscientists. We now have the science and practice coming together.

Liam

Les, can you incorporate action tendency into where we are in this discussion?

Les

The one thing that's true neuroscientifically is that you can't locate emotions in the brain. You can't locate a site. Initially there were attempts to do that, but if you think about it, it was a stupid question. Where is emotion? Where is anger in the brain?

Anger at somebody who cuts me off on the highway is different than anger at my child, or my wife, or someone insulting me. What is most fundamental about emotion is the *action tendency*. Fear organizes my body for flight. Fear is not behavior; it's an action tendency.

When I was an engineer and came into psychology, I definitely thought emotion was what you feel. The biggest shift for me was to understand that emotion is actually the action tendency – *it's not the feeling*. The action tendency is fundamental. If you feel shame, the action tendency is to shrink into the ground. Then, if you feel empowering anger, the action tendency is to thrust forward to protect your boundaries. You can't shrink in shame and thrust forward in anger at the same time. That's one emotion changing another emotion at the most basic level by changing the action tendency. It's not replacing the old emotion, because part of my theory is that the transformation takes place by synthesis. The shame action tendency… the anger action tendency… and the neurochemicals synthesize. Like blue blending with yellow makes a third color – green; two emotions blend and make a third emotion.

Raja

Neuroscientists are now finding that we cannot separate the brain physiology – of cognition, emotion, and behavior. In every emotion there's an implicit meaning, an implicit evaluation of the world in relation to me, and there's an action tendency. You cannot separate them out. It's good to separate them out for analytical or clinical purposes, but we have done it for so long that we believe that they are actually separate. People have gone looking for different functions in different brain areas, and

have come up with maps. But currently, neuroscientists are saying they cannot be separated from each other. How do you separate a child's bonding experience with the mother from the action tendency to want the mother? The child's love for the mother has the action tendency to want the mother, and whether the child has language or not, one can see the mother is a favorable object the child wants to move toward.

Les

I agree. The only thing is that the word *cognition* is undifferentiated. Cognition, through cognitive therapy, has come to mean thoughts and beliefs in language. That's not cognition. Cognition is attention. It's memory. It's perception. And then, there's language. The meaning appraisal in emotion is not in language. In 1/50th of a millisecond, without any conscious thought, I appraise, "Is this novel?" or "Is this dangerous?" Emotion is our primary meaning system. My brain has a global apprehension; it reads global patterns and gives me a reaction without my thinking about it at all.

Liam

Do you think the future of working with the inner experience of a client rests on a constructionist approach or an evolutionary perspective? There are many debates about where we are, how it's all happening.

Raja

Are you talking about a Lisa Feldman Barrett-type of constructivism? As a clinician, I find value in all the perspectives. I'm not dependent on academic publications in order to make tenure. I find validity in all valid research findings. Lisa Feldman Barrett says all the research done on the evolutionary path is wrong. I think she's completely wrong on that one. There is considerable research about the work of Ekman and his predecessors. I don't care where emotions come from – emotions are generated, and I'm working with them. I see the evidence and don't get into disputes. Les, what do you think?

Les

I agree with you. As an academic, she has a point, but I disagree with her totally. I developed something I called a "dialectical constructivist perspective," which says that when there's a feeling, the way we make sense of it creates what it's about to become. It's an integration. She basically says that it's all constructive in the end, and I'm saying there's a complex interaction between the two. But it's important that, as a clinician, you want to know what implications this has for practice. If you're a constructivist, you don't pay attention to the body. If you're a social constructivist, everything is in language, and everything is generated by the brain in its imagination capacities.

Raja

She is actually based quite a bit in the body. Her book is very dependent on how body sensations are gathered – primarily through the body physiology, which includes brain physiology. She also uses the idea that you abstract from those sensations in a higher order body map – what Damasio calls emotions.

Les

The problem is that she accepts arousal and valence only in the physiology. She denies that anger, sadness, fear, shame, or their elements are separate. She uses the body in a primitive fashion with only arousal and valence, and doesn't acknowledge there's much more complexity going on in the body.

Raja

Absolutely. I agree.

Liam

I also hear her talk about the brain as predictor.

Les

The brain is a predictor. But your basis for prediction is the bodily felt sense of what it seems is going to happen. That bodily felt sense is beyond thought and conceptualization. Just as firefighters can tell when a building is about to collapse, based on the smell of the smoke or the visual color of the fire, information is integrated and synthesized in the body, rather than through thought. The brain does predict the future, and we definitely live by that, but emotion is guiding those predictions.

Liam

Let's turn to some participant questions. Sabrina asks, "Is the ability to increase the capacity to tolerate emotions akin to developing greater ego strength or in-the-moment consciousness or mindfulness?"

"In fact, on all the spiritual paths, one of the basic qualifications for enlightenment is the ability to tolerate emotions. That's one of the motivations for me to pursue this line of work."

Raja

All of the above. When we develop more capacity for emotions, our ego becomes more functional in the world. We will not act out because having more capacity gives the brain more time to think about the situation – cognitively, behaviorally, and so on. It definitely increases mindfulness. In fact, on all the spiritual paths, one of the basic qualifications for enlightenment is the ability to tolerate emotions. That's one of the motivations for me to pursue this line of work.

Les

Tolerating emotion, which is what the cognitive-behaviorists talk about, is similar to increasing your capacity? Raja, I'm asking you that question...

Raja

No, cognitive-behavioral therapists are trying to use either cognition or behavior to change the emotion. Tolerating emotion is the ability to feel the emotion in the body without forming symptoms – cognitively, behaviorally, or emotionally.

I'll give you an example. I worked with a woman this week in Chicago, who, when she sat down for the demonstration, said she wanted to work with anger. Somehow, I had a sense that was not her issue. She was using anger defensively without being aware of it. Developmentally, she was born prematurely, in an incubator, had several near-death experiences, and her relationship to fear was not good. As she came into her body and felt the fear, we made it more tolerable by expanding the fear of dying from the chest to the abdomen and so on – until she could sit with it. This led to a big change in the physical symptoms she has been living with for a long time. She just sent me an email: "My thinking has changed. My thinking is now not so focused on today's emergencies. I'm thinking about the future." Because she now has the ability to sense and tolerate the emotion of fear – she got in touch with it, and feels safe – she has emotionally changed.

One of the surprises for me has been in observing how, as more places in the body are able to consciously experiencing the emotion, how quickly not only emotions, but also behavior and cognition change.

Les

I agree with you totally. I had this insight reading your book about the difference between what you mean by expanding the capacity to tolerate emotion, versus what DBT teaches about tolerating emotion. The DBT behavioral way of tolerating really means not getting too emotional, whereas what you're talking about is the capacity to sit with it and go into it.

Raja

Yes, dive deeper into it! Sometimes people ask me if is it just tolerating? No, it's *welcoming* into the body. When I got involved in this field of body-oriented psychotherapy, I found that Reichian and neo-Reichian strategies – you're familiar with these from the 60s and 70s – focused on how the body blocks emotions, how it wants to defend. My focus is on working with the defenses to uncover the emotions in the body, which leads to a greater capacity to tolerate them. For example, if you carry a 50-kilogram bag, is it more strain for the shoulder to carry it with one arm? Or is it more strain to carry it with two arms? You have less strain if you carry it with two arms. That's the intuitive logic I give my clients who sit there thinking, "I came here to get rid of my anxiety – why are you asking me to spread it from my chest to my belly?" A lot of education is involved in this process.

Liam

A question to Les from Mark Ludwig: "Can you elaborate on the psychological mainstream's resistance to the centrality of emotions as you mentioned?"

Les

First, Western rationality privileged control of the process. The majority of psychologists were men, and men had a much more difficult time with emotion and with process – with the fact that things change moment by moment. Emotion is process-oriented. But all over the world, emotions are dreaded. I've traveled a lot in Eastern countries where they deal with the fear of emotions differently. In the West, it's through control or rationality. In more spiritual or Eastern traditions, it's distancing and observing the emotion, and letting it come and go. These different ways of approaching emotion are all based on the fear of emotion. The issue is that emotions happen to us! We don't make them happen, and because of that loss of control, people are very frightened of them. That's what we're dealing with in helping people tolerate emotion.

Raja

The field of psychology has added to this through its emphasis on behaviorism and cognitivism, on making meaning as the way of change. Without doubt, a change in meaning leads to behavioral and cognitive change. But it runs counter to Les' lifetime experience, and to the latest neuroscientific findings in affectivism, which show that it is emotion that determines cognition – rather than the other way around.

Les

I grew up as an engineer, highly rational, but I knew I had feelings. I had feelings as a function of my family history and of my identity. But I had nowhere to put feelings, so I was living a dichotomous true-self/false-self or public-self/private-self. I knew I had feelings inside, but they didn't have a place in the public rational domain of other male engineers. I felt those feelings were determining what was going on in my life. I started off with meaning as central, and it took me time to get to the fact that my emotions produce my meanings.

Liam

A question from Rick Lepore: "Do you see helping someone increase sensorial awareness as a way to cultivate connection with emotions?"

Raja

This is a very important point that I really want to emphasize. Tracking body sensations in detail has become very popular in the last 20-35 years. It came through Vipassana and the Vipassana-based practice of mindfulness-based stress reduction. We know now that when I track bodily sensation – constriction here, strength here, or tingling here, they regulate me. When I sense my heartbeat is fast and become aware of it, there's an automatic feedback loop that reduces it. It's a great way to regulate whatever state I'm in. However, what has unfortunately happened – which I have to correct in every training I do – is that people are taught that experiences of emotion in the body are the same as sensations in the body. This is a complete myth. I've written an article about it on my website called How to Avoid Destroying Emotions When Tracking Body Sensations (https://integralsomaticpsychology.com/how-to-avoid-destroying-emotions-when-tracking-body-sensations/).

"However, what has unfortunately happened – which I have to correct in every training I do – is that people are taught that experiences of emotion in the body are the same as sensations in the body. This is a complete myth."

Damasio says that emotions can be generated in different ways. They can be generated in the brain through neurotransmitter action, either through instinctual circuits honed by evolution, or through the longer circuits involving culture. They can also be generated through higher-order body maps of sensations that arise from physiological reactions to the situation. When the body is afraid, instead of staying with the higher-order body map of fear, if I go in and say, "Oh it feels bad here; it feels tingly here," focusing on such sensations, I would drop down to lower-order body maps, and the emotion would go away.

I learned this in the early 90s when long-term Vipassana practitioners came to me for anxiety attacks. Somatic Experiencing had just become popular. They came to me thinking they could get cured. I would ask, "What causes your anxiety?" and they would answer, "Panic... I can't afford to pay the alimony..." and so on. I would continue, "Where do you sense the emotion in the body?" By then, I had read *Molecules of Emotion* by Candace Pert, where she says emotion is in the body, where it spreads very quickly. From a body psychotherapy point of view, we tend to block emotion, so I wondered, what happens if we undo the blocks and spread the emotion? Will it create capacity? That was the emergence of my emotional embodiment work in a rudimentary form. So I would ask, "Where do you sense emotion in the body?" and they would point at their chest. I would go on, "Please pay attention to it a little bit... where else?" And they would quickly come into a peaceful state. When I asked what they were doing, they said that they were taught to go to the body and track sensations where they had a difficult emotion – track the qualities of constriction and so on. They were going completely *away from the emotion* and the context that generated their anxiety. Since then, I've been warning people about it, even in Somatic Experiencing. The moment people are taught to track body sensations, it's like God handing them a torch. By going to the body and tracking body sensations, they can quickly torch their emotions along with all the cognitions, memories, everything. I'm glad I got a chance to make this point!

"Different diagnoses are not particularly helpful in knowing how to intervene. I can intervene the same way with someone who has anxiety as I do with someone who has depression… A trans-diagnostic treatment is a particular way of thinking about how to work with the cause of problems…"

Les

Wonderful articulation. I'd love to get this paper. I haven't heard this point articulated that well. I agree; I see people destroying emotions by paying attention to their bodies, the tickle here and the tension there, but I haven't been able to articulate it like that.

Raja

I have to live with it all the time because I'm teaching a body-oriented course on trauma. In my course, I never ask students what they're sensing in the body, or where they sense the emotion in the body. Only in the final integration stage do I have them notice sensation in order to see the benefit it has on the body. I'm very specific about it.

Les

This brings to mind Gendlin and Focusing. Do you think about that at all? He talks about the feeling of all of it.

Raja

I'm a fan of Gendlin, but I'm not a fan of the focus on sensation in Focusing, for this reason. Focusing has a tendency to track bodily sensations, because it brings the body back to a neutral state. I don't like unpleasant emotions, and I don't think you do either. So if you give me a tool to quickly go away from my emotions, to regulate my body and breath, I will use it.

Les

I think Gendlin's initial intention was not to track body sensations, because he always talks about feeling all of it, but you're right; its often misused in that way.

Raja

Gendlin was a pioneer in embodied cognition.

Liam

Les, maybe you could share your thoughts about trans-diagnostic therapy or the concept of being trans-diagnostic, because that's one of the other pieces you talk about.

Les

In the medical context, the only way you could get a research grant was to study a particular diag-

nostic group. There are treatments for depression, for anxiety, for eating disorders, and so on. In reality, we've always had the same treatment for all groups. Different diagnoses are not particularly helpful in knowing how to intervene. I can intervene the same way with someone who has anxiety as I do with someone who has depression. The same intervention can be used with all kinds of groups. A trans-diagnostic treatment is a particular way of thinking about how to work with the cause of problems, such as blocked emotions. It doesn't matter what diagnostic grouping you are in; what's important is having a case formulation for a particular client. What is their core emotional processing difficulty? Then you intervene based on that, not on the diagnostic group. That's a trans-diagnostic treatment.

Liam

The issue that emotions are located in the amygdala keeps coming up over and over.

Raja

There's no doubt that the amygdala seems to be involved in strong emotions, including fear. But I don't believe that emotion is generated more in one place than another. The functional specialization perspective tries to locate emotions in different body parts – in Chinese medicine, it's in different organs. In neuroscience, it's in brain parts, like the amygdala or hypothalamus. This has its limitations. I believe in the more dynamic systems perspective, that the entire physiology is involved in the generation and experience of emotions and cognitions. There might be some specialization, but there's simply too much focus on the amygdala. When people talk about the fear of dying, you know where they experience it? In the heart! Or, in the gut! They feel it everywhere. Often, they say, "I feel it everywhere – in my brain and body, all over!" I have a hard time believing that it's somehow located in one place. I've become skeptical about functional specialization. However, research is important, and when it comes to severe dysregulation, targeted medication can be useful.

Les

My view is that the amygdala does play a role in appraising situations and making evaluations, especially of safety. But there's a deeper issue, which is that brain and neurological research is in its infancy. I don't know if you've heard of the phenomenon that happens when they put dead fish in an fMRI machine. It results in all kinds of activities. A dormant, dead organism shows all kinds of activity. We don't know what's really going on in the brain, but everybody turns to the brain because this is the high-level hard science. We have to understand that these are theory games. I have a colleague who showed that depending on the make of your fMRI machine, it gives you different results.

Even with personal medical issues, the information you get is tentative; it's not definitive. They picture theories; they help us think about things in different ways. I do think the amygdala probably plays an important role, but it's not where emotion is by any means.

Raja

In his book *Looking for Spinoza*, Damasio attributes the emotion processing function to the amygdala, and the execution function to the brainstem with the autonomic nervous system base nuclei. Candace Pert, a molecular biologist, says that sometimes emotion seems to arise from the body first, not the brain. Eastern psychologists say all the impulses are coming from the subtle body, the quantum level body. Interestingly, the APA, who will not let somatic psychology in the door, has approved EFT, the energy psychology method – the Emotional Freedom Technique – and Thought Field Therapy. It's a such a simple technique, and it really works, and has over 30 outcomes studies all over the world. I hope that in the future of body psychotherapy we also include energy psychology.

Liam

One more question. What is the relational dimension in the change process? A la Fosha, relational holding is the catalytic context in which emotions can be expressed and release their transformative potential.

Les

I agree with that, basically. I'm a proponent of an approach that includes relationship work. The relationship is the sine qua non of therapy, and of getting to emotion. If you're not safe, you're not going to be able to process your emotions. And there's something about validation by another human being, being seen by another, being witnessed and accompanied by another. That's a very important aspect of the change process, and of facilitat-

ing access to emotion. So, empathic and compassionate forms of relating are very important.

Raja

The ability of a person to access an emotion, tolerate an emotion, and express an emotion – these are different functions in relation to emotion – is mostly dependent on the support they receive from the environment, especially as a child. In therapy, one has to be a bit careful. Sometimes people are trying to develop a relationship while they are experiencing acute symptoms. We need to be with a client long enough longitudinally for them to trust us, to develop a relationship. It also depends on the attunement of the therapist – the more support you bring a client, the faster you can get them to an emotion. What I find very important is the ability of the therapist to sense in their body the emotion that the client is going through. It's empathy in an embodied form. It's very important for raising a securely attached child. I find that in general the more I can sit with the emotion of the client, and sense it, it somehow helps the client to come to it faster. So sometimes you sit with it a little longer; you suffer from it, but then you get paid for it, so it's okay with me!

Les

I want to take off on this notion of "you sense it," because for many years I've done this. We teach empathic attunement to affect, and some people have this ability to sense what the other is feeling, and others are completely mystified about it. I used the phrase "sense it" in a cognitive way, but I've come to understand that sensing is the fundamental process. It's a sensory experience at a bodily felt level.

Raja

There's a lot of research now about how we are constantly exchanging information. The body is exchanging all kinds of information in measurable frequencies through the electromagnetic spectrum. James Oschman has compiled findings about this body-to-body exchange of information in a number of modalities – even involving research by the Pentagon, for whatever reason! But we also have the ability to sense each other, to get information from each other, over long distances through quantum mechanical means. I'm no longer surprised when I'm feeling sick one day in San Francisco, and immediately I get voicemails from my sister and my wife at the same time, asking, "Are you okay? Is something wrong?" We have this ability, and we don't use it in therapy because everybody is afraid of countertransference. This is a wonderful thing that we need to bring into therapy. I teach a lot about it, and call it *interpersonal resonance*. Of course, we have to be careful – we have to vet the information, and be careful how we apply it. Even information from our five senses can be faulty, right?

Liam

Let's go into research. What should future research address on the topics of emotions and treatment? If you had all the money in the world, what would be your next research project?

Les

I would definitely try to show what Raja is calling *increase your capacity*, so that if you feel your emotions and process them, you feel better. That's one. Second, I would want to show that emotion transforms emotion by a process of synthesis. In other words, show that empowered anger helps undo shame, and that you end up with a new feeling of strength or confidence. I come from a Piagetian background studying child development. Piaget showed that development and transformation occur by synthesizing existing resources – not by learning or interpretation or modification. A child learns to walk by synthesizing standing and falling. They develop schemes for standing and schemes for falling, and then they synthesize them. We form the concept of an oval by synthesizing the concept of a square and a circle, and it's by joining things we already have within us that a new form appears. That's transforming emotion with emotion. I would like to see research that demonstrates that, but it's very difficult to achieve.

Raja

It turns out that if you block any part of the body from being involved in emotion, such as if you block emotion from the face by having somebody actually bite on a pen while they're watching a video clip of a movie laden with emotion, the brain doesn't light up, the emotion centers don't light up, the association centers don't light up. It turns out they're not processing the situation well. Two weeks after this experiment, those in the constrained group didn't

remember the details of the situation cognitively, couldn't specify the emotions, and had a hard time remembering the situation. The reason for this is that facial muscles are a very important part of the emotional physiology. In fact, if there's one paper that gave me the confidence to go ahead with the theory and the practice of embodying emotions, it was that paper by Niedenthal.*

Other research involved showing clips of people experiencing emotions of attraction – like loving and liking – while at the same time instructing the research subjects to adopt aversive postures, such as leaning back or crossing their arms over their chest. Clips of aversive emotions were also shown, and the research subjects were told to lean forward, so the posture contradicted the emotion. The same results! If the body is not congruent and involved in the emotion of the moment, then the brain doesn't process it well. The situation itself is not processed well; people forget the emotion as well as the cognition and behavior. This is the science of embodied emotions. That's why, being a body psychotherapist, I said, "Hey! Let me make sure that as many places in the body are involved in emotion by working with the defenses in the body." I would like to see research not so much on the blocked body and compromised emotion, situation, and brain, but on this in particular: As we expand an emotion in the body, does it lead to better emotional, cognitive, and behavioral outcomes? I would like somebody to do it in academia, but I think I'll have to do it, because when I went to the International Society for the Research on Emotion Conference, nobody was interested in this type of research. They were not interested in the body, other than theoretically. They were so far away from the body that I gave up. Outside of a very small circle – especially in clinical work – they are not interested in doing this type of research. I would like to see somebody do it, but perhaps I'll have to do it.

Liam

Les, you speak of a future with unified, emotion-focused cognitive-behavioral therapy. Do you remember writing about that? What will convince CBT advocates that this makes sense? What will change in the work that's done?

Les

What will convince them is research evidence, because third-wave cognitive therapy says anything that has empirical evidence is actually a third-wave cognitive therapy. They need empirical evidence of the kind they respect, which involves clinical trials, which I don't think is real science. It's more politics than science. I think that's what will create change in the work, because now everybody says, "Yes, we work with emotions." But I've been on a panel with Judith Beck from cognitive therapy, and what she means by working with emotions is totally different. So segueing off what Raja is saying, what would be different if cognitive therapists worked on helping people expand their capacity or tolerate their ability to feel their emotions? It's deep diving into the emotion – being able to be aware of the emotion, and name the emotion. They would do a lot more of that; they wouldn't be trying to down-regulate emotion by putting a name on it. They see things in terms of down-regulation, and I see things in terms of acceptance, which often involves up-regulation. That's what the difference would be. Then they wouldn't focus on rational analysis, and errors in thinking. They would focus on processing experience, which is becoming more and more of a catch-all phrase. What is meant by "emotion processing" has to be specified more clearly, and that doesn't mean down-regulating emotion.

Liam

I want to jump to another important piece of today's conversation. You both speak of your approaches in working with emotion as complementary or trans-diagnostic. What are the systemic and multicultural aspects to consider in treatment involving emotions? What are the sensitivities?

Raja

There are differences and there are commonalities and variations, but honestly, I don't emphasize the differences. I'm not worried about going to a culture and being really careful about the differences, other than certain basics.

Les

I would agree, I've travelled a lot. At first I was scared, because there's this emphasis on cultural

* Niedenthal, P. N. (2007). Embodying emotion. *Science*. 316 (5827): 1002-5. doi: 10.1126/science.1136930

sensitivity. There are different rules of expression in different cultures, but at core, we're all pretty much alike emotionally. So when you go to the core, emotions stay the same.

In China, people feel shame and fear and loss and sadness just the same as in North America, or in Africa, or in Australia. The rules of expression in China may be different, and you need to be aware somewhat of the different kinds of expressive rules. There's research that shows that if you have Japanese-born Americans and they're interviewed by a white American, the Japanese are more assertive. If they're interviewed by a Japanese-American, they're less assertive. You're responding to the context, and you understand the rules of these different contexts.

Liam

Let's drill down for a second into experience versus expression. Les, maybe you could start, because you write about that distinction. I'm thinking about the expressive enactment of the emotion.

Les

When I first started out, I had them lumped together, which is somehow accepting your emotion. But then, it became very clear to me that awareness of what you feel is not the same as expressing what you feel. Expressing is a form of doing. You put your body where your mouth is. Awareness is important in naming and labeling, but awareness is a form of knowing.

And so there's a form of knowing and a form of doing. Research illuminated the difference: we showed that higher arousal of emotion and treatment predict a good outcome, because when you're highly emotionally aroused, it's an indicator that you're dealing with significant, painful material.

That's good, because it predicts positive outcome in an emotion-focused therapy. It takes a lot of work to rate tapes. We developed questionnaires that asked people what emotions they felt in a session. We had a list of 16 common emotions. Then we asked how aroused they were, on a scale of 1 to 7.

I wanted to see self-reports of clients' emotional arousal in predicting outcome, and found that there was zero predictive validity. I was disappointed, and began looking into what was going on. For example, one client was sitting in a session in a closed fashion, saying, "I was given up for adoption when I was two years old." She was not talking about or expressing the emotions at all, so there was no arousal. But on the self-report measure, she said, "I felt extreme shame, extreme anger, extreme sadness, extreme anxiety." That really made the distinction between the fact that you could know what you feel, and you can be feeling a whole lot, but you don't show it at all.

When you don't show it, you didn't have good outcomes. But when people begin to weep or express emotion in some form, that tends to predict good outcomes. So you can see the real distinction between being aware of what I feel versus actually showing what I feel. And then in couples therapy, I emphasize a lot that showing the face of emotion to your partner is what impacts your partner.

It's not about talking about emotion. This gets into the conversation between talking about versus experiencing emotion. But I think the distinction between expression and awareness is very important, and you work with it in therapy. Sometimes you ask people, "What's that like?" in order to explore what their tears are expressing. In other situations, during enactments – like in two-chair dialogues – you guide the person to directly voice what they are feeling.

So just to summarize it, in couples therapy, saying to the therapist "I love my wife" is very different than turning to my wife and saying to her "I love you." These are different neurochemical and physiological processes in action.

Raja

Years ago, studying psychoanalytic theory, I read that as children develop, they bring two affect systems together, what was called the facial affect system and the visceral affect system. It's a marker of development. Children who don't do that are prime candidates for forming psychosomatic symptoms in the body.

When I was writing my book, I looked everywhere for the reference, and could not find it. So I experimented with myself. I've had a lot of early traumas, in an environment not supportive for emotions. I tend to form bodily symptoms. I remembered assisting at a training while I was going through a breakup and suffering. That's all I could remember. So I thought, "Let me see whether I can bring it into my face and my throat as a facial expression

and a vocalization," and that opened the whole thing. I could feel the sadness in my body, as opposed to just feeling the physiological symptoms. Everything melted, and I had dreams that were relevant, so I made this experience the basis of an ISP intervention.

I use it all the time these days to quickly help people get in touch and deepen into their emotions, but also to open up the body so that the emotions can spread. I ask clients to imagine somebody else expressing that emotion with their face and through vocalization, but not with words. Or I say, "Imagine yourself doing it," or "You do it and I will do it with you." I make sure that the vocalization is congruent with the suffering being expressed. Sometimes, the early efforts are more accessible through vocalization than through facial or verbal expression. This has become a very important intervention in the practice of embodying emotions. I use it a lot, especially when people are suffering from psychosomatic symptoms and their medical evaluation has come up with nothing.

And it makes sense from that perspective – if you block the face and the throat, your brain is not processing the situation. Niedenthal at the University of Wisconsin, Madison, has done research on this very topic.

Les

I have a comment. I see emotion as a construct from bodily-based experience. The idea of blocked emotion sometimes troubles me. People treat it like there's an emotion that's sitting there blocked, and then it's expressed. I do it myself! We talk about the blocking or self-interruption of emotion, but it's important to understand that it's a construct of many things. The expressive form is one aspect, the bodily senses another aspect, the context is another aspect, and the meaning I make of it is another aspect. All these are brought together to create the feeling I'm about to have. And that feeling can be different tomorrow. So it's a process in which things are always being synthesized. This is where I disagree with Feldman Barrett, who says this is just arousal and valence. There are elements of anger there, but there isn't anger yet. It still has to be formulated or formed in order to become the anger that it's about to be.

Raja

It's a myth that emotions are blocked in the body. It's the generation of emotion that's blocked.

Similarly, people believe that in trauma therapy, there's a lot of energy in the freeze. There's no energy in the freeze. The autonomic nervous system is in standstill. That's more accurate.

Les

That's a good distinction.

Raja

What a pleasure it has been to be with you, Les. I'm a fan of your work, and all the more grateful that you were a pioneer in making emotion the focus of therapy. It is indeed a pleasure to interact with you.

Les

It's lovely to be with you. It's a lonely place to be a proponent of nontraditional emotion. Good to meet a like-minded spirit.

Science, Phenomenology, Body, and Emotion

A Conversation with Giovanna Colombetti

Raja Selvam

Dr. Giovanna Colombetti is Professor of Philosophy in the Department of Social and Political Sciences, Philosophy, and Anthropology at the University of Exeter in the United Kingdom. A philosopher with a background in both philosophy and cognitive science, Dr. Colombetti works primarily on emotion and affectivity from the perspective of so-called "4E cognition" (embodied, embedded, enactive, and extended cognition). Author of numerous journal articles, book chapters, and the book The Feeling Body: Affective Science meets the Enactive Mind, Dr. Colombetti is the editor-in-chief of the journal Emotion Review.

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"… enactivism is an "embodied" approach to cognition, because it regards cognition as located not just in the head but also in the rest of the organism…"

On the enactive approach to cognition

Raja: *Dr. Colombetti, please briefly outline the enactive approach to cognition.*

Giovanna: The enactive approach to cognition, as I see it, is a subset of the broader umbrella of "embodied-embedded," or "situated," approaches to cognition. According to enactivism, cognition is enacted, or brought forth, by the whole living organism (embodiment) in interaction with the environment (embeddedness). So, enactivism is an "embodied" approach to cognition, because it regards cognition as located not just in the head but also in the rest of the organism (of course, the head is part of the body, but "body" in this field typically refers not just to the brain but also to the rest of the organism). Moreover, the organism itself is not floating in a vacuum, of course, so we need to recognize that cognition, as embodied, is also "embedded" in the environment.

Raja: *How does the enactive approach to cognition differ from other embodied-embedded approaches?*

Giovanna: Enactivism has some unique specificities. Most obviously, it emphasizes that cognition is enacted by living beings – entities that are not just physical but alive. Enactivism's radical claim is that it is embodied life that, necessarily, generates cognition. It follows suit that, for enactivism, all living beings (including tiny microorganisms without brains), are inherently cognitive. At the simplest level, they are cognitive in that, through interactions with their surroundings, they discriminate (this is a cognitive operation, even if a very simple one) aspects of the environment that are favorable to them (e.g., nutrients), and those that are not (e.g., noxious substances). Enactivists also call this basic discrimination "sense-making," and characterize it as the most basic instantiation of cognition. Importantly, sense-making thus understood is not representation. It is a form of meaning generation that does not require any internal representations of the external world.

Raja: *What is the basis of the enactive approach to cognition?*

Giovanna: Enactivism is a very rich tapestry of approaches that all emphasize that cognition needs to be understood as brought forth by living systems as they are situated in their environment and as they go about interacting with it. It has its roots in the philosophical tradition of phenomenology – especially the philosophy of Merleau-Ponty, although not only – theoretical approaches to life in biological theory (such as the theory of autopoiesis and, more recently, of autonomous systems), pragmatism, and embodied approaches in cognitive science, such as ecological psychology and theories of affordances.

Raja: *In my understanding, embodied cognition emphasizes that cognition depends not just on the brain but also on the rest of the body; and embedded cognition points out that cognition is also a function of the environment. You have implied that the idea that cognition is embodied does not necessarily entail that cognition is enacted as an activist would think of it. And likewise the idea that cognition is embedded or situated does not necessarily entail that cognition is enacted. Can you think of examples of approaches to embodied cognition and embedded cognition that are not necessarily enactive?*

Giovanna: There are embodied-embedded approaches to cognition that do not think being alive is necessary for cognition. For example, according to some scholars such as Rodney Brooks, the founder of situated AI, an artificial robotic body may be sufficient for cognition. But for the enactivists, not any kind of embodiment will do. In addition, I think enactivism is special and different from other embodied approaches, because, thanks to its emphasis on living embodiment, it inherently acknowledges the importance of what we may call "wet processes" on cognition – for example, endocrine and immune processes, and how they influence both the peripheral and central nervous system. Enactivism in its fullest and richest articulation is not just about action and perception,

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but also about emotions, moods and hormones, illness/health, the microbiome, and so on.

On the enactive approach to emotion

Raja: *You have in your book extended the enactive approach to cognition to the phenomenon of emotion. Can you describe your enactive approach to emotion that you outlined in your book?*

Giovanna: First of all, the enactive approach to emotion as I have developed it entails that emotion is not a psychological faculty separate from cognition and motivation. Enactivists understand cognition fundamentally as basic sense-making (as we just saw). In my view, this straightforwardly entails that cognition, enactively understood, is inherently emotional – or rather, affective, as I prefer to say. Affectivity is broader than emotion; it refers to a general lack of indifference, and encompasses basic motivational drives, moods, and more complex emotions.

Raja: *It is consistent with the definition of emotion I use, that emotion is an assessment of how the world impacts the organism. I see that emotion is a continuous process of affective evaluation with your emphasis on enactivism.*

Giovanna: Yes, I agree. Sense-making is always going on in living organisms (including humans), and that entails that life is characterized by a continuous evaluative process, which is simultaneously cognitive and affective. Enactivism as a general framework has a number of other ideas important for emotion and affect theory – such as that affective phenomena are dynamical or temporal. These concepts apply to life and mind in general, but also to specific affective states. If you want to provide an account of happiness, fear, depression, et cetera, according to enactivism you need to understand them as dynamical, i.e., as unfolding in time. In other words, mind, including specific affective states, need to be understood as processes (rather than states). Moreover, drawing on dynamical systems theory, enactivism emphasizes that these processes proceed at different timescales, and influence one another in complex, non-linear ways.

Raja: *Your book provides scientific evidence of the inseparability of cognition and emotion, not only in the subjective experience but also in the objective physiology of the brain and the body. Isn't that an instance of bringing together what you call the third person methods of science that depend on measurement with the first person and second person methods of phenomenology that take intra-subjective and intersubjective experiences of phenomena just as seriously?*

Giovanna: Yeah, that's a good question. As you know from the book, I think an important aspect of enactivism is precisely this "neurophenomenological" methodological approach. Enactivism is a naturalistic framework; i.e., it strives to be continuous and consistent with science. At the same time, however, it doesn't want to ignore intra- and intersubjective experiences that are difficult to explain, or even just capture, with the quantitative methods favored by the "hard sciences." In fact, the latter tend to avoid or even dismiss subjective experience, regarding it as too private, subjective, and ultimately unreliable as a source of knowledge about mental processes. Enactivists strongly believe that one cannot just simply dismiss consciousness as private, and therefore not worth studying. Clearly, the mind also has this experiential or conscious dimension. Enactivists favor an approach where both experience and physiological processes are taken seriously, studied with the best available methods, and examined both in themselves and in their relationship. We can go from experience to physiology and back, using different methods for studying both that complement one another. My favorite term for this pluralistic methodological approach is "neuro-physio-phenomenology". It is certainly not an idealist position that says all that exists is consciousness and that matter is also consciousness; but neither is it a physicalist-reductionist

position that thinks that one can study the mind only by studying physiological processes.

Raja: *Yes. It is a very reasonable and inclusive approach.*

Giovanna: Going back to the inseparability of cognition and emotion... I have argued that it is supported by both physiological and experiential accounts. As you mentioned, at least some neuroscientists have recently questioned the traditional idea that there are uniquely "cognitive" and uniquely "emotional" parts of the brain (see, for example, the work of Luiz Pessoa). Phenomenologists add that if we observe our own conscious experiences, the separation of emotion and cognition also falters. At the level of experience, it seems evident that when I evaluate something or when I reason (cognition), it is always in a mind that is already motivated and value-laden, and guided by personal interests and involvements (emotion/affect). As I mentioned above, my preferred formulation is that cognition is inherently affective. To be affective is to lack indifference, to give a damn. My view is that cognitive beings, as living organisms striving to maintain themselves, always already (i.e., necessarily) give a damn (care, are not indifferent) about their situation – and, in this sense, they are always already affective. In humans, this implies that even when we are engaged in "higher cognitive processes," such as planning a marketing strategy, or solving a mathematical problem, we are never indifferent or disinterested; rather, we have motivations, we care about something, we have a sense that things are going well (or not), and so on.

Raja: *Since the publication of your book in 2014, more neuroscientists have come forth with the view and evidence that cognition and emotion appear to be inseparable in the brain physiology, as I discovered in the research I did for my 2022 book. In fact, there is even an article in a journal titled* Affect is a Form of Cognition*.*

Giovanna: That is great! Please give me the reference!

On the dynamic systems approach to cognition, emotion, and behavior

Raja: *What is the dynamic systems perspective in relation to cognition and emotion?*

Giovanna: This is a big question to which I cannot really do justice here – please see the detailed discussion in my book. To put it very, very briefly... in the 1990s, existing accounts of cognition as computational and representational – symbolic systems, neural networks – were criticized by "dynamical system theorists" for being too static. These theorists argued that mind needs to be understood as a process, maybe even a continuous one, not just as a sequence of static and discrete representations. *Mind as Motion* was the title of an influential book published in the mid-90s (edited by the philosopher Tim van Gelder and the linguist Robert Port). The editors took the concepts and other formalisms from dynamical systems theory (a mathematical approach to physical dynamical systems) to be the best modeling tools for cognitive processes. So, the important idea developed that cognition evolves, or even emerges, over time, tending toward "attractors" that develop through interactions with the environment. Many dynamicists in cognitive science also criticized the idea that cognition involves the manipulation of internal representations. Ten to fifteen years later, this dynamical approach found its way from cognitive science to the study of affective states – and this "dynamical affective science" is something I discuss in my book, as part of developing an enactivist account to affective states, or rather, of course, processes!

Raja: *Can you give me an example of how it was applied to the understanding of emotional phenomena?*

Giovanna: Yes. *Affective* phenomena. By the way, it is more general than "emotional" in my terminology! Let us take the study of facial expressions of emotions. Rather than taking them as pictures or snapshots – as is still often done within the "ba-

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sic emotions" paradigm – the dynamic approach will treat them as dynamical configurations that emerge over time on the basis of various, and mutually influencing combinations of internal and external stimuli, and/or conditions or influences. Emotions, moods, and other affective states are treated as processes – both physically and experientially. They unfold over time.

I also think that dynamical systems approaches help us conceptualize cognition and affectivity as one simultaneous embodied-embedded – or rather enactive – process that unfolds over time. For example, fear can be seen as a cognitive-physiological process that unfolds over time, involving the simultaneous evolution of evaluative perspectives (I need to get out of here, I can/cannot cope, this is/is not safe), many different, and mutually influencing, bodily events and emerging feelings that can also influence the rest of the system.

On the inseparability of cognition, emotion, and behavior

Raja: *In your book on the enactive approach to emotion, you argue that cognition as a valuation or appraisal is inherently affective, and affect is inherently cognitive. Are you suggesting that there is no difference between the two?*

Giovanna: No, that doesn't follow. That is not what I mean.

Raja: *Please clarify.*

Giovanna: The pragmatist philosopher, John Dewey, can really be helpful here because he talked a lot about how, in order for us to analyze a phenomenon such as a conscious experience, we need certain concepts – such that one is able to "remember" something, or to "make decisions." We can also say that these are "cognitive processes" because, indeed, they involve some elaboration of knowledge – cognition, etymologically means knowledge, understanding. These are of course useful concepts for the purposes of analyzing mind and behavior. Likewise, it may be useful to describe certain phenomena and/or behaviors as "emotional." For example, we may want to use this concept when talking about the combination of certain feelings, values, bodily processes, and so on. At a conceptual level, we can distinguish these things because we have always had a tradition of theoretically distinguishing between cognition and emotion this way. But… Dewey wisely warns us that it is one thing to make and use these conceptual distinctions, and quite another to reify them into separate existing entities, and, relatedly, understand them in such a way that they exclude one another (for example, cognition is non-emotional and emotion is non-cognitive). The latter is a fallacy – the psychological fallacy of reifying concepts initially drawn for the practical purposes of analysis and description into separate psychological faculties.

As we talked about earlier, as the organism goes about its environment, its enactment has, inseparable within it, what we could characterize in the abstract, as part of conceptual analysis, as "cognitive," "emotional," and "behavioral" aspects. But when we look at our experience closely, we find that those are not separate parts of the experience which, at most, merely "interact" with one another. Rather, for example: bodily feelings come with evaluations; evaluations come with bodily feelings and attitudes; understandings are motivated; and so on.

So, I say that cognition is affective, and that affective processes such as emotions are cognitive. But I am not at all saying that cognition and emotion are one and the same! Conceptually, they are different things, and by using those words we single out different aspects of an experience. Is that clear?

On the extent of dependence of cognition on the body

Raja: *Yes. Thank you. We clearly represent our experiences through conceptual categories through language and other symbols such as images. And cognitive categories might appear to be the most abstract of them all as they tend to be more disembodied, without obvious physiological correlates, than emotion and behavior. In the field of embodied cognition, I have heard some people say that even the most abstract cognition depends on the body.*

Some even go as far as to say that there is no cognition that is not dependent on the body. They do not mean it in the sense that the body gives the brain the energy to perform cognitive functions.

They mean it in a more fundamental way. We have an affective system and we have a cognitive system when we think of them as abstract categories so that we can reason, as you have said. They are so intertwined, so inseparable, not just in experience phenomenologically, but also in the physiology of the brain and the body from all the research that we see emerging. They appear to be more concurrent or co-occurring or simultaneous than sequential or back-and-forth processes, even though they might appear to be sequential or back-and-forth processes at the level of abstract categories of cognition and emotion at first glance. All of this suggests that no matter how abstract cognition gets, it appears that it has to be conditioned by what's going on in the body of the organism affectively as it goes about its environment. Are these conclusions consistent with your enactive approach to emotion?

Giovanna: Yes – broadly, they are.

Raja: *Even inferences are enacted?*

Giovanna: Yes. What is special about them? I think that you are referring to reasoning. As I mentioned earlier, I do not think that higher cognitive capacities, as they are traditionally called, are non-affective. Imagine you are thinking really hard – reasoning, drawing inferences – while writing a paper or during a therapy session. How is this "purely cognitive"? I just do not see it! To begin with, you will be motivated to engage in reasoning. As you reason, you will have a sense of it going well or not well, and you will know/feel that you have reached a good answer, or a bad one. You have this sense all the time, and this sense is clearly affective: you are always giving a damn. That's what I mean by "cognition is affective." It is never free of affect because we are ultimately motivated and interested, even if minimally. We care about what is going on in us, or rather in our situation – and so do all living systems, not just human beings, as explained earlier.

On affectivism

Raja: *I sent you a paper called* The Rise of Affectivism, *signed by around 65 leading researchers of emotions. The list includes Damasio, LeDoux, and Barrett. In the paper, the signatories offer accumulated scientific research evidence for the claim that it is emotion that drives all aspects of cognition and behavior in every moment, as opposed to earlier claims of cognitivists that it was cognition that determined emotion and behavior, and even earlier claims of behaviorists that it was behavior that determined cognition and emotion. These perspectives give a sequential order to cognition, emotion, and behavior. They are not saying that the three co-occur and co-determine each other. Earlier, you said that cognition as a sense-making function is never free from emotion. Cognition is driven by emotion, but would you go so far as to say that emotion determines cognition and behavior in every moment in a sequential sense? Or would you say that they are co-occurring or co-determining each other in some way?*

Giovanna: I will go with the latter. I think that paper has been very much influenced by the work of Klaus Scherer, a psychologist of emotion who has worked to put forth a complex view of emotion that involves cognition, physiology, action tendencies, and feelings. He still separates them into components that interact with each other however, which is something I criticize in my book. On the one hand, I really applaud Scherer's efforts to bring everything together. On the other, I think he commits the psychological fallacy of reifying analytical concepts into separate psychological components that interact with each other. You are right; the sequencing of emotion before cognition and behavior, or any other order, is very much against the spirit of enactivism. The real problem is the hard separation of things that cannot be really separated in their nature. Of course, once you start saying that they are not separate and interacting in a linear way, scholars, especially scientists, will want to know whether you are saying that they are the same thing... which is not what I am saying at all. But it is difficult to give a plausible alternative explanation for scientists who want to manipulate variables and measure them to obtain results.

Raja: *Does saying that they are co-occurring and co-determining each other avoid the problem of sequencing them?*

Giovanna: Yes. To some extent. But there is also some kind of causal influence among them, right? There are studies that show that the behavior of judges is more lenient after lunch. This suggests that eating leads to affective states, satiation for example, that influences their judgements to be more lenient. But then, when do the judges

stop being cognitive? They never stop being cognitive-affective, yet there are causal influences among cognitive-affective moments or processes. It's likely to be a complex story...

Raja: *Perhaps we can say that they are co-occurring and co-determining and bouncing off each other, where one process is more dominant than the other at different points in time, as the organism goes about its environment in the enactive sense with the clear understanding that they are not separate things. And operations in the mind at the level of abstract categories of cognition, emotion, and behavior, in addition to affecting the whole organism, might bring about real or apparent sequencing and cause-and-effect relationships among cognition, emotion, and behavior.*

Giovanna: Yes. Possibly. Just remember that enactivists do not want to talk of "inherently" cognitive or emotional processes.

On enactivism and body psychotherapy

Raja: *Yes, I see now in what I just said that it is really hard not to think of them as separate things. Moving on, I don't know whether you're familiar with body psychotherapy approaches or somatic psychology approaches.*

Giovanna: No, or rather just a little. Tell me more!

Raja: *People become disembodied when they have difficult experiences. In addition to psychological defenses such as denial, they do it through physiological defenses such as constriction. An example is the constriction of the breathing muscles as a defense. When people do not breathe enough, there is not enough energy to have the difficult experience. In my book, I describe seven categories of such physiological defenses, involving different physiological systems. The defenses are considered to be self-protective and adaptive in the instances they are formed, but maladaptive if they persist in the future in environments where they are no longer needed. They limit life and lived experience. Just like psychological defenses, they are often unconscious and outside of one's awareness. In body psychotherapy approaches, we work to help clients become aware of these defenses and undo them through one method or another in order to access past lived experiences, and work with them and heal them so clients can be more adaptive and functional in the present and the future.*

When I think of such defenses through the lens of enactivism, I think of them as part and parcel of the organism's enactment as it goes about the world, in that they might persist as maladaptive barriers to lived experiences in the way of being more functional in the present. When I learned Western phenomenology in my doctoral studies, I came across the concept of "bracketing" with the definition that our lived experiences, conscious and unconscious, are "bracketed" or are also filtered through the structure of our bodies. I now see that such filters can also include such psychological and physiological defenses. I understand now that when phenomenologists talk about lived experiences, they are not necessarily distinguishing between conscious and unconscious, or functional and dysfunctional lived experiences in the way we approach experiences in body psychotherapy. Even simple organisms are enacting and learning. Through the lens of enactivism, clients can be seen as going about and enacting their lives in their environments, functionally or dysfunctionally. Through their enactment, they learn that their lived experiences are limited or dysfunctional in some way, by themselves or through others, and that there are some ways to remove their defenses so that they can be more functional. That is how their enactment might lead them to therapy. So all of this can be seen within the framework of the enactment approaches to cognition and emotion.

I can also see that in instances phenomenologists, or others using phenomenological inquiry to explore or validate their understanding of specific aspects of the self or the environment, could benefit from knowledge of physiological defenses gained from body psychotherapy. Understanding how to identify and remove these defenses could help them achieve more valid outcomes.

The evidence that the body is important not just for behavior and emotion but also for cognition has grown, especially in the last 25 years. I see that the enactive approaches to cognition and emotion contribute to this body of evidence in ways we have discussed above.

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Giovanna: Yes, enactivism provides a theoretical framework that allows you to clarify how the body is a source of meaning – rather than simply a response or effect of brain-based cognitive processes. For enactivism, intelligence is not all in the head. The body is constitutive of cognition and intelligence, and so, by working therapeutically on the body, you are already working on cognition.

I have a question for you. The way you describe lived experiences accessed when defenses are removed, it sounded like they are treated as states rather than processes. Like things that are hidden that are found again. Is that the tradition in body psychotherapy?

Raja: *You are right. Many body psychotherapy systems do tend to describe them as stored experiences to be retrieved for processing. I have not found this view to be neurologically tenable. I tend to understand physiological defenses as structures that prevent the formation of a past lived experience from being formed again. I now understand the latter view is more consistent with the enactive approach, where a defensive structure would prevent the enactment, rather reenactment, of a lived experience from the past. I am glad to have a theoretical basis for my view in the enactment approach.*

Thank you so much for your time, Dr. Colombetti, for a very informative interview and an interesting conversation. It is great to have your phenomenological perspective on psychological phenomena that is also, by and large, in line with the emerging science of cognition, emotion, and behavior.

Giovanna: Thanks to you as well.

On Eastern Phenomenology, Psychology, and Body

Dr. Selvam shares a brief account of the contribution of Eastern phenomenology and psychology to the understanding of ourselves and our experience, especially with respect to the different levels of embodiment – levels that are often ignored in the West. Dr. Colombetti comments on the exposé.

Raja: In the West, most psychological approaches assume that there is only one body from which all experiences, including our awareness, arise. Western phenomenology also appears to assume the same in its investigations of lived experiences, if I am not mistaken. Eastern phenomenological investigations of self and self-experiences, including one's awareness, going back thousands of years have revealed that individuals have more bodies than one that bear on their lived experiences. There is the individual gross body that corresponds to the Western notion of the body of an individual. This is the body that is conceived in the womb and ends up in a tomb or on a funeral pyre. The term "gross" refers to its existence also on levels of matter that lend themselves to perception through the five senses, or the interoceptive sense. There is also the individual subtle body, where the term "subtle" refers to its existence only on levels of matter that are not possible for an individual (whose awareness is identified with the gross body) to become aware of through exteroception or interoception. The individual gross body also has a subtle level, levels of matter, that one cannot become aware of through exteroception or interoception when one's awareness is strongly identified with the individual gross body. The body of the universe is the third body, or the third level of the body, of the individual because there is ultimately no boundary between the universal or collective body and the individual gross and subtle bodies on some levels of matter that cannot be easily perceived through exteroception or interoception. Given our modern scientific knowledge, especially from quantum physics, we can infer that the subtle levels of the individual gross and subtle bodies, as well as the universal body, are levels of matter that are extremely difficult, if not impossible, to measure scientifically. There is also a fourth body – the unchanging and unlimited collective body of pure awareness – that forms the basis of the universe. Individuals who can disidentify their awareness from their ever-changing gross, subtle, and universal bodies may ultimately realize this pure awareness as their true self, an achievement often referred to as enlightenment.

What scientific evidence can corroborate the above findings? The scientific approach, with the limitations of its methods as well as the scope of its inquiry, can at best only corroborate, or point towards, because it can neither confirm nor falsify levels of reality it cannot investigate. There is evidence in quantum physics for levels of matter that we cannot observe, either through exteroception or interoception, or measure scientifically. We have evidence for the subtle body in research on out-of-body experiences, during near-death experiences or during meditation, when awareness is no longer identified with the individual gross body. We can also infer from quantum physics that there is no hard boundary between individual bodies and the collective body of the universe at some levels of matter at the subatomic (quantum) level. We have some evidence in neuroscience that the sense of self at the level of the gross body is derived from our experience. It is an abstract neurological epiphenomenon of our experience, as opposed to it being an agent that is initiating, causing, or enacting an action or experience, even though it ap-

pears that way all the time. We also have evidence in neuroscience that there is no free will, and what appears to be local awareness at the individual level might be pan-psychic, suggesting that awareness through which we know all that we know is common across individuals. Even David Chambers, who coined the phrase "the hard problem of consciousness," is saying this of late. The knowledge from Eastern phenomenological investigations of the self and self-experiences is similar. The individual sense of self is derived from experience; it is an illusion, and there is no free will at the individual level. If there is no individual sense of self and no free will, what then is the source of all of our experiences? Eastern perspectives suggest that our experiences at the level of the individual gross body are stimulated and regulated by the individual subtle body, and that our experiences at the level of the individual subtle body are stimulated by the collective or universal body. There are reports of people in all walks of life all over the world corroborating these observations, all the way to their ultimate personal realization of themselves as the unchanging and unlimited awareness that is the basis of the universe, which is at the same time inseparable from the universe. People have had these experiences sometimes spontaneously, or through meditation, or phenomenological inquiry of self and self-experience, or during spiritual practice.

These findings have major implications for body psychotherapy and psychology, as well as for phenomenological inquiry of psychological phenomena in the West. If there are several bodies contributing to the stimulation and regulation of experience at the level of the individual gross body, is the practice of body psychotherapy limiting its effectiveness by overlooking the findings from the East? It is interesting that The American Psychological Association, while yet to approve of a body psychotherapy approach for continuing education for psychologists, as far as I know, has approved two energy psychology methods of TFT and EFT, as far back as 2012 on the basis of their incremental effectiveness in outcome studies with control groups.

These findings from the East are not new. They have been around for thousands of years. Their influence can be seen in some mainstream psychological approaches, such as Jungian psychology, and body psychotherapy approaches such as Biosynthesis. Why have they not influenced Western psychology and phenomenology to a larger extent is a question I asked myself in my dissertation for my PhD in clinical psychology. There seem to be multiple reasons.

One reason is the use of religious or spiritual terms in these extensive Eastern findings, which span thousands of years of phenomenological inquiry into the nature of the self, the world, and their relationship. In the East, the individual subtle body is sometimes referred to as the Soul. And the collective universal body is at times called the Spirit, or God. Carl Jung, taking inspiration from India, called the collective universal body the Self. He also said that the Self was God-like from observing how the whole is symbolized across cultures. For this, he was criticized in the West as unscientific, and called a mystic. You can see how the use of the terms Soul, Spirit, and God might have unfortunately confounded in the Western mind religion and spirituality with the results of a phenomenological inquiry that anyone can undertake to verify the results for themselves. The intermingling of philosophy, psychology, religion, and spirituality is less of a problem in the East. It appears that Eastern phenomenologists benefited from a more favorable cultural environment where religion was not at odds with science, philosophy, and psychology to the same degree at the time of the inquiries. Religion and spirituality on the one hand, and science and philosophy on the other, have been so opposed to each other in the West that the presence of religious or spiritual terms in the findings of Eastern phenomenologists probably made it easier for Western scientists, phenomenologists, and psychologists to instinctively avoid closer examination of these findings and the methods used to obtain them. The fact that many of these Eastern phenomenologists were deeply religious and treated reverently as gurus I am sure did not help.

A second reason is that these findings were obtained through first- and second-person phenomenological methods. This approach may have made it even harder for science to engage with them, especially when scientific methods lack an adequate grasp of their limitations and scope, leading to the dismissal of findings even from Western phenomenology.

A third possible reason is a fundamental difference between Eastern and Western philosophy on the nature of the subject in subject-object rela-

tionships. In Western philosophy, as exemplified by the writings of philosopher Immanuel Kant, it is not possible to think of a subject without an object, and an object without a subject. The citing of Kant is important because his philosophy has informed and influenced Western science, phenomenology, and psychology a great deal. This is one of the reasons why Jung, a Swiss psychologist who incorporated much of the larger Eastern model of the psyche into his own worldview, balked at accepting its ultimate finding that a singular unchanging awareness is the basis of the universe – a finding that even quantum physicists such as Erwin Shrödinger, Niels Bohr, and David Bohm corroborate in their writings as a distinct possibility that is consistent with the trajectory of findings in science.

In Eastern philosophy, phenomenology, and psychology, a subject can be aware of itself without making or splitting itself into an object. One can easily verify this obvious fact for oneself by turning one's attention to the witness consciousness, or pure awareness, in one's mind through which we become aware of everything. Everything becomes conscious through one's awareness. However, the fact that one's awareness can be conscious of itself without becoming an object is often seen as self-evident. The reason why it has been missed for so long in Western science, phenomenology, and psychology might have to do with the basic assumptions that they tend to hold as axioms, as incontrovertible truths, that blind them sometimes to the obvious they could find if they were to drop them. When we strongly preclude things as not possible, we do not look for them. For example, we lived for a long time with the conviction that earth was flat, while even threatening people with their lives if they disagreed.

At the top of the list of such unexamined axioms is probably the basic assumption that awareness does not have the capacity to be self-aware without making itself into an object. Then there is the assumption that all our experiences, including awareness, are a product of one body, the physical body in the West, or the individual gross body in the East. The insistence that only the scientific method can produce valid findings about oneself and the world, despite its obvious limitations, is another. However, because Western phenomenology does not share the illusion that the scientific method is without limits, it might lead the way to further exploration. This could involve examining the nature of the subject of one's experience, rather than just studying the experiences of the subject. Perhaps it could then validate the findings of Eastern phenomenologists on the different levels of an individual's body and psyche so that Western psychology can follow suit, and work with the different bodies involved in the experiences of an individual. This can offer a more comprehensive model of the psyche, not only for greater self-understanding, but also for making psychology more effective in all of its treatment approaches from embodying all levels of the body and psyche, since it is becoming increasingly scientifically clear that cognition, emotion, and behavior depend not just on the brain, but also on the body and the environment.

Giovanna: This is a lot to reflect on and comment on! Do we have a whole day, or more? Let me at least say something about parallels – or rather the lack thereof – in Western phenomenology. In Western phenomenology, philosophers like Sartre, Merleau-Ponty, and many others have pointed out that consciousness, including consciousness of one's own body, is not always conspicuous, obvious, or "in the foreground." It can also include, for example, bodily feelings we only have "in the background" – such as, perhaps, a piercing headache we do not pay attention to because we are giving a lecture. Such phenomena are said to be "implicit," or "prereflective" (i.e., not attended to or reflected on). This goes some way toward the idea that we also have "subtle" bodily feelings... but it is not reflected in notions comparable to the *prana* in India or *qi* in China. The latter are, as you say, often considered as actual types of bodies – the "subtle body" constituted by the chakras, for example. So, there are some attempts in Western phenomenology to say that consciousness is not always full-blown consciousness, explicitness, but it is not the same thing you were talking about.

Another thing I thought about as I listened to you is the concept of "meta-consciousness" in Western philosophy. This refers not just to being conscious, but to being conscious of that, or about being conscious. For example, when I look around now, I'm conscious that there is some blue object over there. And I can also reflect on the fact that I am having, say, a visual perception of the blue object, rather than an auditory one. This conscious reflec-

tion about my perception of blue is "meta-consciousness." There's an extensive discussion of it in analytic philosophy; it is sometimes also called "second-order consciousness." Anyway, the point here is that this notion implies that the mind has more than one level of consciousness. I know that in the Upanishads there is also a famous distinction of different levels of consciousness, although it is quite different (it refers to waking consciousness, dreaming consciousness, etc.). Importantly, the Upanishads also refer to our most inner and true self (*atman*) as "the watcher" or "witness consciousness" – indicating a conception of *atman* as what some Western philosophers call "meta-consciousness."

Raja: Perhaps there is a need for a little more clarification. *Atman* is the limited witness consciousness at the individual level. When freed of its identification with the individual, it is revealed to be the same as *Brahman*, the unlimited witness consciousness that is the invariant basis of the dynamic universe. The East says that all of this can be arrived at phenomenologically by anyone investigating the witness consciousness and the limited sense of self that it is identified with, the sense of self that is an epiphenomenon of experience.

Giovanna: Indeed, in Western phenomenology, pointing out that we can be conscious of the fact that we are conscious is not a consideration that leads to claims about the nature or essence of the world, and/or to religious inferences.

Raja: In the East, meta-consciousness, the awareness that I am aware of something, such as "I am aware that I am thinking," is just the starting point of a longer inquiry into the nature of the witness consciousness. Even in the "I am aware" part of "I am aware I am thinking," the witness consciousness is fused with the sense of self that is a product of experience, a product of the gross body when one's subtle body is interacting and identified with the gross body, and a product of the subtle body when it is outside of the gross body, as in out-of-body experiences. The phenomenological investigation of the "I" with the question who is this "I" that is thinking can lead to the sense of self becoming an object of the pure witness consciousness, and becoming separable from it. Further investigation of this witness consciousness without the sense of self obscuring it can lead to the realization that not only it is who one is, but it is also the very basis of the universe, including all levels of one's body, or all of one's bodies in the universe. This self-realization is possible for every individual who engages in such a phenomenological inquiry into the nature of oneself through one's experience, according to Eastern phenomenologists.

Giovanna: As I am sure you know, enactivism in its origins was developed in a book called *The Embodied Mind* (Varela, Thompson, and Rosch, 1991), which was heavily influenced by Buddhism. Later on, Evan Thompson wrote more about the relation between Western phenomenology and consciousness studies (including neuroscience), and Asian philosophies and meditation practices – see, for example, his wonderful book *Waking, Dreaming, Being*. Whether and how enactivism relates to notions of selfhood, meta-consciousness, atman, and Brahman is a very complex question I will not try to address here. It will be interesting to those of your readers curious about enactivism to also look up, if they do not know it already, the Mind & Life Institute. Many scholars involved with it are sympathetic to enactivism. Francisco Varela was one of the founders of the Institute. They are generally interested in attempts to bring contemplative traditions in dialogue with experimental science. The Institute focuses strongly on Buddhist approaches to the mind, and is open to other traditions as well.

I do see one problem, though, in what you said. When Western scientists hear statements like "the subtle body is a body of subatomic particles," or "the finding in quantum physics that matter and energy also exist at the subatomic level corroborates the notion of the subtle body," they are likely to dismiss them right away. I am very interested in the notion of the subtle body, and I know I sense things that I do not usually sense when I practice Tai Chi and Qi Gong. However, I think we need to be cautious when making claims about subatomic particles and the subtle body, as these are empirical claims that are, however, very difficult to verify experimentally. But we can keep trying.

Raja: Yes. I sincerely hope so. But scientists who cannot admit to the limitations of the scientific method and of the narrow scope of its inquiry are

prone to dismiss things that can only be discovered through phenomenological means. It is good that quantum physicists of the highest caliber, such as Shrödinger, Bohr, and Bohm, are able to see that the findings of Eastern phenomenologists enhance, if not complete, their scientific understanding of the world. I also hope that Western phenomenology, philosophy, and psychology become more embodied by incorporating all the bodies involved in the psyche in their work.

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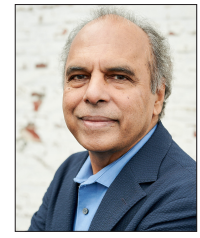

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Creative Agency

Changing Life Trajectories

Larry J. Green

ABSTRACT

In this article, I describe a practice that employs somatic awareness as a method for both disclosing and working with internal conflict. In the two cases described, transformational change became a possibility for one client, and an actualization for another, I instantiate these abstract claims in two case studies. In the first case, I describe the initial launch into the transformational process and, in the second, the unanticipated and beneficial results occurring later. This process is produced by a creative act that replaces limited foundational premises with ones that transcend those limits – thereby changing the person's life trajectory. Creative agency is both the source and force capable of generating this fresh psychic form. This capacity is accessed by stepping outside the confines of personal consciousness. Once there, one can operate from an impersonal consciousness. This possibility is based on the notion that humans are endowed with impersonal consciousness at birth. Originally it is employed to construct a personal self that will eventually become a sedimentation of that individual's experiential history. Transformation requires access to the same psychic powers that produced the original self. Both the original creation and its subsequent transformation occur through the exercise of impersonal consciousness. Throughout the piece, I interpolate theoretical interpretations that clarify how my approach taps into somatic, existential intelligence – creative agency.

Keywords: impersonal consciousness, transformation, agency

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> ***... my support gave them a foothold from which to begin or continue their climb.***

In the following article, I discuss an approach that resulted in a transformative experience for two of my clients. When I began my career, I had thought that the therapeutic project was similar to religious conversion: a shift of the fundamental ground or foundational premise that governed the person's psyche. However, after five decades, I've come to realize that many therapeutic projects only "tweak" the default network. However, the cases I present below refreshed my belief that therapy could be transformative. In both instances, that outcome resulted from the exercise of existential agency. "Do I make a new path or stay with the well-trodden?" I see parallels

between this notion and Bergson's [1] (2022) term "creative emotion." Both terms point to a capacity to make an originary move that first disrupts, then replaces, the previous "settings" that governed the trajectory of one's life.

The capacity for making that shift is ontologically primary, while the mind and will are secondary derivations. I understand the mind as a conceptual distillate of life experience. Therefore, it can only develop variations on themes already in place. Creative agency, on the other hand, is an activity that isn't dependent on past experience. It is employed to create concepts for the mind, but in itself is non-conceptual. Furthermore, it is dynamic, always on the move. The mind, on the other hand, works with stable concepts, repeating patterns, and the will for continuity. At the end of this paper, I offer a theoretical explication of the transformational process both clients experienced.

Methodological caveats

The model that I employ assumes certain family resemblances among different terms. For example, creative agency and existential choice are transformative capacities that are exercised by prepersonal or impersonal consciousness, whereas the structures of the psyche – the pre-reflective self, ego, identity, and personal consciousness – all refer to the products of creative agency. Thus, I am pointing to the relationship between the creator and the created.

Moving through my account, the reader might be tempted to attribute the radical outcomes to the technique or strategy employed. They might try that technique, experiencing success with some clients, and not with others. This mixed outcome would trouble the implicit or inferred promise of many journal articles – "Try this technique and you'll be masterful". My caveat? The outcomes that I describe are not exclusively the result of my intervention – although it seemed to be a deciding factor. Other contextual factors amplified its power. For example, most clients come to me through word-of-mouth recommendations. They arrive expecting me to be helpful. Our therapeutic relationship continues building on that initial platform. Mutual respect and trust quickly characterize our intersubjective field.

Perhaps the most significant contextual factor is my fifty years of experience – I trust my intuition and skills. I don't rely on an agenda to feel confident. I look forward to our exploration into the unknown – something that previously frightened me. I relax, knowing that my unguarded receptivity will eventually generate rapport. I begin by encouraging them to "plug into," and express, their reality as accurately as possible. "Most of the day you're adapting, responding, and receiving others' reality; here, you get a chance to experience and explore your own." When clients do that, a deeper intelligence begins to guide their speech toward a more accurate construal of their relationship to their circumstances. They begin to distinguish "off the shelf" meanings from those that demonstrate fidelity to their unique experience. My function at that point is to apprehend and mirror their emerging description, to accompany them as they explore and describe their reality.

For that exploration to continue they also must summon courage – to make the leap of faith without presupposing a specific outcome (which could only be an iteration of what the mind already knows). As the following accounts testify, these clients did their work; my support gave them a foothold from which to begin or continue their climb.

I've organized the article into sections. With each client, I present my version of the session, followed by theirs. I wanted to make it clear that dual realities are interacting, not some final truth that was in my possession and to which I was guiding them. Second, these accounts reveal that much of therapy is like dancing in the unknown; one must think on one's feet. Recounting the session afterwards never quite captures the twists and turns of the process, including the paths entertained but not taken. Likewise, the sequence or pattern of the interaction that I recount is a verbal sketch that leaves much out. For similar reasons, the phrases that I remember are often not the ones recalled by the client.

1. The concept of creative emotion in the philosophy of Bergson does not depend on intellectual representation; it is primary in regard to the mind and the will, and it comprises the fundamental matrix of creative acts of the human being. "It is the impulse which leads us to seek out new paths…" (p. 4, 2022)

Nevertheless, under these surface verbal disparities, some implicit underlying unity is generating both accounts.

First case study

During the session, Louise (not her real name) talked about the differing rate of change between her and her partner – his speed was slower than hers. When I commented that this might be frustrating for her, she corrected me: "No, it just made me sad [for him]." She continued, "My sadness was at the thought that he may never escape the damage that was done to him in his childhood." She began to cry. I instructed her to say to herself, "That feeling belongs here," and then to notice her body's reaction. (I had previously talked to her about Gendlin's (1997, 2020) notion of the felt sense, which she seemed to intuitively understand). She did as instructed. I then asked her to let that feeling fade away and say a second sentence: "That feeling doesn't belong here." Typically, when someone rejects their experience, their anxiety intensifies, and when they accept it, they relax. But with Louise, something unusual happened. When she uttered the second sentence, she reported that she went into a vast space, initially described as fearful. Then she remarked, "Decisions have to be made." She was glimpsing the possibilities and demands of existential agency. Then, to my surprise, she said that she felt relief, and that many possible "roads" had been presented to her. Furthermore, she reported feeling empowered. These were unusual responses to this approach. No previous clients had spoken of "vastness." Nobody had spoken of empowerment. Rather, they spoke of their relaxation when they "owned" their previously rejected experience. I then referred to Chogyam Trungpa (1973), a Tibetan Buddhist teacher. He described a way of utilizing that vastness to access the required energy for the completion of tasks. I wanted her to know that someone other than herself had identified that space, and connoted it positively, as a place of empowerment. I wanted to suggest that the vastness wasn't her idiosyncratic creation, but rather had some transpersonal validity.

The felt sense

Setting aside this narrative account for the moment, let me offer some theoretical support for this intervention. I am leaning on Gendlin's (1997, 2020) work regarding the "felt sense." It is an embodied awareness of what is existentially significant for this particular person at this particular time. It is not to be passed over lightly, like some intellectual possibility that could just as easily be dropped than explored. Rather, it is an existential marker. Many of the clients who show up in my office have lost the ability to "tune into" that embodied knowing. To help them regain access to that source, I ask them to attend to the sensations arising from the sole of their right foot. I give them a moment to do so. Then I ask, "Were you making any judgments about those sensations – for example, labeling them good or bad?" "No" has always been the response to this question. "Fine," I reply. "Now expand your awareness to take in the sensations of your whole body, the whole force field that your body is generating, that your consciousness is inhabiting. Don't think about it, don't judge it, just register it. Now I'm going to give you a couple of sentences to repeat, and I want you to notice how that force field responds when you entertain those thoughts." Typically, I reverse the order that I employed with "Louise." That is, I start by aligning my suggested sentence with their presenting complaint; that sentence expresses their rejection of some aspect of their experience. For example, one of my clients announced that she had dreamed of her previous partner the night before. "I want my ex out of my dreams and out of my mind." Later in the session, I asked her to repeat that sentence. "Pay attention to how the force field responds," I add. Then I instructed her to let that feeling fade away, after which I offered the second sentence – something like, "I have to admit that, yes, my ex is still preoccupying me." Typically, clients report that their anxiety or tension goes down when they say the second sentence. I attribute that result to the shift from denying to accepting their experience. With Louise, however, I reversed the order of the questions that I offered: first accepting – "That feeling belongs here"; then problematizing – "That feeling doesn't belong here."

Competing agencies: The ego and impersonal consciousness

Because my client's reactions were so unexpected, I found myself wondering if different domains of her psyche were responding. Could it be that the first utterance is welcomed by the ego because it eliminates self-contradiction, whereas the second

elicits a response from beyond the ego – that impersonal part of the psyche that makes existential decisions? Let us delve a bit further into the first response, where acceptance of what was previously denied might produce relaxation. Could it be that anxiety is a signal from the psyche to the ego that something is being overlooked, that some bit of reality has not been accounted for? When that bit is allowed to enter, and then integrate with, the ego's system or network, there is no further need for anxiety. As for the second sentence, does it catapult the person beyond the ego's "default network" – into creative agency?

Let us return to the case study. In a follow-up email, I asked "Louise" to write an account of our session. In my request, I employed the term "guardrails," as that which had confined her within a limited set of possibilities. I wondered about their function. I did so because it seemed to me that she had moved past those rails when she said the second sentence: "Many possible roads had been presented." Many young people, seeking to establish their independence, often discard their parent's rules, moralities, guidelines, choosing instead to make their path. They were attempting to construct their lives by first abandoning or deconstructing their parent's admonitions. Often, they get lost and can't find their way "home." Fears of homelessness or loss of sanity begin to arise. To avoid that disaster, they begin to construct their own rules – intended to return to and maintain them on safe ground. At first, they follow their rules consciously, but eventually they "forget" that they authored those guardrails. Now their consciousness is operating from inside that construction – the outside is non-existent. As a result, the limits are experienced as objective givens – this is the horizon of the world. However, when they're in enough distress – "I can't go on like this!" – then, out of desperation, they approach and begin to critically inspect those guardrails. In doing so, they are invoking their creative agency. They begin to realize that the rules they designed to protect themselves also restrict the range of responses available to them.

For example, another client of mine has an alcoholic mother and an ineffectual father. She is enraged by their impotence. Why? Because she has a rule that she must be sweet, generous, and helpful. In short, she believes that she is responsible for her parents' well-being. Her rule demands that she give up her life and serve theirs. She feels like she would be violating a taboo if she were to critically inspect that rule. To do so would risk an identity crisis. It is an existential dilemma. Resolving it requires the courage to think beyond those guardrails. Out there, she might decide to keep, revise, or replace them.

I offer this description because it instantiates the transitional journey as one moves from operating within the parameters of the constructed ego to an acknowledgement of one's affective experience as expressed through the felt sense – from "I'm a sweet, nice person" to "I'm becoming a rageful monster." From there, it is a short step to "I can't go on like this." Do I resign myself to my fate, or do I call upon my creative agency to discover or invent fuller possibilities for myself?

The client's version

The following account describes the first client's experience. When I thought it necessary, I inserted a word to make her meaning clearer. Those insertions are indicated by [...].

I believe what kicked off some of the deeper conversation in the session was an initial discussion of the concept of "felt sense," and my curiosity to learn more. I made a comparison to somatic therapy that I had experienced, and you offered some helpful clarifying info to illustrate the difference between them, which then segued very naturally into leveraging the felt sense to go deeper into what was at the bottom of some of the relationship issues I was feeling. The main feeling that surfaced was one of sadness on my part, and your effective paraphrasing helped to further clarify my feeling of "It's such a waste," and a deeper frustration because I can't change [my partner].

This is where it continued to go deeper. You had me "try on" the statement "This sadness belongs here," and say it out loud. In my stomach, there was a heaviness, and at the same time a release, because I hadn't allowed myself to feel the sadness to this level. It created space and permission for the feeling to show up fully and be realized. In addition to heaviness, there was a feeling of a confined space, perhaps a subtle constricting feeling. [She was uncovering and exploring the ambiguity and ambivalence present there.]

Then you had me try on another statement to say out loud, which was "I don't want this sadness." I sat with this, and a lot of emotion and tears welled

up immediately. The most fitting word that came up for me to describe sitting in this space was a "vastness," which came with the initial reactions (and in retrospect some resistance) to this place as "overwhelming," "scary," "uncertain," and "unknown." I remember you holding this space, and then specifically asking if I felt okay to go into the vastness a bit more. This was a key moment, because it gave me the pause I needed to truly think about whether I was ready. In that pause, I realized I felt very supported by you (particularly by how the question was asked), so I knew I was in a safe place. I also became aware of both my inner courage and a desire to keep going. [By asking her about her willingness to go further, I was acknowledging that it was her choice. If she chose not to go further, that would have been accepted and explored.] I think deep down there was also a recognition that we were on the verge of a big discovery that could unlock something important. [By staying present through the process, the client begins to experience an evolving, rather than a concluding understanding.]

I remember taking what felt like a good amount of time. It felt like at least a minute, but it was likely less, and I consciously closed my eyes and went deeper into the vastness. What happened next was what I remember to be the most profound moment of the session. I recall having a very clear image emerge of what looked like a vast canyon, and blue skies with clouds (it has stuck with me even as I write this). And then what followed was a flood of recognition of what truly lives in this vastness, which is love, possibility, openness, strength, and acceptance for what is, what could be, and what is yet to be. There are many roads and potentials in this space, and whereas [predefined] outcome has been my overt focus in the past, the most important [thing] is the beauty of the journey, no matter the outcome. I remember describing this to you as a deep knowing that this is where love lives. It felt like an empowering space, versus one of fragility and fear. I remember putting my hand on my chest to connect to myself, and perhaps to lock in my memory of that important moment.

To wrap up, overall I felt there was a sense of natural flow, despite the many twists and turns of the session. There were difficult topics covered that could have resulted in some sticking points, but I didn't feel that happened at all; there was a consistent, healthy pace that felt natural and not rushed at all. I felt this was largely in part to your guidance and intuition of where to go, and then me tapping into my inner courage to go deeper in the right direction. As you said, I really "showed up." Well, we both did.

Second case study

I had been working with "Glen" for some time when I related the therapeutic interaction described above. I did so because of the experiential parallels between her experience and one he had undergone previously in our work together. In that earlier interaction, he had moved from a long-standing position of "Everything would be better if I didn't exist" to an existential decision to live. As he began to recall the experience, I wondered if it would be revivified. Would his memory come to life as he discussed it? After a short time, he said, "Just talking about it is bringing back some of the sensations…my hands are tingling." His existential sense was being reactivated.

I initiated this exploration because I thought that hearing an account of another's parallel experience had the potential to validate his own. Feeling validated, he might be encouraged to explore his experience further. Before describing that further exploration, let me take a moment to describe outcomes that had prepared the ground for this further investigation. At the beginning of our work together, he protested that his wife was disconnected and unavailable to meet his needs for intimacy and authenticity. His relationship premise seemed to be that if she loved him, she would always be available. He also referred to her as his life source. In light of that, his constant need for intimacy and authenticity would be understandable. However, in a subsequent session, he reported a conversation in which he told her, "You are my life source [responsible for my well-being], and that is totally not fair to you… that is too much of a burden to put on you." He had begun to loosen his identification with, or attachment to, his initial premise. By so doing, he was able to make explicit what previously had governed him implicitly. That is, his consciousness was no longer compelled by his yearning for connection. Rather, he had enough psychic distance to be able to "see" the attachment to which his yearning had fastened. Now, he was seeing, rather than being, that attachment. By seeing it, he was confronted with an existential choice. He could now choose to take responsibility for his well-being, rather than

continuing to offload it onto his partner. He could see the road not previously taken.

My account has now arrived at the most recent session. During our conversation, he related an incident that occurred the previous evening. He had put his arm around his wife; she shrugged him off. He was okay with that – actually okay, rather than pretending to be. Later, she asked him if he was okay, and he responded authentically, "Yeah, I'm fine." Then he revealed to me that he had interpreted her manifest question as a camouflaged version of her real question – "Are you okay with the fact that I pushed you away?" He answered the question she asked, rather than the one he surmised. This move invited her to be responsible for her communication, rather than expecting him to mind read her intent, as had been their habit. That is, their shared history had established the expectation that all she had to do was imply intend, and he would fill in the missing content. Now, he was performing a new interactional pattern. Just as he no longer expected her to be an extension of his needs, he no longer needed to be an extension of hers through "mind reading." When I shared my interpretation of their exchange, he replied that he previously didn't have genuine conversations with others. Rather, he responded to what he surmised the other was thinking. No reality checking. Ultimate loneliness.

One criterion for transformation is that the new premise is applicable in a variety of contexts. His new premise was, "I'm responsible for my behavior, and others are responsible for theirs." This is not tethered to one specific context (e.g., his relationship with his wife), but also generates new responses in other contexts. For example, he described a recent meeting with government bureaucrats who were attempting to set up a jobs program involving his business. He was able to bring clear communication to their meeting. He observed that when he was clear about his position, they became clearer about theirs. In the past, when he was conflict-avoidant, he would have joined them in their obscure, inoffensive communication style, and nothing would have been accomplished. I'm relating these two instances – first with his wife, and then with these bureaucrats – as evidence that transformation had occurred.

He then went on to say that the event that initiated these changes occurred after I "walked" him through the same therapeutic procedure as I had used with the first client. When "Glen" began therapy, he related a recurring thought: "Everyone would be better off if I was dead." That is the sentence I asked him to repeat. "As you repeat those words, notice how your body or felt sense responds," I added. Almost immediately after uttering the sentence, he said, "That's not true; I want to live." As best I can recall, he added, "I could feel a protest rising within me as I was saying it." That protest was irrefutable existential evidence that he wanted to live. "Since then, I haven't considered my non-existence, with one fleeting exception. I was under a lot of stress having to deal with a fractured family's issues when my grandmother died. The desire for my absence arose and departed almost in the same breath, and it hasn't come back. It's almost like I've forgotten to think about it so completely that I don't have to stand guard over these negative thoughts."

This remarkable outcome seems somehow existentially connected to an experience that originally brought him to therapy. Here's a sketch of what happened. He had been raised by a drug-addicted father. During a recent phone call, his father said, "Well, despite all your faults, you've done a good job of raising your sons." This set off an intense emotional reaction: "I don't want to talk to you ever again; if you have something to say to me, do it through my uncle." He then drove over to a friend's place, went immediately to his basement, and had an intense cathartic release that lasted for about twenty minutes. He was quietly supported through that existential storm by his friend.

Subsequently, he seemed to, at least partially, have left the old "Glen" behind, and now inhabited or was giving life to a new one. Did his cathartic experience involve tapping into his life force? Or did his life force, his prepersonal consciousness, simply push aside the defenses of his personal consciousness? Perhaps he had stopped waiting for his father to be the father that he had always wanted and needed. I can't help but notice the theme of dependency that was being worked through both with his father, and later with his wife. He had found his own ground.

The client's version

I started my session today not knowing what I was going to discuss, and frankly, I thought it started out a little light, talking about the news and ar-

thritis. It [shifted] when I began sharing about my partner and the disconnect I had been feeling with her. I recounted an experience where I was initiating intimacy but was pushed away. In past experiences, this would have been very upsetting to me, as I would have felt rejected or dismissed. But this time, I was completely fine, accepting that my partner wasn't interested at the time, and wanted her own space. The work I have been doing over the past eight months has resulted in amazing growth and understanding of myself. [In the past] I would quickly go to a place of feeling unwanted and rejected when things didn't go the way I was hoping. I would say that it would just be easier if I wasn't here, if I was dead. In a previous session, I was particularly feeling this way, and Dr. Green asked me to repeat two sentences. The first was, "I want to give up," and I said this sentence with ease. The second was "I don't want to give up." An immediate overwhelming emotion came over me as he said this sentence. I broke down and got very emotional, crying uncontrollably, trying to say the words "I don't want to give up." Once I finally composed myself and was able to speak these words, I was more at ease.

In our session today, I mentioned to Dr. Green that that moment was a turning point for me, a new normal [a new foundation?] almost. I knew I wanted to be here, and that I wanted to fight, to work, to live. I didn't want to quit or give up. Since that moment, I have had those feelings again, but they are just a blip. I feel them for a second, and I say to myself, "I want to live, I want to be here." The funny thing is now when I'm in a place where the feelings used to creep in, they don't, but I am aware that they don't, and I can remember that they used to, and now they don't. Another meaningful moment in our session today was when I was talking about my growth, and how in the past, I felt connected to my partner and wanted her to have the same growth [as I was experiencing] at the same time. Dr. Green called it being tethered, and that was a perfect description. That I was tethered to her, and as I grew, the line or elastic became tight, and was strained or stressed. It's almost as if my growth was hindered by the tethering. I realize now that I can regress [or progress] on my own, unaffected by my partner. We can be in different places at different times, and it's okay. I used to say we were like a balance scale or a seesaw; when one of us was down, the other counterbalanced to make it straight. But that's not true; we are separate beings completely on our own just sharing the same space.

As the reader has probably noticed, mine and the client's account don't always line up. Even the rendering of the chronology differs. Nevertheless, I hope the underlying existential theme generating both versions can be recognized.

Interpretation

How can I account for these events theoretically? I offer my provisional and revisable explanation. My counseling approach involves first identifying my client's internal conflict. In other words, they are paralyzed by ambivalence, and typically try to eliminate it by banishing one pole of their experience. For example, "I don't want to see myself as a jealous, insecure person; I want to get rid of that part of me." They've previously thought that it would be just a matter of willing it away – until they can't help but notice that insecure persona continues to show up. They are futilely trying to use their mind to resolve the conflict.

Next, I introduce them to a reference point other than their mind – their affective responses. I am showing them how to become aware of the interaction between their conceptual meanings and their existential, affective response. When they initially come to me, they are mostly aware of their conceptual processing, with its explicit and distinctive meanings. Their affective experience, on the other hand, is implicit, and initially murky. I direct them to move back and forth between those two regions of "knowing" – trying on words, phrases, and metaphors that have the potential to capture and express their experience faithfully. When they find the apt meaning, clients momentarily experience wholeness, or a totality where both conceptual and affective factors refer to the same existential source. This is the moment when the mind catches up to the body, no longer disowning the ambivalence. Instead, both sides of the conflict are acknowledged as expressing some aspect of the self. The client begins to look for some arrangement where they can live together. The previous experience of internal conflict and its resultant anxiety is replaced by an experience of integrity, bringing with it a sense of empowerment.

In addition, the client consciously experiences their vitality affects. That is, they get direct evidence of

meanings that increase or diminish their energy or vitality or life force. That evidence supplies them with the means to navigate through the multiple choices that everyday living requires. They can present their action options to the totality of their being, and observe how the life force responds to each of those alternatives. The option that produces the most congruence is the best bet – not as a guarantee, but as a probability.

Furthermore, having noted what spontaneously increased their energy, the person will be on the lookout for associated or related phenomena. What other people, books, and movies might stimulate further enlivening? If reading Rimbaud generates excitement, read more of him. If the theme of identity becomes compelling, read what philosophers and psychologists have to say. If transition and change seem to be daunting prospects for continuing the journey, read everything you can on liminality. On the other hand, when your vitality falls, notice if the meaning assigned to the event, or the brute event itself, initiated the withdrawal. For example, your partner leaves you and you feel wounded by the loss; that is a tragic event, and the resultant grief is a necessary if unpleasant emotion that needs to be respected and worked through. However, if the meaning that one attaches to that event is "I'm unlovable," then further possibilities are foreclosed by that conclusion. The process of becoming has been arrested.

Conclusion

Let us end by returning to the title of this paper: *Creative Agency*. What is meant by that term? The creative agent makes decisions and engages in actions that will have real consequences (some intentional and some not). An apt metaphor would be hiking a treacherous mountain trail for the first time. As you move through the fog-enshrouded landscape, you come to a branching path. You don't know where either branch leads, but still you must choose. Should I marry, divorce, have an affair, start a business, or move to a region that will have fewer climate change catastrophes? Should I speak my mind instead of flying under the radar? One makes those decisions knowing that they entail risk, that the unanticipated, as well as the intended, will show up; one's life might get worse – or much better.

I contrast the movement or progression that characterizes creative agency with the circular, conceptual "looping" that characterizes rumination and obsessing. These processes are a misguided attempt to do away with signal anxiety without having to act. Signal anxiety is the implicit awareness that something important is being overlooked – the affective or felt sense. The mind is trying to solve the dilemma without acknowledging and factoring in that "important something." It prefers to stay within its pre-established framework – recycling, even rearranging, familiar meanings while giving the illusion of "doing something." One eventually arrives at the same unsatisfactory conclusions that leave one's circumstances unchanged, because no originary action had been attempted. A sense of resignation develops when one fails to open and critique those "given" meanings (which would undermine their absolute status). Thus, critiquing opens new potentialities. Obsessing, on the other hand, is a futile attempt to find an interpretive framework that masks the internal conflict with a rationalization. Often, the ruminator just circulates around the question like a leaf caught in a whirlpool. The creative agent, on the other hand, decides, acts, and registers the result. That fresh information is factored in as the basis for their next decision – action guided by perception in an ongoing dance between the subject and their circumstance.

They realize that they must choose, and act based on that decision. If the choice enacted makes their situation worse, then they have the confidence and courage to course correct. Client number one had many "roads" presented to her, and she knew that the choice was hers and not mine.

There were interesting differences in the transformational process of each client. The first client was at the beginning of the process; options were being revealed, and a decision would have to be made. The second client was remarking on his transformation retroactively. He noticed that he no longer felt "tethered" to his wife. His account made no mention of a conscious intention to untether. He was aware of the result, but not of the intention that produced that result. I'm surmising that something other than his mind or will was responsible for this outcome. Recall Bergson's claim that "creative emotion" was primary, and mind and will were secondary. When my client was reporting outcomes to me, it was from his mind, whereas the untethering was the result of creative agency.

My provisional explanation is that he got in touch with his life force during his cathartic experience. Perhaps it would be more accurate to say that his life force got in touch with him – revealing its presence to his personal consciousness. Much to his surprise, he wasn't torn apart by the encounter. Rather, he discovered that he was stronger than he thought. That realization made his dependency on his wife less critical. She was no longer his "life source," because he had experienced his own. Our sessions since then have been characterized by a kind of shuttling process where he first attends to his felt sense, and then employs his mind to generate meanings that capture and express his affective experience. A momentary sense of wholeness is achieved through matching meaning to experience. By so doing, he creates a new point of departure for his next move...and so on. Creative agency at work.

To summarize, many seek therapy when the forward momentum of their lives has come to a halt. The first task for the therapist is to help such clients realize that their "stuck" state is a result of unrecognized internal conflict. I teach the client to attend to their felt sense as a method for revealing that their existential self might be at odds with the injunctions that their mind or personal consciousness deems worthwhile. This revelation encourages the patient to "outflank" their personal consciousness, and enter the realm where creative agency is possible – impersonal consciousness. From that vantage point, they can become aware of their mind's injunctions, their affective responses, and the situational demands. Transformation is then a two-step process.

First, the creative agent or impersonal consciousness can discover and critique the limiting premises that produced the "stuck" condition. Second, it can discover or create premises that transcend the limits of the previous personal consciousness. For example, a person who has been torn between competing needs to be their authentic self and to belong – first one, then the other demanding priority in an unstable flux – finds a position where they can be their authentic self and belong.

The implication in much of the above is that the subject invents these new premises *ex nihilo*. However, in studying developmental psychology in children and adolescents, it seems that the movement from one stage to the next is facilitated through encounters with classmates who are operating at a more sophisticated developmental level. That is, the struggling person has concrete models available who instantiate a more satisfactory way of being. As we move deeper into adulthood, encounters with others who might serve that purpose become rarer. As an alternative to creation *ex nihilo*, one can access the mythic dimension and wisdom traditions as cultural resources. As Joseph Campbell said, "Myths are clues to the spiritual potentialities of the human life."

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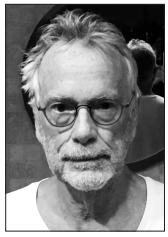

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Bioenergetic Psychoanalysis

Embodied Emotions as Seen Through a 21st-century Lens

Leah Benson

ABSTRACT

Bioenergetic Psychoanalysis (BioPsyA), in alignment with 21st-century science of brain function and emotion, posits that emotion and cognition are functionally indistinguishable and arise from the brain's continuous process of interoception and categorization. Emotions are learned cognitive constructs applied unconsciously to affective states within situated contexts, though emotion construction is not to be mistakenly conflated with cognitive appraisal. Physiological and energetic defenses against feeling are understood to be characteristic patterns of chronic muscular tension that are shaped in the early caregiving milieu. Methods for accessing and regulating emotions include building observational skills, practicing tailored movements, and engaging in relational exercises. Interventions are guided by a practitioner's creativity and the client's needs. Body-oriented interventions aim to enhance self-awareness, self-expression, and self-regulation, thus empowering clients to reach their personal and relational goals. Through integration with contemporary neuroscience, BioPsyA offers new insights addressing the interplay between the body and emotions within therapeutic contexts.

Keywords: theory of constructed emotion, Bioenergetic Psychoanalysis, predictive processing, active inference, character types

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> ***... emotion and cognition are functionally indistinguishable and arise from the brain's continuous process of interoception and categorization.***

From intuition to computation

By publishing the book *Character Analysis* in 1933, Wilhelm Reich, MD introduced the world to the idea of attending to the body during the practice of psychoanalysis (PsyA). In the 1950s, inspired by and expanding on Reich's ideas, Alexander Lowen, MD developed a psychotherapy he called Bioenergetic Analysis (BioA). From its beginnings, BioA has been understood and practiced in distinct ways by various practitioners. For some, BioA is understood as a coaching approach, wherein body-focused exercises and protocols are used to provide and teach symptom relief in the manner of cognitive-behavioral therapies. Other practitioners see BioA as a relationship-oriented depth psychotherapy wherein a conscious focus on embodied experiences facilitates the process, but is not central.

For distinction, the term Bioenergetic Psychoanalysis (BioPsyA) is used here to denote the relationship-oriented depth psychotherapy perspective, which is my own.

Originally, the BioA understanding of the role of the body in emotions came from the intuitions shared in the writings of Reich and Lowen, and were based primarily on classical theories of emotion. Today, the classical theories of emotion, including basic emotion theory (Tracy & Randles, 2011), and their foundations in the idea that emotions have distinct essences (Panksepp, 2010), have been refuted, as has the notion of a triune stimulus-response brain, which was found in most of the classical theories of emotion (Cesario et al., 2020; Steffen et al., 2022). As a result, Reich and Lowen's intuitions remain unanchored.

Fortunately, the 21st-century predictive processing/active inference framework of brain function – rooted in the physics-based free energy principle (Friston, 2010) – along with the theory of constructed emotion (Barrett, 2017a), provide a computational foundation for the BioA/BioPsyA understanding of the body's role in emotions.

The unified meshwork of emotion, cognition, and behavior

In alignment with the 21st-century understanding of brain function (see appendix A), known as predictive processing/active inference (Parr et al., 2022), and as posited in the theory of constructed emotion, BioPsyA assumes that emotion and cognition are functionally identical. Despite the subjectively distinct experiences of each, instances of "emotion" are indistinguishable from "cognition" at the neurological level (Hoeman & Barrett, 2019).

Cognition, like emotion, never occurs without affect (Duncan & Barrett, 2007), which is understood as a generalized and subjectively experienced summary of the brain's 24/7 process of interoception (Russell & Barrett, 1999). As a property of consciousness, affect is an ingredient in every mental experience (Barrett et al., 2016). From this perspective, instances of emotion are the result of learned cognitive constructs that have been applied automatically and unconsciously to affective states in situated contexts. In other words, emotions cannot be reified outside the contexts in which they occur. Emotions are a social reality (see appendix B). Counterintuitive as this may sound, attempts thus far to refute this understanding of emotion have failed.

Further, the predictive processing/active inference framework posits that, in the brain, the relationship of behavior to emotion and cognition is also indistinguishable (Clark, 2023, p. 102; Zhang et al., 2023). Cognition and emotion, only ever differentiated for purposes of efficient communication, are experienced subjectively only after the brain has already generated a plan for action (i.e., a behavior), and a synchronous, categorized, affective state. This is because the brain evolved in order to coordinate and control the systems of the body in service of movement (Barrett, 2017a, p. 3). Emotion, cognition, and behavior are all derived from the all-encompassing, simultaneous, meshed process in the brain known as predictive processing.

Subjective reality unfolds as follows: The brain launches a plan for action, also known as a prediction (Clark, 2015, p. 2), and sends a copy of that plan to the sensory and motor cortices. Simultaneously, the sensory consequences of that predicted action plan are generated as affect, which the brain categorizes based on the situated, external context.

This predictive sequence happens continuously at every moment of every day. It is the constant cascade by which the brain generates conscious experiences of thinking, feeling, and acting, which may or may not be experienced as emotion. If an emotion is experienced, it is because an emotion word has been previously learned to categorize that specific affective feeling in an associated context. Alternatively, a process called ad hoc conceptual categorization has occurred to make sense of bodily sensations in that context. For example, before the word *schadenfreude* made its way into the English lexicon, people were perfectly capable of experiencing pleasure derived from seeing someone else's misfortune, despite the fact that no single word efficiently categorized the experience (Barrett, 2017b, pp. 104-105).

Emotion words are tools that regulate the body's state. This process of emotion construction is unconscious, automatic, and learned through experience in much the same way that every other human concept is learned (Barrett, 2017b, p. 103). Importantly, constructed emotion is not to be understood as another name for cognitive appraisal, wherein bodily feeling is later synthesized with "high-

er-level judgment about what it means" (Clark 2023, pp. 99-100). Despite various attempts, this theory has not been disproven. It represents the latest best guess from the scientific community about what emotions are and how they function.

Character types to the rescue

Traditionally, BioA understands the physiological and energetic defenses that can make emotions inaccessible or dysregulated as characteristic patterns of chronic muscular contraction and movement that arose in response to the early caregiving environment. These patterns are understood to correspond to generalized mental conceptualizations of the self and the world. They are also understood to be associated with stories and meanings particular to each individual person.

BioA identifies five of these character types and understands them to have originated in the physical developmental phases of childhood. Whether or not they are identified as emotions, typical physical and mental defenses against strong feelings arise in the body of each character type. These defenses align with the physical and conceptualizing abilities a child had during the developmental phase when they needed to manage that feeling (and perhaps its expression) in a particular context (Lowen, 1958/2006).

While there is massive complexity across the presentations of each character type, in many cases it is possible to assign a primary and secondary type to a person. Occasionally, a typical manner of defending against strong feelings will cut across many contexts. This is generally a signal that disruptions in the child's environment during a particular developmental phase catalyzed chronic unmet needs or traumatic experiences (Lowen, 1958/2006).

This characterological understanding of defense arises directly from Reich's original understanding of the body's role in the process of psychopathology, and his concept of bands of tension ("armor segments") from the eyes to the pelvis (Reich, 1933/1990, p. 368).

The BioA character types are as follows: schizoid, oral, masochist, narcissist, and rigid (Lowen, 1958/2006, p. 151). Since their introduction, people have assigned less pathological-sounding names to these "characters" in an attempt to destigmatize them. The schizoid type is now known as the dreamer/creator, the oral type as the communicator, the masochist type as the solidifier, the narcissist type as the inspirer, and the rigid type as the achiever (Robbins, 1988/1990, p. 14).

The physical and conceptualizing abilities of each character type to defend against insult or overwhelm follow along developmental lines.

- Schizoid (dreamer/creator), 0–3 months: Babies have no control over their body, and cannot conceptualize. This correlates with the primary defense of dissociation.
- Oral (communicator), 3–24 months: Babies have very little control over their musculature, collapse easily, and have minimal ability to conceptualize. The primary defense will be making a ruckus, followed by collapsing.
- Masochist (solidifier), 18–48 months: Children have developed a sense of self and other. They can stand, walk around, and understands many concepts. The most salient concept is "no." The primary defense is refusal.
- Narcissist (inspirer), 24 months–7 years: Children are developing all the gross and fine motor skills, and have nearly reached the age of reason. Their conceptualization skills and physical capacities are well-developed in a manner that reflects a caregiver's expectations of who they "should" be. The primary defense is to passively or actively control others.
- Rigid (achiever), 7+ years: Children have reached the age of reason. They have developed all childhood gross and fine motor skills. The concepts used to understand the world, themselves, and others have been passed from caregiver to child, and will continue to develop over time. The primary defense is intellectualization. Muscular contractions correspond with the most typical concepts used to defend against feeling or the movement of energy in the body, as concepts are literally tools to regulate the state of the body.

Before addressing methods for working with character defenses, it is important to note that these conceptualizations of character type are not akin to zodiac signs. Character types are not destiny any more than it is destiny to not speak a second, third, or fourth language simply because English was learned first. Character defenses developed in a particular environment at particular developmental phases. Each present moment is an opportunity

to add new experiences of thought and movement that can be deployed in the future.

Furthermore, understanding what makes an emotion inaccessible or dysregulated changes along with the predictive processing/active inference understanding of brain function, and along with the theory of constructed emotion. In these frameworks, emotions are never actually inaccessible or dysregulated. Rather, the predictive brain either chooses poorly (or does not choose) emotion concepts for the current moment. Past experience is embodied in the concepts most typically chosen (including emotion concepts), and therefore in the person's character. Thus, past experience continues to unfold in the present moment via the person's actions and thoughts.

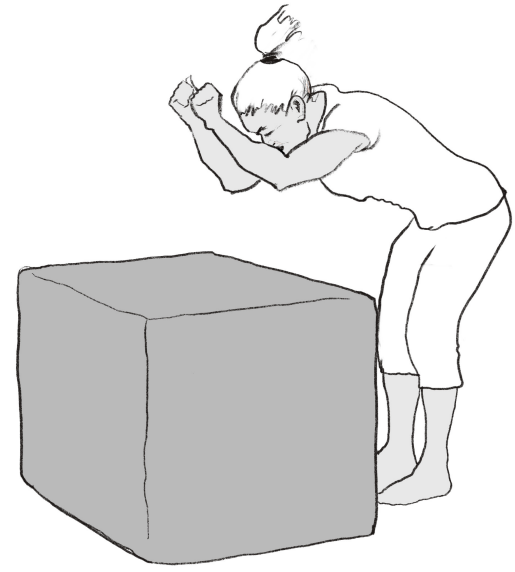
Deconstructing character defenses and building a better model

From the frameworks of predictive processing/active inference and the theory of constructed emotion, what it means to access and regulate emotions departs dramatically from the perspective held by classical theories of emotion. From this 21st-century vantage point, accessing and regulating are merely conceptual terms that facilitate efficient communication. They do not represent distinct processes occurring in the brain vis-à-vis emotions (Barrett, 2013).

Myriad as they are, methods for working with individual presentations of character defenses will be limited only by the practitioner's imagination. There is no specific protocol or exercise that works for every person, or for each person every time.

Specifically, the way I work with defenses to access and regulate emotions is by utilizing observed relationship patterns between the client and me, in the manner of psychoanalysis, and through hundreds of movements and relational exercises I've learned over years of bioenergetic training and exercise classes – or often invented on the fly – to expand an individual client's repertoire of actions and feelings, including emotional states, that may be restricted by being "locked in character."

At any given moment, the choice of intervention, be it interpretation, movement, or exercise, is directly related to the particular trouble a person is experiencing or wishing to address at that moment. An intervention can be as subtle as identifying the patterns of relating between client and therapist, and discussing how those translate into the client's life. It might simply involve pointing out the client's embodiment patterns as they speak. It might be as dramatic as a client screaming into a towel or pounding their fists on a foam block, or anything in between.



For example, if a client has trouble maintaining their confidence and resolve in the face of a strong personality, an exercise could involve inviting the client to notice what happens in their body as the therapist approaches them with an agenda, as if they were that person in the client's real life.

This allows the client to recognize the physiological state they automatically switch to in the face of that person – in this case represented by the therapist – and consciously choose to practice altering or regulating their state: i.e. changing the automatic, unconsciously chosen winning predictions for action that the brain has been using to navigate that moment.

Generally, the client might recognize, for instance, that they tense up, lock their knees, limit their breathing, and stop being able to think. They might acknowledge that they want to disappear or run away, and that they have far more energy in their body than they would like. They might also recog-

nize a word they use to name this emotional state, or they might notice that they don't have an emotion word for it. Some will call it fear; others terror, alarm, agitation, or even panic. The choice of an emotion word will depend on that person's past experience with categorizing that type of situation.

Recognizing all these factors will lay the foundation for choosing specific targets for changing their physiological state and their intellectual conceptualization of the situation so they can successfully navigate interactions with a "problem person" in the future.

Once this awareness is established, the exercise is repeated until the person has gained some mastery of their original physical state's new categorization – and of consciously switching themselves into a new physiological or energetic state more useful for managing themselves in that scenario.

This might look like naming the physical state "over-readiness," or "too much energy." The physical state could be modified by changing the client's breathing pattern, and softening the rigidity they notice in their body while the therapist repeatedly approaches them with an agenda.

The process of facing that person differently would be gradual. It would need to be repeated ad nauseam in order for the brain to encode the new patterns and deploy them automatically as situations demand.

It is important to note that this is not a process of overcoming an emotional state in the traditional sense of regulating emotion using cognition, rationality, or logic. It is an example of the brain learning something new – technically known as encoding prediction error in the 21st-century framework, and updating its model of the body in the world (Barrett, 2017a).

Desired outcomes of bioenergetic psychoanalysis

The goal of BioPsyA is always to increase a person's capacity for self-awareness, self-expression, and self-possession (more commonly known today as self-regulation).

We expect the client to gain the capacity to recognize the most common automatic affective states in which they currently live, as well as which contexts generate which affective states, and what categorizations (emotions or other meanings) they make of those affective states within different contexts.

We expect that by practicing new, unfamiliar, and uncomfortable cognition and movement patterns until they become more automatic and comfortable, clients will gain the ability to express themselves in previously inaccessible ways that are associated with improved life outcomes. In 21st-century parlance, this is expanding the model of self in the world (Clark, 2023, p. 217).

Finally, we predict that by having practiced expression of a broad range of feelings (i.e., soft and hard feelings) in a broad range of ways, and having built the capacity to generate meanings and affective states that facilitate their ability to take action toward the attainment of salient personal and relational goals, people will feel more empowered, fulfilled, competent, and satisfied with and in their lives.

Conclusion

It is a time of celebration for the nearly century-long tradition of body-oriented psychotherapy. Through the 21st-century science of brain function and emotion, Reich's early 20th-century intuitions about the functional identity of mind and body have been validated. Classical theories of emotion have been refuted, and the functional equivalence of emotion and cognition are computationally clear.

By integrating contemporary neuroscience with body-focused relationship-oriented depth psychotherapy, Bioenergetic Psychoanalysis offers clients a unique process for reaching a nuanced understanding of their own emotion construction process, and unraveling the unique ways they attempt to regulate those feelings through embodied experience. Identifying and working through both psychological and physical defenses allows clients to discover new ways of inhabiting their bodies, and experiencing a more empowered way of life.

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APPENDIX A

What is the 21st-century science of brain function and emotion? Simply put, it is a paradigm shift in the way both brain function and emotion are understood.

By way of background, the 20th-century classical theories of emotion suggest that humans have an emotional brain (the limbic system) that can be triggered and is controlled by a rational brain (the prefrontal cortex). A lizard brain (the brainstem) houses control of bodily functions and of most primal impulses, while fear gets its own special locus in the amygdala. If the rational brain cannot control the emotional and/or lizard brain, one is likely to be labeled as mentally ill. On the other hand, if one refuses to control behavior, one is deemed to be a social deviant or a loser. These theories propose that certain basic innate emotions are universal, and that our brain sits passively in a stimulus-response mode. All of these claims have been falsified by "large and convincing studies" (Clark, 2023, p. 97).

Fast forward to the 21st-century, where we find ourselves faced with the brain science of predictive processing/active inference, and the theory of constructed emotion that arises from this research.

Predictive processing/active inference suggests that brains are predictive, not reactive. Through a process known as allostasis, "The core task of all brains is to regulate the organism's internal milieu by anticipating needs and preparing to satisfy them before they arise" (Sterling, 2012). A predictive system is more efficient than a reactive one, and efficiency is the name of the game when it comes to survival. In utero, the brain begins to build a model of our body in the world, from which it makes predictions. When it encounters sensory data it did not account for, it encodes prediction error. Prediction errors either facilitate updates to the model (i.e., we learn something new), or the brain ignores the prediction error and proceeds with the current model, whether or not it best serves the organism.

The theory of constructed emotion suggests that emotions are not innate. Rather, they are socially, psychologically, and neurologically constructed. The brain unconsciously and automatically categorizes varied experiences of affect as functionally equivalent instances of emotion within situated contexts. Colloquially known as mood, affect is the subjective experience of the brain's never-ceasing process of interoception. "The brain models the world from the perspective of its body's physiological needs. As a consequence, a brain's internal model includes not only the relevant statistical regularities in the extra personal world, but also the statistical regularities of the internal milieu. Collectively, the representation and utilization of these internal sensations is called interoception" (Barrett, 2017a, p. 6). Interoception is the origin of feeling, otherwise known as affect. Computationally, the process of interoception and the simultaneous subjective experience of affect, however they might be categorized, are evidence of mind-body unity (Clark, 2023, p. 35).

APPENDIX B

What does social reality mean? And how is this useful in therapy?

Social reality or social constructs are concepts that groups of people agree upon as useful for efficiency of communication. Money, for example, is a social reality. Currency has taken many forms over the millennia: shells, gold, coins, bills, etc. Money creates efficiency when trading goods and services. Once upon a time, the French franc had value. Now, it is worthless, simply because a group of people decided in 2002 that the Euro had value and the franc did not – all because it was more efficient to use a single European currency than to have many different currencies.

Emotions, like money, are a social reality (Barrett, 2012). An instance of emotion can be summed up in a single word that efficiently enhances communication: I'm angry, I'm scared, I'm overjoyed, etc.

In certain cultures, including most post-industrialized Western cultures, emotion concepts (along with many other concepts for understanding and navigating life) are learned in early childhood from primary caregivers. As an infant wires its brain to its environment, the world is curated for that infant by its caregivers (Atzil et al., 2018). "Concepts are not merely a social veneer on top of biology. They are a biological reality that is wired into your brain by culture" (Barrett, 2017b, p. 145).

Emotion concepts vary from culture to culture. They are not universal. For example, the !Kung people of the Kalahari Desert do not share our concept of fear (Barrett, 2017b, p. 145). More surprising still, there are even cultures that do not experience thoughts and emotions as separate the way we do in the West.

Knowing that emotion concepts are a social reality, rather than inborn circuits in the brain, facilitates our work with clients in a journey towards emotion deconstruction and self-awareness that reveals important clues about their context, culture, and childhood.

Embracing Shame

A Conversation with Bret Lyon and Sheila Rubin

Aline LaPierre

> ***Angels fly because they take themselves lightly.***

Bret Lyon and Sheila Rubin are the founders and codirectors of the Center for Healing Shame, the creators of the Healing Shame–Lyon/Rubin Method, and authors of the recent book Embracing Shame: How to Stop Resisting Shame & Transform It Into a Powerful Ally. *In this conversation, they share the essence of their transformative work which they have taught to thousands of therapists, coaches, and helping professionals world-wide.*

Aline: *Let's start with shame as an embodied cognition. How would you describe embodied cognition?*

Sheila: When I was growing up, I had a secret conversation going on a lot of the time about something being wrong with me. If I could just figure out what that was and fix it, I would be okay. It turns out that this is how shame speaks to us – through this belief that something's wrong with us. That's embodied cognition. The cognition is up here in our head, and we feel it in our bodies. It goes back and forth, and back and forth.

Bret: Embodied cognition means it's happening simultaneously in the mind and the body. Not only do we believe that something's wrong with me, but we also feel terrible. We feel terrible, and we don't understand why. We need to make sense of it. The important thing about embodied cognition is that we can experience it either way – either we can feel rotten, and try to trace that to something wrong with me, or we can feel something's wrong with me, and then feel rotten. They're happening at the same time in the mind and in the body. This is somewhat true of all emotions, but shame is the most characteristic of this pattern.

Aline: *You talk about shame as a binding emotion. You write about how no other emotions can complete if we don't address shame.*

Bret: That's what is most striking about shame. It interferes with everything, and it's always there. When something isn't completing, you can be sure shame is there. Shame does not allow the grief, the anger, or the fear to complete. The idea of *action tendency* is fundamental here. The action tendency of shame is to freeze, hide, and disappear. This interferes with the action tendency of all the other emotions.

"The idea of action tendency is fundamental here. The action tendency of shame is to freeze, hide, and disappear. This interferes with the action tendency of all the other emotions."

This is why we can't work with emotions generally unless we work with shame, because shame inhibits them. Shame is the key to the whole thing. The action tendency of anger is to yell and lash out in some form. It's a powerful outward-going emotion. The action tendency of grief is to cry and seek solace, and ultimately to put things in the past by purging the emotional feelings and seeking solace with other people. And the action tendency of fear is to run away. If you can't run away, you're cornered, and you will fight. How can you fight when the action tendency of shame is to hide, disappear, vanish, and not be there? It's a very frozen feeling. This is very confusing for helpers and therapists, because they cannot get something to finish.

The five realms of experience

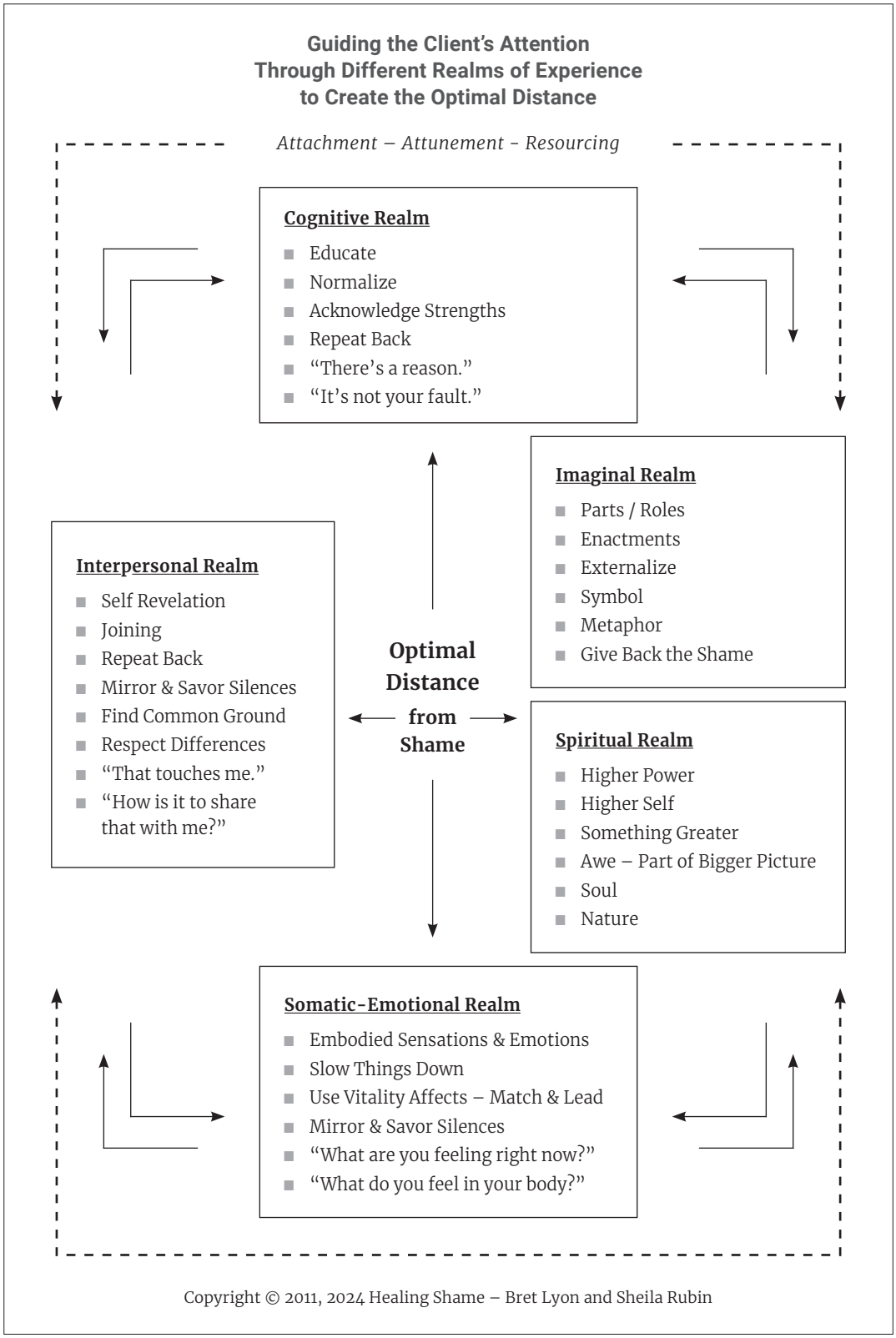
Aline: *Unbinding emotions from shame sounds complex. You list five realms of experience with which you approach the shame unbinding process; Sheila, you touched on the cognitive realm. You also approach shame through the interpersonal bridge, the somatic emotional realm, the imaginal realm, and the spiritual. Would you describe how freeing an individual from shame must address these different realms?*

Bret: Let's say you're a helper or therapist with a client. It's your connection with your client that allows you to begin to move their shame. But shame interferes with the connection. All the realms of experience are affected, so you can start with any of them. We ultimately need to bring all the realms back into connection.

Aline: *Can you address each of the realms briefly?*

Sheila: Gershen Kaufman said that shame is a rupture of the interpersonal bridge. A misunderstanding between a parent and child creates a rupture in the interpersonal bridge. That's when shame comes in. The shame breaks down when we can restore the interpersonal bridge and let clients know we see them: *"I hear you; I understand you; tell me more."* We're reaching across the interpersonal bridge, and we're countershaming to bring a client back into the relationship with the therapist. This is one of the ways to go.

Bret: I'll add to this. The key to repairing the break in the interpersonal bridge is restoring the connection between the helper and the client. That is the key. It has to be there. Other things must also be there, but interpersonal repair absolutely does.



The ultimate shame is exile from the tribe. Shame, at its core, is about exile. Shame is an intense, horrible feeling of *"I'm alone."* It's an aloneness that believes that somehow it's my fault. That's where shame starts. Not just *"I'm alone*," but somehow *"I'm responsible for this."* So, the key to all the work is reaching through that gap in the connection between two people.

This may be the first time they've felt connected in a client's life – the first time they experience that bridge that was broken being repaired. People in shame tend to keep the bridge broken. Some part of them wants to reach out, but there's another part that's been burned. It reached out as a child, didn't get what it needed, and now it will not reach out anymore. It's saying, *"No, I'm alone in my misery."* So being there and beginning to repair that bridge is absolutely key, but you also need more than that.

Aline: *Might a person believe that re-establishing the interpersonal bridge will open them to another wave of shaming? Might they imagine that the interpersonal bridge is how they get shamed?*

Bret: Yes, that is what they imagine, and it's true. That is how they got shamed. There was an attempt at repair that failed. So yes, that's how they got shamed in the first place. I think of the lyrics from Paul Simon's song "I Am a Rock" (1966). "If I never loved, I never would have cried." To me, the image of the rock relates so much to the isolation of shame – "I have no need of friendship, friendship causes pain. It's laughter and it's loving I disdain." I disdain it because I can't get it.

The somatic emotional realm

Sheila: The somatic emotional is in the body. We ask: *"What are you feeling right now?" "What are you saying, or what are you not saying, with your breathing?"* We do a lot of breathing together with our clients. Sometimes, with our hands over our hearts, breathing in hope to feel what is happening in the body. We go to the body quickly, and then to another realm. We're trying to guide a person around all the different realms, to learn to distance from what could become too much.

Bret: The term we use is *optimal distance*. We're trying to keep an optimal distance from the shame so we can feel it and not have it take us over.

Aline: *There is something unbearable about the shame. I imagine it would be difficult to touch into it, for them to go there when you ask where a person feels the shame in their bodies.*

Bret: Yes. In fact, that's a vital piece for somatic therapists. Somatic work is incredibly valuable and has to be done with shame. You can't begin to heal shame without a somatic connection with it. The first somatic connection is breathing together – connecting on a breathing level with your client. However, it's so close to the actual body experience of shame that we're very cautious about asking too many questions about shame, or trying to go into shame. We believe in keeping an optimal distance from the shame at all times. With somatic therapy, you must be careful because it's so powerful. You put it exactly right. Clients are uncomfortable with the shame, and do not want it pointed out. They're often ashamed of the shame, or they are simply not aware of it. That's one of the reasons we have the realms, so we can say okay, that's enough with that realm.

There are people with whom I don't go into the somatic for a long time, or only go into it for a short time. I'm cautious with it. I'll touch in and touch out, and move to another realm. Many clients aren't breathing very much, and therapists tend to mirror in their bodies how clients are breathing. That's when they feel rotten at the end of the session.

We work on the idea that whoever has more control of their breathing wins. The breathing pattern and shame are all tied up. We are careful. For example, we might say, *"Can you feel the connection between us right now?"* Or we might go to a spiritual place: *"What is your strength spiritually; where do you go for sustenance?"* For a lot of people, it's nature.

Whenever you go to something bigger than yourself, that gives you comfort. It's like zooming out. You might move from the inner bad feeling to zooming out, or to feeling the connection with another person. These are ways to help deal with the shame, and experience it without getting lost in it, without getting flooded. We want to stay within the window of tolerance. In some ways, the somatic realm is the most powerful, the closest to it, and so you have to be really careful with it.

Aline: *In the somatic resonance, the more conscious person entrains the other. Either we let*

ourselves be entrained by the other's shame, or we hold a solid, expansive container in which we can hold the other's shame. That's the practitioner's job, right?

Bret: Exactly. Initially, that's the parents' job. However, rather than helping the child with their shame, the child ends up experiencing the parents' shame, because the child gets entrained in their shame field. We need to hold that container the way you describe it. What tends to happen is that helpers will either sink into the shame rabbit hole with the client, or try to get the client out of the shame – for example, by saying: *"There's nothing wrong with you. You're fine."*

Sheila: A lot of us have had that experience. My first therapist in my early 20s asked me: *"Why are you here?"* I kind of whispered; I couldn't figure out how to say it, how to get support, and finally I was so brave as to whisper, *"Something's wrong with me."* She looked at me and said, *"There's nothing wrong with you. You're fine."* That felt shaming, because I was standing there, finally saying: *"There's something wrong here."* After that, I couldn't figure out how to bring that question to a professional. I went to graduate school with that question still unanswered. It turned out it was a shame.

I co-created The Center for Healing Shame with Bret because I couldn't figure out how to get support for the felt experience from childhood of "there's something wrong with me." How can there be a pause to check in and reassess when there's misattunement in childhood?

Bret: Our job, as we see it, is to be in presence, no matter how much shame a client goes into – not jolly them out of it, not dismiss it, not try to fix it, which is the biggest problem, and not having an agenda where we are going to solve it. Letting go and being with; it's an organic process, a life-forward direction if a person is held and not lost in the shame. There's something within the person that wants to get better.

To do our job as helpers, we must work with our own shame. Our shame gets triggered by the client's shame. Therapists start thinking, *"I'm a lousy helper. I'm a lousy therapist."* Then they work too hard, try too hard. They can't allow the person to be where they are, and be there fully with them.

The Imaginal Realm

Bret: Sheila's specialty is the imaginal, which is the weakest realm for most people, even in somatic therapies. This is especially where Sheila deeply contributes.

Sheila: I'm trained in Hakomi and also as a drama therapist. I'm able to go into the imaginal realm with role playing, with introjects, with figuring out symbols. I work a lot with hatching the symbol – something positive a person would love to see happen. Maybe it happened in the past, or perhaps they saw it in a movie. People often resist the imaginal because they believe it's childish: *"I'm not going to go there."* I suggest, *"Let's do this experiment, and see what you've been doing that got you this far in your life. Why don't we imagine that there is a golden light?"* There is a lot to imagine – a grandmother that could hold them, a sunset that brings beauty, or trees they could imagine leaning up against.

Shame is an introject, and it's the opposite of what they need. I say, *"Tell me a little bit about how you know there's something wrong with you? Is there someone who told you that?"*

For example, I worked with eating disorders years ago. I worked with a woman who was terrified of her belly. She said, *"There's nothing there."* And I said, *"Of course, there's nothing there. We haven't put anything there yet."* I suggested we imagine together there was something there: *"If it were an egg or a plant, let's plant it, water it, and explore what you could grow." "Who would it be if we could water it and grow it?"* And they're amazed. I go with them, gently, gently into the imaginal realm, tiptoeing with the shame, then away from the shame, with the shame, away from the shame. It's like a dance. And things start to shift, because that is where the healing can happen, because they've never been there before.

Bret: A key to healing through the imaginal is to put it together with the somatic realm. They work together. Sheila has a journey – go to the woods, feel it in your body. The imaginal and the somatic really connect well. When you start imagining things, they start to happen. If you combine the realms, it's extremely powerful. The big problem with the imaginal by itself, such as affirmations like, "*Every day in every way, I'm getting better and better*," is that it's too abstract. We want a body-based imagination.

One of the primary interventions Sheila does that was revolutionary to me is getting the shame out of the body, and putting it on a pillow or somewhere else outside the body so it's not in there running things. It's an imaginal leap that's incredibly helpful, and one of the more accessible interventions that opens things up. You get to talk to the shame, listen to the shame, and throw the shame across the room! I've watched her, *"Are you ready to throw it?"* They throw it, and Sheila brings it back to them. They've got to throw it again and again, so they anchor that experience in their imagination and in the body.

The penultimate imaginal work is what we call *giving the shame back*. We tell people to do it only in the imaginal realm, because some therapists suggest going back in their current life and talking to the mother or father to tell them what they did wrong and how they were affected. This is tricky for two reasons. One, the person they're talking about is not the same person who affected them in the first place. Secondly, there's a good chance they'll encounter the same shaming they did before. So they're going to get the same experience again. However, in our imagination, we can have the results we want. The imaginal is amazing, because children grow up with imagination and then, it's taken away. As adults, we're less and less comfortable using this incredibly powerful realm.

Aline: *I'm struck by how you approach developing imaginal skills – it's like developing a muscle. We develop our cognitive skills, our ability to self-regulate, but we don't think to develop the imaginal. The imaginal gets impoverished, weakened by binding shame in a similar way to what happens to braced muscles.*

Bret: The whole society shames people's imagination. By the time you're eight or nine, you'll get flak if you have an imaginary friend. Now that you're grown up, you shouldn't have an imagination anymore. It's crazy, but you're exactly right. I had never thought of it quite that way.

Sheila: The imagination is able to counter shame, or is able to send people back into shame. It's so important how we work with people. When we open the door to an emotion and say, *"Oh! That's how you've been shaming yourself!"* they're amazed. Now, they have more skills for sensing the body, but also more judgement coming on. A tendency to shame yourself twice as much can come on board, because now they have more skills, so we teach having a kind inner coach to help develop emotional skills to grow positive places where they can go, where the shaming messages get put in a box.

Aline: *So, can the tendency toward negative judgment, or perhaps the negative bias of the brain's default mode, be recruited in service of shaming?*

Bret: Yes! Shame is a master manipulator. It will take whatever it can get. We joke that shame is the devil. It's seductive and very dangerous. We also call shame a multi-headed hydra, because it keeps coming back. You cut off one head; it finds another way in. It always will. Sheila and I tell people that this is not a one-shot deal. It's coming back, and you'll have to deal with it because shame is an essential emotion. It's part of our makeup. We never get rid of it. What we want is to transform it when it rears its head, and keep using it as a tool to learn from.

Aline: *That brings up the question of healthy shame. Can you say something about healthy shame?*

Bret: In our new book, Embracing Shame: How to Stop Resisting Shame and transform It Into a Powerful Ally, the most radical concept we have is the concept of healthy shame. We're not alone in using this term, but for us, healthy shame is key. That is what we're looking for. In our book, we go through ten or so qualities of healthy shame. The main one is self-compassion. There's also seeing what your part is, taking responsibility for your part, seeing the bigger picture of what went on before, what's going to go on after, and who's involved.

Sheila's main thrust is kindness in the imaginal, and my main thrust is precision. The more precise we are, the more clearly we see the big picture, because shame makes us stupid. Shame clouds everything. It actually lowers your IQ. It works against you in every way it possibly can. If you can learn to see more clearly, rather than having your vision obstructed by toxic shame, you know what is happening, what is really going on, and what needs to be done about it.

So healthy shame, to us ultimately becomes about learning from what happened. *"What can we learn from this mistake I made?"* It's very different from beating yourself up, and telling yourself you are defective, flawed, or a mistake. That's toxic shame.

Healthy shame allows us to look at what we did, why we did it, and how not to do it again.

Aline: *Would you categorize that as making friends with the devil, or would you name it differently?*

Bret: It stops being the devil at that point. That's what's so amazing...

Aline: *Disarming the devil.*

Bret: Disarming. There's a line I like to quote. I think it's from Lincoln: "I conquer an enemy by making him a friend." That's what we want to do with shame.

Aline: *Hence your book,* Embracing Shame.

Bret: If you embrace it in the right way, it stops having power over you.

Sheila: Not only does it stop having power over you, but healthy shame has precision and boundaries. We realize that what happened in the past is toxic shame. We are going to keep about 2% of the toxic shame to remind us of what happened in the past, so we don't repeat it again. I have precision now, I have boundaries now, and I can use healthy shame to make different choices, and have different reactions to shame. I have the ability to move forward with my shame, to keep my awareness of shame with me, and it reminds me not to make the same mistake again, not to act in ways that hurt or shame others. Healthy shame wants us to grow, and do the things we did not get to do in childhood because of toxic shame. When we transform shame, we can now have a life full of self-expression and beautiful things that we couldn't have imagined when we were in toxic shame.

Humor, vulnerability, discernment

Bret: Humor is important. Not satirical or insulting humor, but more self-deprecating, like *"Yikes! I sure blew it!"* or *"I didn't do a very good job!"* Making a joke about our failures in some way. The wonderful line is, *"Angels fly because they take themselves lightly."* Humor makes a difference.

The other word we like, which Brené Brown popularized, is *vulnerability*. Shame makes you hard because you're scared. The shame-fear bind is what makes you scared – being afraid of being shamed. Vulnerability is being willing to take a risk.

However, to be vulnerable, there's another important quality we hope to instill in our clients: discernment. Precision is from the head, but discernment is from the heart and the gut. It's knowing what to share, and with whom to share it. When restoring your interpersonal bridge, you won't fix it with the toxic relatives, or teachers, or friends, who broke it. In childhood. You need to repair, but with someone else – with life, with society, with your therapist, with your partner, but not with the original toxic person.

When you have all these healthy shame qualities lined up, along with self-compassion, you have a sense of the big picture, of taking responsibility with precision, discernment, and vulnerability. Then, you can reengage with life.

Healthy shame is a withdrawal and a re-engagement. We withdraw to reassess, learn, and grow. When we return, we now have moments of healthy shame, rather than ongoing toxic shame. You still have shame, and it's still going to affect you, but it's not going to take you over in the same debilitating way.

Aline: *I can see how feeling shame becomes a signal for growing one's awareness.*

Bret and Sheila: Yes! Exactly right!

Bret: You are still going to feel the shame.

Sheila: When supervising interns who go into shame and think they are not good, I tell them to hold their shame, to hold the client's shame, to ask what they are learning, to ask about it in a kind way, to restore the interpersonal bridge, and give tools to the client. Realize the shame is a signal that can be a beautiful golden beacon, a lighthouse lighting up to say: *"Oh! This is shame. Whatever can come from these moments can be beautiful."*

The binding aspect of shame

Bret: Recently, we started talking about the binding aspect of shame. Shame doesn't exist all by itself. It's very purpose is to bind with other emotions, and lower their affect. That's what it's designed to do. Shame binds with anger, grief, and fear in particularly powerful ways.

We believe shame is designed to bind with anger because anger is the most dangerous emotion. If you lash out at your parents when you're very

"Shame doesn't exist all by itself. It's very purpose is to bind with other emotions, and lower their affect."

young, when you're helpless and dependent on them, they could reject, abandon, or punish you. So, shame is there to control anger, but it ends up controlling everything. It binds with all the emotions.

Then, there's compensatory anger. You're blaming others, getting angry at them rather than feeling your shame. In other words, you're getting angry about stuff that's not what you're angry about. If you're having intense feelings, and the situation is not appropriate to that level of feelings, we say 90% of that comes from the past, and 10% is in the present. First, you get curious about that 90%: *"What might have happened in the past that is making you so angry right now?"*

We believe in healthy anger, which is not about violence. It's about standing up for yourself and setting boundaries, holding your space. That is the way to transform anger when it's not bound with shame. When anger binds with shame, it quickly becomes an attack directed at the wrong people. We give back the shame in imagination – you can be angry at your parents, but with precision, so that you go through what happened, what they did wrong, how it affected you, and how it still affects you. And you imagine giving it back to them. We work on this over time, until a client can see the parent actually hear and react to them and accept some responsibility,

We understand that the shame is passed down through generations. We have one student who's a shaman who talks about giving it to the previous generations, all the way to the original event, to the Holocaust, to the genocides, to what initially happened to create the shame. And we use this as well to get to the multi-generational transmission of shame.

Shame also binds with pleasure. That's the most obvious, and we all know that one. The blocking of the ability to feel pleasure is one of the most destructive qualities of toxic shame.

Grief is interesting, because there's rarely a death where people don't feel a lot of shame in the form of regret. There's almost always shame that comes in to interfere with the grief. The manifestation of a shame bind is that the person can't complete their grief. Either they can't feel their grief, or they continually feel it, so they are in perpetual grief that goes on year after year. That's a sign of a grief-shame bind. Grief is designed to complete. Shame

"Shame is an anti-life force. Sheila just gave us a beautiful description of how we actually work with shame."

keeps everything in a perpetually frozen present. We work to help clients separate their grief from their shame so that they realize there is shame there, which helps them feel more fully into the grief. What happens then is that people cry, let it out, get it out of their system, and finish processing it. Not that it's gone forever, but it's more manageable.

The third one is shame and fear. I used to be a performance coach and taught acting, where the element of fear is, of course, very strong. In coaching, we have two terms: performance anxiety and social anxiety. The trouble with those two terms is they leave out shame. People are afraid of being humiliated, of being ignored, of being made fun of? They are afraid of being shamed.. What is troubling about the fear-shame bind is that instead of lowering the affect, the fear and shame intensify each other.

Transforming shame

Sheila: Panic attacks are another fear-shame bind. I work a lot with different shame binds. People cope with their shame by using food, substances, and acting out in different ways. I normalize and educate how shame sends us into brain freeze.

How can we transform shame and trauma when there is a multi-generational transmission, which happens a lot with my clients? We give it back to the family and to specific family members. We may give it back to the generations, and then we ask for the pain to heal, for something to transform. There's a gift in all of this. They get a gift back.

Then, there is the age when a person was shamed. How old were they when they were shamed? Was it how they dressed, or talked, or something else? We go back to the age when it happened; we transform it, and we give them a new ability to counter the shame with clear perception. What do they wish they had been able to say to that teacher? What do they wish someone had said to them? Stand up to the bully in the bus. What do they wish had happened?

We do it through imagination. We give the shame back to its source. We transform it. And then, something amazing happens; the person's life force comes back, they feel lighter in their body, and their eyes begin to glow. They come alive, perhaps for the first time. It's what happens when we undo the shame.

Bret: Shame is an anti-life force. Sheila just gave us a beautiful description of how we actually work with shame. Trauma, as we understand it, is an extreme shame-fear bind. We always see shame in trauma – certainly in any Western society where it's not okay to be powerless. It may be different in the East, but in the West, shame and trauma go hand in hand.

When I work with trauma, and I'm trained in Somatic Experiencing, and get to T-zero – the actual moment when the trauma reaction takes over – there's always a moment of shame. It's not the moment when the accident happened; it's the moment when the other driver wanted to fight, and you didn't want to. It's the moment you tell someone what happened and they don't believe you, or actually shame you further.

We just gave you a lot of material there!

Aline: *Beautiful. Does this cover everything, or is there anything else you would like to add?*

Bret: I want to mention one more thing: curiosity. It's an emotion that conquers shame. Shame can block curiosity. We can see this in people who can't hear anyone's opinion but their own. Their shame has shrunk their curiosity. But if curiosity is encouraged, it can actually conquer shame. That is a big part of our job – to encourage curiosity in our clients, and in ourselves.

Sheila: I want to talk about somatic countertransference, because I didn't know what it was for many years. I would feel all these feelings in my body, and no one would talk about it. It was not until I became a supervisor that I started telling my interns who were training to be therapists: *"If you start feeling things, that's the somatic part of the countertransference."*

It's similar to countertransference, where we take on something from the client, and because we're working somatically, there's a somatic countertransference. We may feel it as a punch in the belly, or a heavy heart, or maybe our throat begins to close up. This is a gift. Figure out what it is telling you. Take care of it. Is there some shame bind that might be happening between you and the client simultaneously?

Bret: That's our specialty. Both of us have the ability to somatically feel the client, and be okay with that. We're not running from it. We're actually feeling it with the client. In somatic work, you can be with a client in a way that's impossible any other way – you really feel them, you're right there with them. That's where the shame comes in, because if you feel the shame, the tendency is to run away or quickly get past it. But if you stay with it and realize that *your* shame is related to their shame, in that moment, everything changes.

Aline: *The term resonance comes to mind. Would you say you are describing somatic resonance?*

Bret: Exactly. With shame, the resonance is both somatic and cognitive, because shame is an embodied cognition. Not only do you have the somatic resonance, but you start feeling bad about yourself. That's the tricky part right there. Somatic resonance is a great term.

The last thing I want to mention is resourcing and countershaming. Resourcing we share with all the somatic people. We resource every realm. The first resource is getting the client to breathe. We then talk about internal and external resources. Our job is to find the resources clients have, but aren't even aware they have.

Sheila: In countershaming, I might say, *"That's a really cute scarf,"* or, *"I like the color you're wearing."* Something I notice about the client that I'm enjoying, and then, I get curious about it. *"Where did you get that?"* or *"Is it new or old?" "How did you choose that color?"* I'm asking questions, and putting my hand on my heart, and breathing a little. I work with myself and I encourage the client, saying, *"Well, nobody's breathing here!"* or *"We need to breathe!"* And I might put my hands on my heart, and breathe in and out a couple times together as a welcoming.

They might not follow me and say, or think that it's silly. And I'll say, *"You don't have to join me, but I need to have more of myself to be with you, because I really want to hear you. So I'm going to breathe a couple of breaths so that I can be more in my body."* So that is a way of countershaming somatically and in terms of grounding.

Bret: People with a lot of shame take silence as rejection. So you have to be very careful with your silences. There are times when silence is appropriate, but at other times, you need to intervene. When they're talking too much is another place where you need to intervene, because the goal is to make

"When Sheila put her hand on her heart, I immediately touched mine. It's automatic, because I'm right there with her. That kind of joining goes beyond words… Being right there with the client and breaking the aloneness is so important."

it a "we", to build the interpersonal bridge between the two of you. We're together. We constantly emphasize, *"Let's breathe together,"* not *"You do this"*, but let's do it together.

Oh! And it's important to physically move as well. Talk therapists get a certain rigidity sitting. They're very still, and they're not mirroring the client. We do a lot of mirroring. When Sheila put her hand on her heart, I immediately touched mine. It's automatic, because I'm right there with her. That kind of joining goes beyond words. We're joining on a physical level. Being right there with the client and breaking the aloneness is so important.

Aline: *And here you are, coming back to the interpersonal bridge.*

Bret: Yes. We start here, and we end here.

Sheila: I often say to clients at a first session, *"I'm really proud of you. You showed up, and I hope you come back. Each day we're going to do a little bit of work."* I know they think it's never going to end, and it's never going to change. I tell them all their parts are welcome, all their feelings are welcome. And at the end of a session, *"What is something you're taking with you from today?"* They might say, *"I'm taking with me that you actually trusted me."*

Bret: The last thing I don't want to forget is the importance of leveling the playing field. A major part of what we teach in the interpersonal realm is that clients are not coming to someone with no problems who's going to fix them. You have to disabuse them of that very quickly! You have problems too. You're a person too. The phrase we is, *"We are a caring friend and a trusted expert. You can be a trusted expert, but you need to be a human being as well."* That's essential.

Aline: *Thank you. It's wonderful to see the two of you working together. Bret and Sheila, it's so inspiring to witness the beautiful collaborative partnership between the two of you. You generously shared with us the rich outcome of your years of teaching. It feels like you encapsulated years of heartful personal experience in these past sixty minutes!*

Bret: We love working together! We are so excited to have finally written our book, which is the culmination of 20 years of collaboration at the Center for Healing Shame. And we are so excited to still

be growing our online workshops and discovering new insights and new material.

Sheila: Fantastic! I'm so honored to have had this opportunity to share through this interview today. There is an evolutionary purpose to shame and we are leading the exploration through our workshops and book.

■ ■ ■

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Somatic Shape and Emotions

Integrating Formative Psychology with Accelerated Experiential Dynamic Psychotherapy

John Cornelius

ABSTRACT

The thesis of this paper is that the body psychotherapy model of Formative Psychology can be combined successfully with the emotion-centric model of Accelerated Experiential Dynamic Psychotherapy (AEDP) to enhance clinical outcomes for individuals. AEDP softens defenses and regulates anxiety by privileging positive experience, and being actively responsive in order to access adaptive core affective experience or seek to transform maladaptive affect. The Formative Psychology How technique can be applied to the somatic shapes of the AEDP defense/survival strategies, maladaptive affect, or complex self-states. The How technique increases a somatic shape to understand its meaning and function, then undoes the shape to discover a more resilient, resourceful body organizing. The paper explores and analyzes two case studies that illustrate and offer qualitative evidence for the paper's thesis. The conclusion is that Formative Psychology and AEDP are complementary models that successfully work together to access adaptive core affective experience, deepen it with congruent somatic shapes, and help undo the stuck places of maladaptive affect.

Keywords: Formative Psychology, AEDP, emotion, body

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> ***Formative Psychology explores the somatic shape of an emotion with micro-movements that either intensify or lessen the body organizing of an emotional experience.***

Body

The body psychotherapy field has a long history of describing the somatic shape of an individual and its significance to a client's well-being (Marlock and Weiss, 2015). An innovation in this paper is to point to how the body psychotherapy model of Formative Psychology can both benefit from and contribute to the psychotherapy model of Accelerated Experiential Dynamic Psychotherapy (AEDP). AEDP is a sophisticated and efficient model for working with emotions. Consistent with this paper's thesis is that combining these two models will have an enhanced outcome effect for the client, given the positive complementary effects these two models can achieve. They can both give to and benefit from each other.

An important insight in Formative Psychology is that individuals have a unique somatic shape relative to most experiences in life. These experiences

can include disappointment, urgency, dismissal, temptation, holding onto and letting go, being in love, plus a myriad of other emotional experiences. The somatic shape, how the body organizes itself in an experience, can be very helpful as a therapy intervention in enhancing and making possible an individual's capacity to experience, express, and receive emotions fully. Therapists can either see an incongruent shape that is inhibiting the individual's full access to feelings, or they can invite the individual to be curious about the tensions in their body, and explore the body organizing meaning in their current life situation (Keleman, 1975, 1985, 1987, 1989, 1994).

Formative Psychology offers an important tool for working with emotions. It can be used to help an individual undo a defense, regulate anxiety, deepen an emotion, or undo being stuck in maladaptive affects like despair, hopelessness, or loneliness. It explores the somatic shape of an emotion with micro-movements that either intensify or lessen the body organizing of an emotional experience. Each body organizing of an emotion has a specific meaning and unique opportunities for choice, action, and healing (Keleman, 1987; Downing, 2015).

An important focus of AEDP is helping an individual get to a new experience of affect, agency, or intimacy, and then deepening this experience with meta-therapeutic processing. AEDP tracks glimmers of the positive, and enhances these beginnings. It privileges the positive to resource the client, regulate anxiety, and bypass defenses. It uses empathy, responsive attuned therapist engaging, naming, joining, pausing and being with, sensing, shame reduction with validation, agency, early attachment cooing, and micro-tracking to help create safety, connection, and interpersonal care to undo aloneness, grow a secure therapy relationship, and create transformative healing experience with resourced corrective experiences (Fosha, 2000, 2021; Russell, 2015; Prenn, 2011).

When these insights and skills of Formative Psychology are combined with the important insights and skills of AEDP, much creative synergy can result. It is the goal of this paper to articulate how these two psychology models can work together to enhance emotional work with body focus. This goal is pursued by both theoretical discussion and the use of two case studies to illustrate the points and provide qualitative evidence.

Formative Psychology and AEDP

Important models of change

Stanley Keleman's Formative method for change, known as the *How Technique*, involves five steps (Keleman, 1987).

- **Step 1** involves noticing what somatic shape one forms regarding a particular situation in relation to one's self or others.
- **Step 2** comprises exploring and being curious about this shape by intensifying it with micro-movements, and noticing what feelings, perceptions, cognitions, and behaviors are tied to each somatic shape a person creates.
- **Step 3** often requires undoing this shape by lessening it with micro-movements, and noticing what new ways of being result and are possible as one explores each new shape. Each way of organizing the body has its own accompanying feelings, perceptions, sense of agency, intimacy prospects with self or others, new cognitions, grounded self, etc.
- **Step 4** has to do with pausing and exploring a new shape that feels helpful and resource-rich; listening to what it is like, and being open to its freedoms as well as its likely awkwardness.
- Step 5 involves sitting with what has happened, and noting how one can choose to return to this useful somatic shape and make it a part of one's future life.

Diana Fosha developed AEDP as a four-state model of change for working with emotional experience, intimacy, and agency (Fosha 2000; 2021). An array of change affects accompany each state. The AEDP model involves a State 1 that represents the current compromised self with its defenses (developmental survival strategies) and prohibitive affects of anxiety and shame that a person has acquired growing up. The model seeks to help the client to move from the inhibitory constraints of State 1 into a new experience of affect, agency, and intimacy, known as State 2. The model aims to help the client regulate anxiety, and explore the healthy survival role of their defenses as well as their current barriers to experience. Validating a defense can help the client feel less shame, and be more open to a new experience in State 2. Additionally, AEDP privileges the positive as a means to resource the client's nervous system and set the stage for having a State 2

"Formative Psychology offers an important tool for working with emotions. It can be used to help an individual undo a defense, regulate anxiety, deepen an emotion, or undo being stuck in maladaptive affects like despair, hopelessness, or loneliness"

experience. After a client is able to have a new experience of affect, intimacy, or agency, then the goal is to deepen this new experience in State 3 by metaprocessing it, pausing with it, exploring what it is like, and deepening it in the body. Sometimes a client will drop down into a core affect state, known as State 4, in which the client feels fully in touch with feelings like genuine fit, a sense of deep personal truth, and feelings of enhanced wellbeing.

From the perspective of the triangle of experience, an AEDP tool, State 1 is at the top of the triangle. The top left of the triangle involves defensive behavior and survival strategies. The top right of the triangle represents the inhibitory affects of anxiety, guilt and shame. At the bottom of the triangle exits both maladaptive affect and adaptive core affective experience (Pando-Mars, 2021).

Integrating Formative Psychology and AEDP: Insights, Skills and Models of Change

Formative Psychology within the AEDP model

Opportunities to apply the Formative How technique within the AEDP model are many. For example, one can explore the somatic shape of a defense – in other words, beginning in State 1. As one intensifies or undoes the defense, the therapist and client find themselves in State 2, where the client is having a new experience that they can explore and be curious about. When one asks ultimately what this experience is like, and uses the metaprocess tool, one finds oneself in State 3 of the AEDP model. And at some point, one may find a somatic shape that feels very helpful and fitting, in which case one can be at State 4 of the AEDP model.

Another important use of the Formative How technique is with maladaptive affect. This is the affect tied to states of despair, helplessness, and hopelessness. This is not a categorical affect like anger or sadness, which have adaptive action tendencies towards completion. Maladaptive affect is a serious way an individual is stuck. This is State 2 work. AEDP often uses the Internal Family Systems parts model with excellent results when working with maladaptive affect. Likewise, I am arguing that the application of the Formative How technique to states like despair, helplessness, and lacking hope can be equally effective and is most worthy of integrating into the AEDP model.

Lamagna (2021) and Russell (2015) agree that it is important to create differentiation from maladaptive affect so that space exists between the self and aversive experience, thus opening the door to holding, tracking, and transforming the maladaptive affect. The AEDP portrayal and the Formative How technique are ways to achieve this task. Fosha (2000) sees portrayals as the "pinnacle of experiential-dynamic affect work" (p. 284).

AEDP within the Formative Psychology model

If one begins therapy with the Formative How technique by exploring an individual's somatic shape around a particular experience, dream, feeling or problem, then one can be curious about the meaning of the shape of the affective experience, and what occurs as one first intensifies and then later does less of this particular body organizing. If one is working with maladaptive affect, then one can seek to transform it by seeking its meaning, and listening to what sort of suffering and desires it points to and healing paths it needs.

One can begin using the How technique with a defense, an avoidant behavior, confusing feelings or thoughts, specific body tensions, parts of the self, and sensory or affective states. One could look at the somatic shape of catastrophic thinking or hope, bitterness, or impatience. The possibilities are large. As one explores the meaning of a somatic shape, new experience is generated to metaprocess and explore. Intensifying the shape can clarify its purpose, and undoing it can open up new body organizing that is more grounded, centered, and

"An important focus of AEDP is helping an individual get to a new experience of affect, agency, or intimacy, and then deepening this experience with meta-therapeutic processing. AEDP tracks glimmers of the positive, and enhances these beginnings."

available to embodying self-expression, receptivity, feelings, self-agency, and intimacy. All of this can be happening within the AEDP framework of attuned mirroring, responsiveness, and privileging the positive. Giving positive emotions enough time to sink into the body and metaprocessing them to help a client understand and sense their rightness can help to "broaden-and-build" new neurobiological healing transformation (Frederickson, 2009; Yeung, 2021).

Formative Psychology within the AEDP Model: The case of Anya

Background

Anya has been in therapy for approximately six months prior to this session. She has developmental trauma from a father who was unavailable and unkind. My first intervention is to get a deeper sense of her hurt. I find out she has no desire to forgive her father. She did no harm, hence feels no reason to forgive. She feels a deep lack of trust. She has more closeness to her grandparents and mother. Trust requires showing interest and care for her. As her therapist, I make a point to show interest and care, and to display both empathy and responsiveness. I also help her to feel connected and not alone in the therapy office – all of which are key skills in the AEDP model. Anya shares that she is surprised at her father's cluelessness in the area of parenting, and feels he shouldn't have had kids. I speak of nice narcissists (Behary, 2012), and this resonates with her. Anya is concerned that if she shares her feelings with her father, he will have a panic attack, which has happened in the past. She is upset her father feels that she owes him care later in life.

Portrayals and their purpose: Working with emotional experience and somatic shape

As an intervention, I suggest we use an experiential portrayal to help Anya differentiate from her father, access her unknown and/or unexpressed feelings and thoughts about him, and by doing so, seek to help her heal, feel safer around her father, and be able to create boundaries with him. In AEDP terms, she can make the implicit explicit regarding her lived experience with her father, seek a self-corrective experience, and discover implicit somatic shapes she has embodied in her life tied to him. Consistent with Formative Psychology, we will seek to discover and explore the body organizing of her developmental self, work to undo self-destructive somatic shapes, and create new healthier ways of being. We will move through cycles of imagined responsiveness or not, different feelings and insights, and engage with client reactions to new cycles of affect and memories as the implicit becomes explicit. Finally, we will use the dynamics of the portrayal process to test and solidify new body organizing within the changing interpersonal and intrapersonal contexts.

Anya's portrayal with her father

A AEDP work within the portrayal

I have the client imagine her father across from her in a portrayal. I ask what she notices in her body and what she might like to say.

She says, "Papa, I think you know at some level you were neglectful and forgive yourself. You should know that I know, and that I do not forgive you. You made a mistake and hurt me. You think I should take care of you, but I do not want to, and feel you do not deserve it. You do not realize how toxic your neglect was on your wife, and yes, you are a nice narcissist and took behaviors to protect yourself."

I ask the AEDP metaprocessing question, "What was it like to say that?"

Anya says, "It is hurtful."

I ask what she sees in her father's face. She shares an imagined "blank stare" and perhaps a "storming off." Anya reports she can't imagine healthy responsiveness from him. I ask what other feel-

ings are there. In the portrayal, she shares with her father: "I'm sad that I grew up in a middle-class family with an unavailable father."

I inquire about her body. She shares that her sadness is spreading throughout her body quickly, and she is feeling a sense of stillness. Anya enters into a sensory awakening and hears birds outside the office windows. This is a good clinical outcome. Anya is entering more into the ventral vagal complex (Porges, 2011). Feeling her sadness fully is grounding and is resourcing her a bit.

At this point, I notice she is in a particular somatic shape in relation to her father; her ankles are crossed and her hands are compliantly folded. I will address this soon in the unfolding portrayal. Anya then has a memory of a garden between her house and her grandmother's. This is a potential resource, as her tie to her grandma was strong.

I suggest she feel the garden. She reports: "It's comfortable, familiar, and homelike." Yet it also contrasts with her experience with her father, and hence also deepens her sense of upset and depression.

Anya next shares with her father: "I'm angry because I feel you behaved in a way beneath your emotional capacity. It is infuriating that you either did not know or did not care." Anya shares with me that she does not deserve to feel shame about everything. She reports that she feels it and hides it. Anya is beginning to have an insight.

I ask AEDP metaprocess questions: "What is this like to not deserve shame, to feel it and to hide it, and to have the shame not be so internalized?" I psychoeducate that it was not her fault.

She shares the insight: "I took my Dad's lack of shame and put in on myself!" I suggest she sit with this. She does, and says, "I feel like I am on the brink of something."

In the AEDP framework, a new experience is showing up. New experience is the engine of transformative change. Anya asks, "What causes a person to not feel shame?" She replies, "Perhaps because they were told they are perfect." Her thought is: "He's good, so he needn't forgive." Anya reports she is beginning to feel unbelievable anger. She reports the anger is all over her body.

Anya speaks to her father in the portrayal (while imagining him): "I am angry that you put your shame on me. That you are a callous shell of a person. I'm angry at your inhumanity, cowardice, shallow self-loathing, weakness, and that you do not care enough for yourself." Anya shares that her hands are sweating a lot. She feels some smooth muscle anxiety tied to her deeper feelings and insights.

B Formative Psychology enters explicitly into the portrayal

I next explicitly engage in a Formative Psychology intervention, and share with Anya that she is holding her hands together and her ankles are crossed. I mention that this somatic shape is likely incongruent with her emotional experience of anger and agency. I suggest she explore uncrossing her ankles, and letting her hands be a bit more separate from each other, and perhaps even exploring placing her hands on the arms of the chair. I let her know she may feel both stronger and yet also more vulnerable in this new body organizing stance. I then have her explore feeling and expressing her emotion in this somatic shape. Anya predictably does feel a bit vulnerable at first. Her anxiety rises a bit, and she feels some numbing. She feels as if she is screaming into a cavern. I suggest that she try moving her hands fully apart, and say, "I'm here!" I am suggesting she feel her full presence and existence with her feet on the ground and chest exposed.

Anya reports something very new at this point. She says: "I never have had these thoughts before. The sending of the shame to father; that the shame belongs to him. And the experience of feeling less shame."

I note Anya is leaving the magical child place of idealizing her father. In other words, she is coming out of what Firestone refers to as the "fantasy bond" (Firestone, 1987). She is differentiating from her father in a major way. I reinforce her new awareness by validating that she as a child deserved attention and love, and that nothing was wrong with her as a child. She starts to see the abusive side of her father more clearly, and its many implications in her life. She is also beginning to see the compliant somatic shape she has habitually had in relation to him. And that there is a more satisfying, more differentiated, more boundaried, and self-enhancing body organizing place to be.

However, there is an interpersonal dynamic to be faced regarding this new, more resilient self, as

AEDP calls it. Anya's more differentiated, self-enhancing somatic shape brings forth an inkling of her father now being angry at her. She shares that her somatic shape is becoming shorter and more braced. She reports she is seeking to "hold it together and not be scared." I point out this is likely the way she stopped herself from receiving more active abuse – for example, by fighting in an active fashion. Anya is experiencing another somatic shape that is congruent with the passivity of her internalized shame in the past. Her body is braced and passive. I validate this somatic shape of shame as having helped her survive her childhood. By validating this somatic shape, I can help Anya further undo her shame feelings – a paradoxical healing intervention.

I next explore an intervention involving her hands, arms, and active engagement. I hold up a pillow, and have her explore punching it. This is too scary for her. We later discover that she finds pushing against the wall easier. So I suggest we instead explore her expressing her scared feeling to her father. I educate her that letting a person know he is scary is not a compliment. I am inviting Anya to be open to embodying her agency and power in a grounded, ventral vagal place of honest emotional self-expression.

She enters the portrayal again and says to her father, "I feel scared when you look at me."

We are now no longer dealing with the blank stare that existed earlier in the portrayal. As the client has acquired more insight, more capacity for feeling expression, less shame, and a stronger body-organizing self, she then begins to be more vulnerable as she takes up space in the world, and begins to see actual anger on her father's face in response to her new strength and resilient self.

Anya reports she does not know what to do next: "Shall I cry, run out, attack, lash out at self or other?"

These are all reasonable questions, and could involve the trauma therapy work of Somatic Experiencing that addresses fight, flight, freeze, or collapse (Levine, 1997, 2010). Anya and I have done Big T trauma therapy work in the past. This session is focused more on developmental trauma, and the somatic shape of bracing and being less tall within the window of tolerance.

Analysis of Anya's portrayal work: Formative Psychology and AEDP

In Anya's portrayal case with her father, we see a cascading of self-states, emotions, maladaptive affects, insights, and questionings. This is common in a dynamic portrayal. We see things come to the foreground, get worked on, recede, and then the next element appears from the background. Anya moved through truth-telling, orienting, sadness, stillness, auditory awareness, her grandmother's garden, anger, shame, insight, body-organizing, big anger, shame reduction, fantasy bond reduction, feelings of being scared, shifting her interpersonal relationship to father, and questioning what comes next. There is much of the implicit becoming explicit, and then becoming engaged and worked with therapeutically.

Two somatic shapes show up in this portrayal. First, there is Anya's hand holding and her crossed ankles; and second, there is her becoming less tall and more braced. The hand holding and ankle crossing is complex and could have multiple functions. As a defense against her feelings toward her father, it helps regulate her anxiety. It is also a self-protective compliant body-shape strategy of signaling to her father she is not a threat. This kept her safe as a child. It could also be part of her maladaptive affect; hence, a complex phenomenon. At a Psychotherapy Networker workshop on March 17, 2016, Janina Fisher spoke of shame body organizing as a self-protective stance that needs to be validated, and ultimately therapeutically transformed. This would be consistent with AEDP's approach.

When we use the Formative How technique to undo this compliant somatic shape, it opens the door to a more resilient shape. Satir (1976) would speak of this resilient somatic shape as more congruent with Anya's words, feelings, and actions. In the AEDP sense, this new resilient body organizing is a new experience. We are at the bottom of the triangle of experience, in core affective experience. This new resilient somatic shape – ankles uncrossed, hands unfolded – allows Anya to more deeply experience her core affective experience – anger at her father, and insight about shame ingestion – and to have a transformative experience when something new shows up. In AEDP fashion, there is a slowing down to metaprocess this new experience and insight. Keleman (1979, 1987) also speaks much of slowing down and digesting what is happening – waiting

for and processing new connections and somatic organization in the present moment.

The second somatic shape shows up when Anya feels stronger and more vulnerable as she comes out of the fantasy bond with her father and confronts him with anger over his not owning of shame, putting it onto her, and not being present in her life in a healthy way. This new somatic shape of being less tall and more braced is not ideal for the long run, but it paradoxically is helpful in the short run. It is an understandable reaction to her now seeing her father more clearly. The therapy interventions with this new compromised somatic shape involved assertive physical movements – using a pillow, wall, and physio ball – and experiencing and expressing her scared feeling (a categorical emotion) to her father in the portrayal. More therapy work will be needed to help Anya become less braced and taller, a more resilient body organizing, in future therapy work.

Keleman (1989) discusses the "bracing against pain" (p. 49), "surprise and stiffening" (p. 53) responses to insult. He explores ways to work with these phenomena very slowly and carefully, unwinding shapes and pausing with each place of this body-organizing continuum process. He also addresses these issues in the context of distortions of love (Keleman, 1994).

Anya's portrayal incorporates her early childhood, adolescent, and adult experiences with her father. Thus she is reorganizing her body across the lifespan of her experience with her father. When discussing Erickson, Mahler, and Benjamin, Russell (2021) speaks to the importance of the transition from dependence to independence to interdependence. Here individuation, self-autonomy, and growing self-capacities are important. The individual is expanding against a hoped-for healthy "we" into a more developed and pronounced "I" (p. 245). We see this happening in the portrayal with Anya evolving out of a fantasy bond and shame ingestion into a more alive, empowered, and differentiated self.

Downing (2015), writing in Keleman's tradition and within his own model of Body-Focused Therapy, speaks of individuals developing a "complex repertoire of body organizing 'know-how'" (p. 309) over the lifespan of infancy, childhood, adolescence, and adulthood. Grand (1998), who edited Keleman's *Journal of Somatic Experience*, likewise emphasizes that the "shaping of bodily experience and bodily structuring of emotion, feeling, and efficacy continue throughout the life span," (p. 172) both inside and outside the family of origin. Finally, in his colloquy with Joseph Campbell, Keleman (1999) also addresses the lifespan from a hero's journey myth perspective.

AEDP within the model of Formative Psychology: The case of Pedro

Background

My client, Pedro, has developmental trauma from a dysfunctional family. His being gay was not accepted by his religious father; however, his mother was accepting of his sexual orientation, and gave him good love and connection growing up. His father is narcissistic, and Pedro wrestles with many self-worth and body image issues. He is now well-adjusted to being gay, but struggles with dating and finding a life partner.

Pedro enters my office and shares that the last couple of nights he has lain in bed, with no alcohol, overcome with a wordless, deep sadness. He reports feeling lonely, isolated, and not enjoying what he is doing. He often lies in bed, which he reports is often the only time lately that he allows himself to relax. I share with him that lying horizontally can lead to feeling more vulnerable and to states of regression. It is one reason why Freud worked with clients on the couch. So he accesses this lonely, deeply sad part of himself when he lies down.

Formative how technique applied to maladaptive affect and categorical emotions of the AEDP model

A decision is made to explore the somatic shape of this wordless, deep sadness that Pedro shares with me. Keleman (1987) sees feelings as having two functions: one is to communicate deep organismic states, like hunger, love and pain; the second is to organize states of awareness and action. In seeking expression, feelings become form. In Keleman's words, "Form and feeling are thus a continuum from liquidity to solidity, from internal experience to external expression" (p. 34).

Keleman (1987) shares that sometimes feelings have few avenues for expression, given societal constraints. Other times a form exists, like "obedience to authority or feeling small," (p. 34) that is no longer of use. Also, feelings can be based in present reality or in the past. This also needs to be closely attended to. Helping new shapes to form for past feelings and present realities is an important task in therapy.

In AEDP there is the important distinction between maladaptive affect and categorical emotion (Lamagna, 2021; Gleiser, 2021). Maladaptive affect needs a unique set of tools to transform it. Categorical emotions have adaptive action tendencies that can move towards completion. Engaging desire, agency, and action is an important pathway to undoing maladaptive affect (Russell, 2021).

I will use the Formative How technique to join Pedro in exploring first a feeling of sadness that is tied to the maladaptive affect of being stuck in loneliness and with fragility. The second part of the case will apply the Formative How technique to a feeling of anxiety and a state of fear tied to avoidant behaviors in a romantic dating context.

Pedro's formative work with his AEDP maladaptive affect and being stuck in avoidant behaviors

A Working with the maladaptive affect of loneliness, despair, emptiness, desire, and a brittle self

I invite Pedro to see if he can reaccess his experience of deep sadness when lying on his bed. He shares with me that there is an afterglow of emptiness in his chest, and that his entire body feels like a brittle shell, cracking into his emptiness.

I proceed to join Pedro in this somatic experience and invite him to explore it. I use the Formative How technique. I ask if he can make this brittleness a little more intense. He does, and I ask what this is like. Pedro replies, "At any point it could break."

I suggest intensifying it a little more to continue to learn about what this brittleness means. He does, and says there is "no coming back from this." This is informative, and helps us know how fragile this brittleness is. I also decide it is wise to move in the other direction of undoing the brittleness, and keep Pedro within the window of tolerance.

Continuing with the Formative How technique, I ask Pedro if he can lessen this brittleness a bit. He does, and shares he experiences a deeper breath in his body. I ask what this body organizing place is like. He says he "feels empty, pieces missing, and less imminent danger." It is good he is feeling safer in this place, and can notice and name that there are missing pieces. I suggest to Pedro that he again lessen again this brittle somatic shape a little bit with a micro-movement. Pedro joins me, and notices that he is feeling the "need for less emptiness and more pieces" in his body. I respond by noting his emptiness is asking to be filled up. He is experiencing his deep sense of loneliness.

I decide to employ a resource to create a self-corrective experience for Pedro. I suggest he imagine someone he loves. I ask him what that might be like. He says he could imagine one of his ex-boyfriends. I say that will work. He imagines this, and I ask what it is like. He says he is experiencing being filled up. Pedro shares it is scary and vulnerable to feel a lot less empty. I explain how new positive experiences can be scary sometimes, and when we feel stronger, we can also paradoxically feel vulnerable. Our heart is more open to intimacy, and yet also more open to potential hurt. I invite Pedro to feel his lessened brittleness, and join it with some breath of air to deepen the feeling of this new somatic shape with a resource.

I ask what it is like to be in this place. Pedro replies that he feels sad, since he can access this new more resilient somatic shape only through memory, and he feels little hope of achieving this in life. The maladaptive affect is being engaged and treated in a safe space, and transformative change on Pedro's issues continues to unfold.

B Working with the somatic shape tied to anxiety, the fear emotion, and avoidant intrapersonal and interpersonal behaviors

In the next therapy session, I decide it would be helpful for Pedro if we explore the body organizing of his anxiety about going to a queer book group alone in order to find a partner. I ask Pedro to imagine going to the club, and we can be curious about his somatic shape. As he imagines, I ask him what he notices happening in his body. Pedro

shares he has muscle tightness in his shoulders and his breath is shallow. Using the Formative How technique, I suggest he make his shoulders a little tighter, and see what that is like. Pedro shares that he feels more stable in his somatic shape. He feels he can be less hurt by someone, yet he also has less ability to flee. So we pause and notice the positive aspect of safety, and the negative feature of less flexibility to flee. I then suggest he intensify the tightness in his shoulders a second time. Pedro shares he has less space to be filled up, and less need to do so. He is reporting that the greater somatic tightness has now moved to a numbing place that is less open to nutrition and satisfying his needs. Pedro has growing awareness of the meaning of his shoulder tightness, and how it can contribute to his getting stuck in avoidance, lack of action, and self-destructiveness.

Next we use the Formative How technique to undo this somatic pattern of anxiety. I suggest to Pedro that he do a little bit less of his shoulder tension, and notice what happens next. Pedro reports he feels more grounded, with more security in his core. I ask him to say more. He says he feels his spine. I suggest he stay with that a moment. Sensing his spine helps him feel stronger. I then have Pedro imagine going to the book club from this somatic shape. He says he is able to deal with not knowing anybody. He says his biggest fear is running into his ex-boyfriend.

I then suggest he undo the shoulder tension a bit more. I ask what this is like. Pedro shares that he feels more at ease, centered, and nimble. I ask if he still senses his spine. He says yes. I ask where he feels his centeredness inside his body. Pedro says that his centeredness is in his chest. I suggest he just be with these sensations and body organizing. I ask what it is like.

He says, "It lacks something negative." I ask what is it like to notice this. "Interesting," he replies.

I explain to him, as we slow down and enhance his awareness of this body organizing, that he is able to appreciate what it positively does for him, as well as help him get a sense of how his somatic shape of anxiety limits him. Pedro wonders if these good feelings have to do with his recent good sleep and eating well. I reply that they may contribute to a base of wellbeing, but that he was engaged in his avoidant behaviors and somatic shape of anxiety prior to this time. So essentially, his new resilient somatic shape is the source of his feeling centered, grounded, at ease, and nimble. Pedro finds the psychoeducation helpful.

I next suggest he imagine going to the book club from this new resilient somatic shape of ease, centeredness, and nimbleness, which he senses in his spine and chest. Once again, Pedro is feeling strength, and reports going to the book club is "doable." We discuss for a moment how the stability he felt from increasing the shoulder tension made him less nimble, and ultimately numbed him out from his desire. In contrast, by undoing his shoulder tension, he contacted his spine and chest, his ground, and his center and nimbleness. Pedro gets to digest the paradox that softening himself a bit in this context allows him to be stronger, to contact his desires more deeply, and be nimbler in his life choice maneuverability and feeling.

Analysis of the Pedro case example: Formative Psychology, AEDP, and emotions

The brittle somatic shape with emptiness and missing pieces

Two reparative happenings take place when working with Pedro's brittle somatic shape, emptiness, and missing pieces. First, he experiences agency by using the How Technique in the context of AEDP with his maladaptive affect, and his accessing, contacting, and feeling his unmet needs. Second, through his self-corrective experience of imagining a past lover and feeling filled up and satisfied, he discovers viscerally his unmet need for romantic contact, and opens the door to joining me in scheduling queer book club meetings.

Using the Formative How technique, I suggested Pedro do less of the brittle somatic shape. The resulting body organizing allowed for a deeper breath of air. Exploring this further, he shared he "feels empty, pieces missing, and less imminent danger." This is a very good result. Keleman (1987, 1989) feels that being able to shift one's somatic shape and impact one's well-being can be very enhancing to one's sense of personal agency and life control. Also, growing the ability to sense, influence, and contain difficult emotional experiences of emptiness and missing pieces is important to a client's wellbeing. Having a somatic shape that is both firm

and fluid allows Pedro to contact his pulsatory self, contain it, and be informed by it.

Keleman (1987) states the "basic action of living is pulsation, a jelly-fish like pumping motion. It is seen in all the organs, all the muscles. It gives the organism its ability to alter its own movement" (p. 22). He also shares: "Like an accordion, the human is a flexible hollow tube with many chambers that are capable of expanding and elongating, shrinking and compacting, squeezing and releasing" (p. 23). Pedro is using his pulsatory, formative self to shift his maladaptive affect and contact more of his essential self.

Russell (2021) speaks to how important accessing a sense of "agency, will and desire" – core affective experiences – can be for a client to free themselves of maladaptive affect, characterized by hopelessness, terror, and experiences of collapse (p. 249). She speaks of how agency, will, and desire are "affectedly laden self-experiences that can get disrupted, derailed, repressed, denied, and even turned against the self" (p. 252). This turning against the self is the resistance Rank (1978) speaks of as the negative will. The goal is not to let go of resistance, but to transform the negative will into positive will: to support clients in their agency when it manifests, whether in opposition to the therapist or in expansion in life situations. Russell (2021) speaks of the importance of the therapist mirroring the "being of the person's self" (p. 252).

We can see both Pedro's transformative experiences of feeling agency in exploring his brittle somatic shape, and feeling satisfaction/frustration in a self-corrective experience as helping to transform his negative will into positive will. We can use Rank's (1978) concepts of negative to positive will to understand the transformation of Pedro's maladaptive affect of brittleness, emptiness, and missing pieces.

The anxious and avoidant somatic shape with fear and potential for action

Pedro's somatic shape of anxiety and avoidance tied to going to the queer book club alone is different from his brittle body-organizing of his feelings of emptiness and missing pieces, which is connected with maladaptive affect. His somatic shape of anxiety has more place in the outer world. It is what he presents to himself and others; it has more muscular form, is less fragile, and is likely a defense against Pedro engaging with his core affective experience – his unmet need for romance – at a queer book club. In the AEDP triangle figure, the somatic shape of anxiety/avoidance would be in the upper left (where defenses are) on the triangle of experience (Pando-Mars, 2021). Ironically, in the upper right of the triangle of experience is the inhibitory affect of anxiety. The Formative How method can be used to both undo the compromised somatic shape of anxiety as well as help calm and regulate the sensation of anxiety – thus, having two benefits.

In the experiential dynamic world, there is a distinction between anxiety and fear. Anxiety is often tied to one's phobic reaction to internal emotional or intimate experience. Fear is considered to reference an external event, like a tiger or hurricane approaching. In this example of Pedro and his anxious somatic shape, it is possible we are dealing with both. Pedro is working with his internal world of sadness, agency, courage, love, and experiences of intimacy. Hence, he could be feeling some anxiety about embodying these inner life possibilities, needs, desires, challenges, and feelings. He also is facing the external fear of meeting people he does not know, running into an ex-boyfriend, being found uninteresting or unattractive by gay males who are "very fit, catty, and mean, or super smart." These external fears have a catastrophic side to them, could be tied to Pedro's projections, and could also have some reality to them. People can sometimes be unkind or entitled, unfortunately.

When Pedro intensifies his body organizing of his anxiety, he begins to understand the positive hook of his compromised self-pattern: it is safe, rigid, and numbs out his unmet needs. When he does less of the somatic shape of anxiety, he has contact with his needs, more flexibility, and contact with his spine and chest – all which can support him in embodying his core affective experience of agency, intimacy, and desire.

Conclusion

A thesis of this paper is that AEDP and Formative Psychology can be integrated with each other to the betterment of clinical treatment of the client. Somatic shape can be worked with in an AEDP portrayal to deepen and alter emotional experience.

When it shows up organically in the portrayal, it can be seen by the therapist, brought to the client's awareness, and jointly explored with the Formative How technique to discover a more resilient body organizing that is congruent with the emotional experience being explored. In addition, this shift in somatic shape supports the deepening of these emotions and insights, as well as opens the door in this dynamic portrayal to new insights, emotional experiences, and somatic shapes to be encountered, engaged, and developed in the future.

Beginning one's therapy session using the Formative How technique to explore the somatic shape of AEDP maladaptive affect (helpless, hopeless, stuck) or complex self states (impatience, the catastrophic, bitterness, etc.) can be most useful. Doing more and less of the somatic shape of maladaptive affect sheds light on the body organizing of a client's being stuck, helps the client feel and understand this tenuous condition more deeply, and creates scaffolding for self-corrective experiences with the maladaptive affect.

Starting therapy with the Formative How technique applied to the somatic shape of a defense/survival strategy or a complex self state (AEDP state 1) can help clients discover the meaning of, and potential solutions to, their body organizing around these matters. This also involves a client dropping down into the AEDP state 2 with a new core affective experience. Then, as one explores this new shape and core affective experience, one can also use the AEDP metatherapeutic processing to enter the AEDP state 3 of syncing this experience more within an individual's neurobiology. If it feels right and true to one's self, then one may be in the AEDP state 4 core self.

AEDP and Formative Psychology are informed by both phenomenology and science. Their models of change are designed to elicit, explore, and deepen new experiences. They are experiential, curious, and respectful of each individual's unique being and its unfolding. They complement and fit each other in many ways. All these together lead to successful therapeutic outcomes.

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Affecting Gestures*

Katharine Young

ABSTRACT

Gestures are inflected with affect. In the course of a somatic therapy session, a woman conjures up an embryo in the process of gastrulation in the gesture space in front of her body. The gesture iconically represents at once a baby, a baby in a dream, her future self, and the interior of her body. The gesturer's tactile-kinesthetic engagement with these virtual entities makes them palpable to her as well as visible to her interlocutors. Her palpation of her own virtual interior, her virtual others, and her virtual self affects her. The gestures people make as they speak configure the meaning of the words they accompany. Co-speech gestures also configure the feeling the gesturer has about the meaning. The capacity to affect oneself is key not only to how somatic psychology works, but also to how gesturers shape their own affect in ordinary interactions.

Keywords: phenomenology, affect, gesture, somatic psychology, intraaffectivity

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> ***Formative Psychology explores the somatic shape of an emotion with micro-movements that either intensify or lessen the body organizing of an emotional experience.***

The gestures people make as they speak configure the meaning of the words they accompany. In this paper, I argue that co-speech gestures also configure the feeling the gesturer has about the meaning. Meaning and feeling intertwine in a loop that feeds the feeling back into the meaning, and the meaning back into the feeling. Meaning and feeling affect each other. This bi-directionality is evident in a somatic therapy session in which a woman's gestures configure the meaning of the word *gastrulation*, and her feeling about the meaning. The woman affects and is affected by her own gesture. I designate the faculty of the body to affect itself intraaffectivity. The gesture communicates this intraffectivity to the perceiver, who affects and is affected by the gesture in the interrelationship Daniel Stern designates as *interaffectivity*. The capacity to affect and be affected by one's own movement is the root of somatic psychology. Psychoanalytic psychology focuses on what the person says. The therapist intervenes at the level of language,

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affecting what a person means and feels by changing how the person talks about them. Sigmund Freud described psychoanalysis as the talking cure, a method of treatment conducted through an "exchange of words" (Freud, 1963, p. 17). Somatic psychology extends its focus from what individuals says to how they move as they say it. Therapists intervene at the level of the body, affecting what participants mean and feel by changing how they move. The talking cure becomes the moving cure. The affect at work in the therapy session is perceptible in the gesture I analyze in this paper.

Affect theory is the antithesis of emotion theory. Fredric Jameson points out that traditional theories of emotion propose the body as a "monadlike container, within which things felt are then expressed by projection outward" (Jameson, 1991, p. 15). Affect theorists argue that we are not sealed up inside our bodily containers, but connected along various modalities to things inside and outside ourselves. Emotions that used to be understood as feelings inside bodies now surface to become *intensities*, in the term Jameson took from Jean-François Lyotard, moving around, through, and between them (Jameson, 1991, pp. 15-16; Shuman & Young, 2018, pp. 399-400). The changes brought about in the body by its affects ground its actions. This theory of affect is rooted in Baruch Spinoza's 17th century refutation of Cartesian dualism (Spinoza, 1677). In Spinoza's philosophy, the universe is a monad composed of both thoughts and things, melding into a single substance qualities that René Descartes split into antithetical substances, *res cogitans* and *res extensa*, mind and body. Spinoza's affections are modifications of the indivisible mental/material substance of which the body is constituted. The affections of which we become conscious are the ones we think of as emotions. "Emotion is intensity owned and recognized" (Massumi, 2002, p. 28).

Because they are at once mental and material, Amy Schmitter writes:

> "... affects can spread through association between their objects, including the most accidental of associations in memory or imagination, as well as through causal relations... An affect can produce new affects with the constitution of the body changes, e.g., appetite can turn to disgust as we become sated. Affects can spread through our imagination of the affects others feel. They can spread as we reflect on ourselves" (Schmitter, 2022, footnote 6).

We affect and are affected by these associations between thoughts and things. It is this inextricability of mentality and materiality that made Spinoza's monism the *locus classicus* of affect theory.

Gestures stretch the body into things. As they pass intensities among heterogeneous elements, they constitute visible and tactual evidence of the workings of affect (Massumi, 1987, pp. xvi, 28; Jameson, 1991, pp. 15-16; Seigworth and Gregory, 2010, p. 1). As I reach for something, my hand shapes itself to the object in anticipation of its grasp. The object has taken hold of my body before I have taken hold of it. The shape of my hand embodies the meaning the thing has for me. It and I are conjoined in a loop of intentionality. This is the condition of mutual implication Maurice Merleau-Ponty describes as the intentionality of consciousness:

> "In the action of the hand which is raised towards an object is contained a reference to the object, not as an object represented, but as that highly specific thing towards which we project ourselves, near which we are, in anticipation, and which we haunt. Consciousness is being-towards-the-thing through the intermediary of the body" (Merleau-Ponty, 1962, 1995, pp. 138-139).

I am not a consciousness contemplating as if from elsewhere other bodies and objects strewn around outside me, a subject in a world of objects; I come to consciousness with objects in the inextricably mental/material substance to which we both belong. In Phenomenology of Perception, Merleau-Ponty calls this intertwining of bodies, objects, and others *intersubjectivity*, as if it were a sort of mindreading (Merleau-Ponty, 1962, p. 352). Far more felicitously, in his last work, *The Visible and the Invisible*, he calls it *intercorporéité*, now customarily translated as *intercorporeality* (Merleau-Ponty, 1968, p. 140-141).

Gestures project into the world the gesturer's consciousness of the world. Merleau-Ponty writes:

> "The essence of consciousness is to provide itself with one or several worlds, to bring into being its own thoughts before itself, as if they were things, and it demonstrates its vitality indivisibly by outlining these landscapes for itself and then by abandoning them. The

> world-structure, with its two stages of sedimentation and spontaneity, is at the core of consciousness" (Merleau-Ponty, 1962, p. 112).

Gestures materialize thoughts as things. They are instruments of invocation: they bring my thoughts before me as things, and mold the things into the meaning they have for me. I now inhabit the space around me as world-structure and my world-structure coalesces and evanesces with my gesture. As Elena Cuffari and Jürgen Streeck write:

> "Hand gestures both fit the world and form it. The fitting has to do with what from the environment gestures appropriate. The forming has to do with what gestures disclose – that is, what they reveal, forefront, show in a new light, and create" (Cuffari & Streeck, 2017, p. 176).

The gestures that bring forth the gesturer's world-structure envelop the perceiver of the gestures in the meanings they draw out of (and into) things. Gestures have made the gesturer's world-structure not only perceptible to, but also present for the perceiver. Things have been changed. The perceiver now apprehends the world in light of this other consciousness. The pull the gestures exert on objects pulls on the perceiver's intentionality of consciousness as they pull on the gesturer's. The perceiver is present to an environment of meanings partially constituted by the other's gestures.

Intentionality clings to the shape of the hand. Even if my gestures are lifted away from actual objects in my surround, they project into the space around me the objects their shape portends. They remain, in Charles Goodwin's terms, "environmentally coupled" (Goodwin, 2007). When speakers accompany words with gestures, their gestures project the virtual objects the gestures shape into the space around the body. Gesturers can tether their virtual objects to actual objects to create blended spaces, the term Eve Sweetser takes from Gilles Fauconnier and Mark Turner, for the symbiotic coupling of the virtual and the actual (Sweetser, 2001, p. 305; Sweetser, 2012, p. 13; Fauconnier & Turner, 2002).[i]

Co-speech gestures create a world-structure gesturer and perceiver co-inhabit. The world-structure evanesces and coalesces with the gesture. As Elena Cuffari and Jürgen Streeck maintain:

> "Speech, painting, music, facial expressions, the written word, and – we add to this list – hand gestures – signify according to a play between conventionality (what Merleau-Ponty often describes as sedimentation) and creativity (spontaneity). This means that the meaning of expressive gesturing (in Merleau-Ponty's broad sense) is a local, collaborative, and in some cases temporary or transient achievement. We suggest that, in complement to the spontaneity-sedimentation dialectic, intercorporeality and interpretive effort ground the meaning of expressive gesture." (Cuffari & Streeck, 2017, pp. 174-175)

Co-speech gestures are not representations of the objects the words they accompany mention; they are invocations of intentional objects, the objects as they are for the gesturer. In Cuffari's rendering:

> "A gesture for Merleau-Ponty is the way that meaning inhabits a body and a body inhabits acquired ways of expressing, which is to say, the way that a particular existing, thinking, and communicating body-subject lives – and creates – a particular meaning. A gesture is a meaningful bodily act, the way a human body always transcends itself towards some significance... Expression is the outcome of the dialectic of sedimentation and spontaneity, in that expression is the body's appropriation of acquired form in a new act of meaning-giving" (Cuffari, 2012, p. 615).

The redesign of the habitual gesture to address the moment engenders the act of creativity as the gesture attunes itself to its object afresh, changing thought, body, and world in one movement.

Gestures draw meanings out of either the objects in the actual space around the gesturer, or out of the objects the gesturer has made present in the virtual space in front of the gesturer's body – the space

i. In Gilles Fauconnier and Mark Turner's Mental Spaces Theory, blended spaces combine elements of a real space with elements of an imagined space (Fauconnier and Turner, 2002). Eve Sweetser extends this cognitive blending to gestures (Sweetser, 2001, p. 305; Sweetser, 2012). Here, the actual body making the gesture is combined with the virtual body the gesture represents.

John Haviland designated the *gesture space* (Haviland, 2000, p. 18). The gesture space is a fluctuating sphere whose rim is roughly defined by the reach of the fingertips. Inside the sphere, gestures materialize objects in an alternate reality, a remembered or imagined world made virtually present to gesturer and perceiver (Young, 2021, p. 92). The alternate reality can take form fleetingly in association with a single gesture, or it can be elaborated into a world inhabited by characters in a narrative acting in their own space. In acts of narration, gestures make perceptible the world-structure of the realities the storyteller inhabits: the actual world of the telling and the virtual world of the tale, both made present by the gestures that accompany the telling (Shuman & Young, 2018, pp. 400, 412). When the alternate reality is contained inside the gesture space, it presents itself as a miniature world outside of which gesturer and perceiver stand, and to which they have unrestricted access – an implicitly objective, detached, and omniscient perspective. When the gesture space expands to contain the gesturer as a character, gesturer and perceiver have access only to whatever that character can perceive – an implicitly subjective, engaged, and biased perspective on events of which the character has only partial knowledge (Genette, 1980, pp. 62-163; Rimmon-Kenan, 1984, pp. 74-82; Young, 2000, p. 88).

Gestures pick out, take hold of, or turn into their intentional objects. Even deictic gestures dispose the body toward its objects of interest, extending it out of its own space toward the object's space. Gestures that outline the contours of their objects inscribe its trace into the air; gestures that grasp their objects impress its shape into the hand, along with the trace of its weight and heft; gestures that make themselves into their objects embody the object's thickness, density, and opacity. In contrast to the deictic gestures, these gestures are in some sense like their objects. They are, in David McNeill's terminology, iconics (1992, p. 12). The gestures that McNeill terms metaphorics deploy iconic gestures toward metaphorical objects (1992, p. 14). Metaphors juxtapose two different domains of discourse. Classical literary theories hold that metaphors bring forward a property the two domains share. Linguists George Lakoff and Mark Johnson argue, on the contrary, that the metaphors map one domain onto the other (Layoff and Johnson, 1980, p. 294). "Each metaphor has a source domain, a target domain, and a source-to-target mapping" (Lakoff, 1987, p. 276). Until the metaphor accomplishes the mapping, it is not apparent that the two domains share any particular properties. The mapping makes the reader or hearer see the target domain in terms of the source domain. As a consequence of this new seeing, an unexpected metaphor can take us by surprise. Metaphoric gestures make the source domain of the metaphor perceptible in the gesture space, and map it onto the imperceptible target domain the speaker mentions but does not materialize. The perceiver's perception of the source domain configures the perceiver's conception of the target domain. Unconventional metaphorics give gesturers and perceivers a fresh hold on their intentional objects.

Affects traverse the intentional arcs that connect bodies, objects, and others. Bodies are never unaffected. As the phenomenologist Martin Heidegger held, we are always in a mood:

> "For Heidegger, we are always in some mood or other: he discusses such examples as fear, boredom, hope, joy, enthusiasm, equanimity, indifference, gaiety, satiety, elation, sadness, melancholy, and desperation ...We can slip over from one mood into another, but we can never be free of moods altogether...even the pure, 'disinterested' theoretical attitude is a mood with its own way of disclosing the world" (Guignon, 1984, p. 235).

Affects are not bestowed on objects by consciousness but felt in, through and around objects by bodies: mood brings forth a world. Heideggerian moods affect external perceptions as well as internal states – not just because they introduce a subjective bias about what I perceive, but also because I perceive different things in different moods. Affects are not self-disclosive, but world-disclosive. As Paul Ricoeur writes in his phenomenological account:

> "Being afraid does not mean feeling my body shake or my heart beat; it is to experience the world as something to shun, as an impalpable threat, as a snare, as a terrifying presence" (Ricoeur, 1966, p. 271).

Moods are not in us; we are in them. Psychologist and psychoanalyst Silvan Tomkins moves out of this dualistic seesaw to argue that affects are neither in the body nor in the world, but in between.

In his analysis, they are bi-directional expressions that animate the world for the body even as they animate the body for the world:

> "… affects are not private obscure internal intestinal responses but facial responses that communicate and motivate at once both publicly outward to the other and backward and inward to the one who smiles or cries or frowns or sneers or otherwise expresses his affects" (Tomkins, 1965, p. vii).

We are affected by experiences of our own affects.

Affects cannot be categorized as emotions. "Usually," acknowledges psychologist Daniel Stern, "one thinks of affective experience in terms of discrete categories of affect – happiness, sadness, fear, anger, disgust, surprise, interest, and perhaps shame, and their combinations." Stern calls these categorical affects, after Charles Darwin's classification. But he thinks there are other affects, less susceptible to categorization, which he calls vitality affects. "These elusive qualities are better captured by dynamic, kinetic terms, such as 'surging,' 'fading away,' 'fleeting,' 'explosive,' 'crescendo,' 'decrescendo,' 'bursting,' 'drawn out,' and so on" (Stern, 1985, p. 54). Vitality affects cannot be correlated with any particular categorical affect. Stern distinguishes among them by their *activation contours* – the intensity, timing, and shape of the behaviors that express them – rather than by the internal states they are supposed to arise from or bring about (Stern, 1985, pp. 56, 146).

> "Vitality affects occur both in the presence of and in the absence of categorical affects. For example, a 'rush' of anger or of joy, a perceived flooding of light, an accelerating sequence of thoughts, an unmeasurable wave of feeling evoked by music, and a shot of narcotics can all feel like 'rushes'" (Stern, 1985, p. 55).

As affect theorist Anna Gibbs notes:

> "These activation contours qualify the discrete affects corresponding to the pace of rising and falling levels of their arousal… Whether an affect is coming or going is information that is then conscripted into semiotic systems of meaning: joy arriving means something very different from joy departing or deflating" (Gibbs, 2010, p. 192).

Stern continues:

> "Expressiveness of this kind is not limited to categorical signals. It is inherent in all behavior… There are a thousand smiles, a thousand getting-out-of-chairs, a thousand variations of performance of any and all behaviors, and each one presents a different vitality affect" (Stern, 1985, p. 56).

Interactants attune themselves to their own and each other's affects by participating, consciously or unconsciously, in the activation contours of the behaviors that express them (Stern, 1985, pp. 54, 55, 56). *Interaffectivity*, in the term Stern introduces into effect theory, arises in the "match between the feeling state as experienced within and as seen 'on' or 'in' another" (Stern, 1985, pp. 132, 138). Because affects inflect all behavior with expressive qualities, they "can thus be an almost omnipresent subject of attunement" (Stern, 1985, p. 157). As affect theorist Thomas Fuchs writes:

> "… in every face-to-face encounter, the partners' subject-bodies are intertwined in a process of bodily resonance, coordinated interaction and 'mutual incorporation' which provides the basis for an intuitive empathic understanding. It can also give rise to self-sustaining interaction patterns that go beyond the behavioural dispositions of isolated individuals. According to this concept, emotions may not primarily be localized within a single individual, but should rather be conceived as phenomena of a shared intercorporeal space in which the interacting partners are involved" (Fuchs, 2016, p. 196).

The mimesis that attunes interactants to each other is not an imitation of the behavior that expresses the affect; it is a translation of the intensity, timing, and shape of the behavior into other intra- and intercorporeal modalities. Gibbs describes it as "isomorphism without identity" (Gibbs, 2010, p. 195). "Affect attunement, then, is the performance of behaviors that express the quality of feeling of a shared affective state without imitating the exact behavioral expression of the inner state" (Stern, 1985, p. 142). The intentional arc of a gesture is just such a mimesis of affect. The web of gestural arcs interactants display over the course of conversations materializes the interaffectivity their attunement creates.

Somatic psychology

The practice of somatic psychology makes use of this perceptible interaffectivity to bring about somatic change. Somatic psychology is anchored in a monistic understanding of the body that abjures the false dichotomy between mentality and materiality. The body is not materiality magically infused with mentality, nor is the mind disembodied immateriality detached from the flesh. Somatic psychology invests materiality with mentality at its root. Somatic psychologist Stanley Keleman describes this investment as an emotional anatomy.

> "Emotional anatomy is layers of skin and muscle, more muscles, organs, more organs, bone, and the invisible layer of hormones, as well as the organization of experience. Anatomical studies tend to depict images that are two-dimensional, thus missing the most important element, emotional life. At the same time, psychology, which is committed to the study of emotion, lacks an anatomical understanding. Without anatomy, emotions do not exist. Feelings have a somatic architecture" (Keleman, 1985, p. xii).

In his own work, Keleman brings out, dismantles, transforms, and reconstructs this somatic architecture to bring about changes in his subjects' affective experiences.

Every year in mid-winter, Keleman held the Dream Workshop [ii] at the Center for Energetic Studies, his institute in Berkeley, California.

During his 1995 workshop, Keleman showed a film about gastrulation in order to demonstrate the formation of emotional anatomy. "Gastrulation is an early developmental process in which an embryo transforms from a one-dimensional layer of epithelial cells, a blastula, and reorganizes into a multilayered and multidimensional structure called the gastrula" (Muhr, Arbor, and Ackerman 2023, unpaginated). Workshop participants told stories of their dreams. They dream their bodies and, in the workshop, embody their dreams. "By various techniques of practice, Keleman appropriates certain gestures as apertures through which to pull the dream embodiments into the space of interaction – the therapeutic space – where they can actuate somatic change" (Young, 2002, p. 47). In the dream narrative I examine here, the dreamer, Victoria Ruiz, has recounted a dream of having a child. In somatic theory, human beings evolve different embodiments for different stages of life: the infant body yields to the child body, which transforms into the adolescent body, which gives way to the young adult body, and so on over subsequent life stages. Within the body at any stage, a new body is already taking form for the next stage even as the old body loses hold. On this occasion, Stanley takes the embryonic body, of which Victoria [iii] dreams, to be the coalescing body of her future self.

Sphere

After Victoria has narrated her dream:

Stanley: "What is the experience now, you know, there's this child, having this fourth child, right? What is that like, something coming from your inside."

Victoria: "Uh, it's a feeling of getting more used with my powers, my-more calm. And uh …" Victoria follows her partial utterance by forming a sphere over her belly with rounded arms and hands, a sphere that is both herself and outside herself.

The sphere gesture affect

- The sphere gesture is a double iconic: it is a baby and it is a second self.
- The gesture space is a blended space: it is an iconic representation of a pregnant belly mounted up over Victoria's actual belly, and it is the interior of her body conjured up outside her body.
- Her body both stretches itself outward, swelling from within toward the outer curve her arms offer, and opens up a hollow space between itself

ii. Therapy sessions from the Dream Workshop of 1995 were videotaped for Keleman by his videographer Terry McClure. Clips were uploaded for my transcription and analysis from McClure's video cassettes by visual anthropologist Peter Biella, who also captured and edited the still photographs for publication. The analysis was conducted and published with consent from all participants.

iii. The name of the participant is pseudonymous.

a. *"Something is inside."*

b. *"Something is going to come out."*

Figure 1. *Inside/Outside*

and her body as an interior in which something can take form.

- The body is drawn into the hollow it makes for itself gesturally. For the gesturer, the gesture space and whatever is represented within it is not just seen, but felt. It has tactile-kinesthetic presence.

Inside/Outside

At the same time Victoria speaks:

Stanley: "Something is inside."

Victoria: "Something is inside. Something is going to come out." She wraps her arms around underneath the large oval shape she has just delineated (Fig 1a), and shifts the sphere to her right (Fig 1b).

The inside/outside gesture affect

- The coming out is not represented as a birthing or as a rupturing of the membrane that constitutes the rim of the gesture space. It is represented as a detachment of the whole gesture space from its adherence to her body, or as the instantiation of the displaced gesture space as a container with a separate exterior, a container that can be moved aside.
- This introduces the oscillation between being the gesture space, and being in dialogue with the gesture space that sets up a vibration between them. She is in interaction with herself as she is in interaction with others, objects, and spaces. Interaffectivity becomes intraaffectivity.

Gastrulation

At the same time, Victoria makes this gesture:

Stanley: "What is that like. What's it like to have an inside?"

Victoria: "Very mysterious, very powerful. Very alive. Very moving. Like the second image of cells on this movie with the gastrulation."

The gastrulation gesture affect

In George Lakoff's analysis, metaphors take language from a source domain and direct it to a target domain. The source domain for Victoria's metaphoric gestures is the substance she manipulates with her hands; the target domains are the abstract ideas she mentions: mystery, power, life, movement. Lakoff argues that concrete source domains are designed to project entity status on target domains that have none (Lakoff, 1987, p. 276). The substance materialized in the gesture space that is iconic for the inside of her body is at once Victoria's felt interiority, the iconic and metaphoric baby, and her new body.

Gastrulation is the early stage of embryonic development in which the zygote splits and folds. The image is in her mind because the therapy group has just seen the film of this process. But the gesture exceeds the requisites of iconic representation. It is both more and other than gastrulation. It is this gesture that makes it clear that the gestures are animating Victoria even as she is animating the gestures.

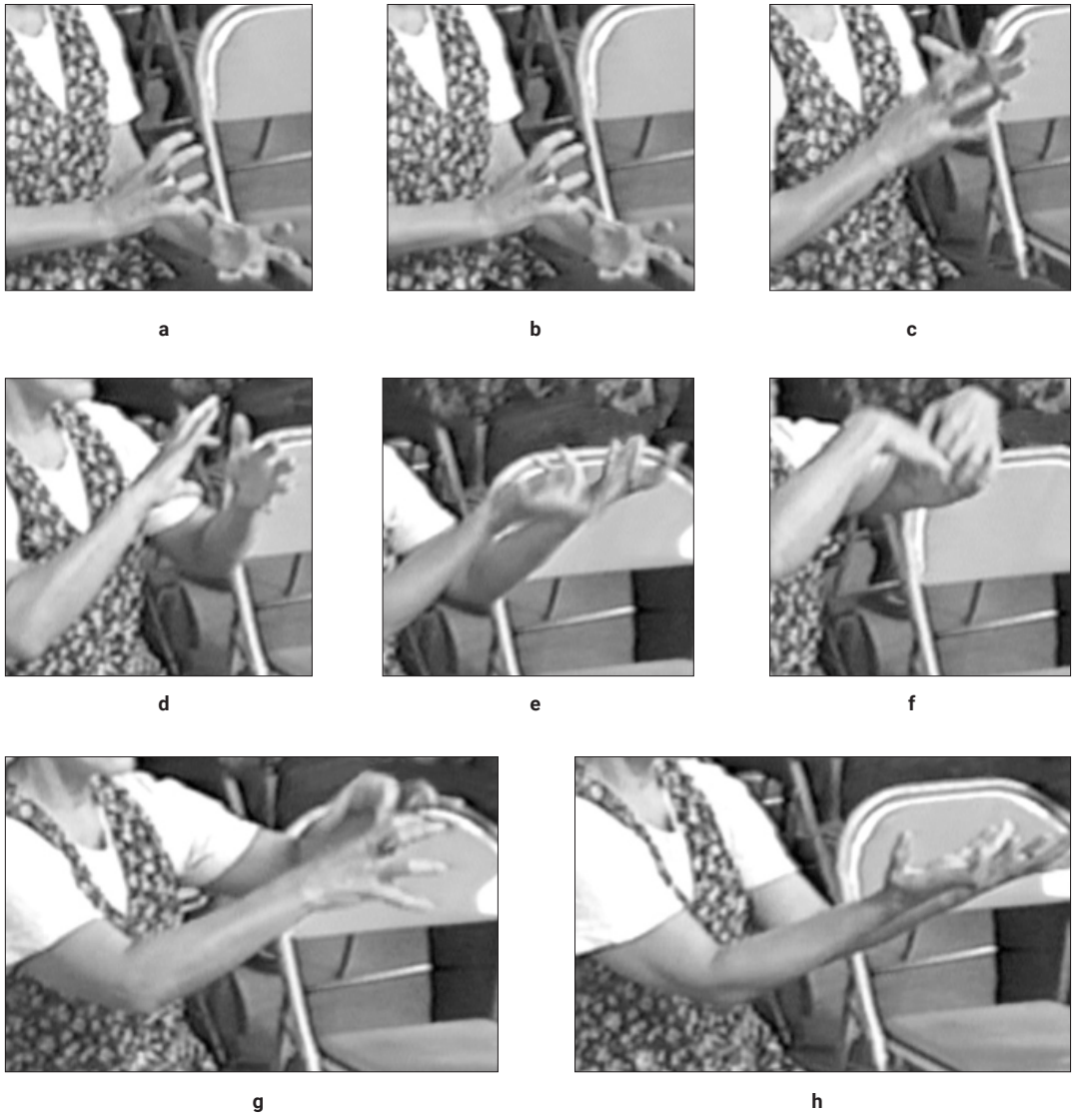

Figure 2. *Gastrulation*

- **a** *"Very mysterious, very powerful" – She wiggles her fingers while raising her hands one above the other from her lap, lifting up and layering the substance of her feeling, which fluctuates on its surface.*
- **b** *"Very alive" – She kneads the substance, which expands and contracts under her still wiggling fingers.*
- **c** *"Very moving" – She turns her hands around each other as the substance leaps and flows from hand to hand, beginning to spin.*
- **d** *"Like the second image of (cells)" – she lifts up the modulating sphere and opens her hands toward the upper right hand corner of her gesture space, and on cells, she taps the corner with her right forefinger, pegging the image.*
- **e** *No speech. Stretches.*
- **f** *"On this movie with the gastrulation" – she forms a constantly transmuting substance that folds in on itself again and again from another side.*
- **g** *No speech. Invaginates.*
- **h** *No speech. Pouches out into a new sphere reminiscent, as she says, of the gastrulation of an embryo in the film Keleman has just shown.*

a. *"comes up"* **b**. *"through the spine"* **c**. *"through the brainstem"* **d**. *"makes something"*

Figure 3. *Tube and Hemisphere*

a *"comes up" – In the gesture space in front of her body, Victoria creates a tube in a single gesture*

b *"through the spine" and the substance flowing upward in the tube – The gesture indicates both form and movement.*

c *"through the brainstem" – The substance issues from the neck of the tube into two hemispherical shapes.*

d *"makes something that balloon out and tuck back in" – She replicates this ballooning out with her cheeks in a face gesture. She adumbrates the tuck in a popping gesture of the cheeks and in a sounding gesture of the lips, and she replicates the uprising of the fluid in an intonational gesture of gurgling and in a plosive gesture of the lips. At the same time, she describes the tube as her spine and its neck as her brainstem so that the two hemispheres are iconic for her brain.*

Circle

Stanley: "Right. Where do you experience it?"

Victoria: "Here." As she says this, she brings her right hand up to her belly and rubs it in a great circle.

Stanley: "Settle into it." Victoria brings her other hand up over her belly and swells them outward.

The circle gesture affect

This is the moment Victoria, as it were, rubs the gesture back into her own body. It is as if she were undertaking to impart to herself the affect she is generating in the gesture space, at once pressing it into and holding it away from her body.

Tube and hemispheres

Stanley: "Now what is this gastrulation feeling in your brain?"

Victoria: "It feels like something that comes up, through the spine, goes up through the brainstem, makes something" (Fig 3a-d).

The tube and hemispheres gesture affect

This gesture is very intricate in itself, and it reverberates in several places in Victoria's body. The fluid effect she describes has now been transferred inward so that it both represents and affects the interior of her body. The sheer kinesthetic virtuosity of the gesture suggests that it involves her whole body.

Bubble

Stanley: "So let's stay with that. That's it." Let's go with that movement.

Victoria: "Like bubbles." She sketches in a one-handed pipe gesture with the bubbling noise, but with her hand angled toward her own interior rather than mounted in front of her body.

The bubble gesture affect

Here deixis has an intentional arc. It is as if pointing at herself has thrown the gesture into her body. Pointing gestures act as virtual pseudopods that extend the body out toward its indicated objects. It is not just the gesturer's body that responds to the point. We sometimes feel other people's pointing at us as a prick in the membrane surrounding our gesture space, and we wince. Victoria's self-pointing pricks the membrane between the gesture space in which she represents her own interior and her interior itself.

Conclusion

Victoria's gestures animate the interior of her body even as they animate the embryonic baby, the baby in the dream, and her future self. She is affecting and being affected by her own gestures. This intraaffectivity enters the body into a dialogue with itself. The dialogue materializes in the interplay among the alternative embodiments brought forward in the therapeutic session. The intensity, timing, and shape of her affect modulates as it traverses these embodiments. Affinities and disparities among embodiments create a vibration Fuchs describes as *intrabodily resonance* (Fuchs, 2016, p. 7). The body is alive to its possibilities. Somatic practice brings this intraaffectivity to the gesturer's attention in order to make it possible for her to affect herself intentionally.

Merleau-Ponty writes:

> "To pay attention is not merely further to elucidate pre-existing data, it is to bring about a new articulation of them by taking them as figures. They are preformed only as horizons, they constitute in reality new regions in the total world" (Merleau-Ponty, 1962, p. 30).

Under this condition, I form a new self, not because I undertake to think something about myself or to do something to myself, but because I come to myself refigured in the new regions my affect makes perceptible. Somatically, an old body deliquesces as a new body coalesces. Victoria's gestures are luminous instances of the affects all gestures animate within, across, and between bodies.

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The Poet in Advanced Old Age

Marcel Duclos

Epigrams

The look of the world withdraws
into the vein of memory.

Wendell Berry in *The Porch Over the River*

We must walk a long way in the world
to know the truth of certain things.

Pablo Neruda in *Muchas Gratias*

■ ■ ■

Unless the Seed

I stretch beneath a sugar maple as a child.
Dream I taste the boundless amber syrup
in every spiraling seed. Old now,
I dream myself to be a seed
within a body-envelope
from swollen feet to balding pate.
Hard to believe a blade of grass will rise
out of this parchment shell—
the seed planted before the birth of time
a logos
sailing space
swimming in a galactic soup of
breathing blueprint siblings
programmed to land on a nameless speck
at the edge of a numberless universe
to course the return journey to its timeless core

Regrets

When we meet again—
dear ant, curious spider, annoying fly—
will you forgive me for killing you?

As for you,
little green frog,
do you remember?

I am the one
who hammered you
lifeless

in the back yard
behind the garage
at age five.

I wanted to see you jump
again and again
and again.

I overdid it.
And you,
you lay flat bloodied.

Will you
forgive me
if we meet again?

Under Snow

When the robin
tugged on the first worm
silly enough to seek the warmth
in a blanket of leaves
crying the winter
the boy—now a living memory—
thought of nothing else but
hungry brook trout

By the River

Now galloping winds
strip my bark
leave me naked

I face the flames
coursing up the canyons
of my pleading heart

I seek escape from despair
while drinking my last drops of hope

cup of juice this morning

for W. S. Merwin

I find these lines by Rumi
in the skylight shadow of my study
in the bamboo hutch
in a drawer
in a book
sleeping a dream long ago quenched
deprived of today's parched ground that strangles
my thirst to know
to make sense of what I will never understand
that bends me
hurls me to my knees before the cup
brimming with *the juice that leaves the intellect in ruin**

* from *The Big Red Book*, Tr. Coleman Banks

the one and only task

to come into the moment
no longer in the past
not yet in the future

Last Night's Dream

The path from the cottage
at the edge of the village
soon rises to the east

After morning gruel
frock beret cane in right hand
le viellard wearing his years

no loner delights in
l'hirondelle's chirp song
He swallows meals of grief

Bent forward he walks up the hill
rounds the corner to the woods
hears not the other's trodding steps

Poor eyesight disguises
a lifelong friend on foot
the direction of his coming

Soon enough cold wet winds
will shiver leaves to the ground
Two old companions will join them

breathe the morning air
escape the old churchyard
welcome the rising

After the Book Is Printed

After the book is printed,
he speaks of sitting in the waiting room,
of having his furtive step slowed down,
of needing to caress the last budding rose,
that there is always time for love songs and sorrows—
all an invitation to reach calm.

A New Paradigm for Psychotherapy and Body Psychotherapy Research

Courtenay Young

ABSTRACT

This two-part article looks at what is appropriate research for the psychotherapy profession today, mainly from a perspective in Europe, where psychotherapy is establishing itself as an independent profession, distinct from psychology and psychiatry. Given the wider parameters and the different nature of psychotherapy training, modern research methods more appropriate to clinical practice, the client-therapist relationship, and greater interest in the therapist's desire to tailor the therapy to the client's needs, are discussed. The second part of the article looks at a particular mainstream within psychotherapy, that of Body Psychotherapy (body-oriented psychotherapy/somatic psychotherapy), and examines its researched evidence-base and what appropriate methods exist to support it being considered as an empirically validated form of treatment.

Keywords: psychotherapy research methodologies, competences, body psychotherapy, evidence-base

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PART 1

Psychotherapy Research Today

Starting from the basis that it is clearly established that psychotherapy is generally effective; the 2012 APA Recognition of Psychotherapy Effectiveness is sufficiently clear about that. It is also clear that one of the most significant factors is a good working alliance between the therapist and the client:

> "WHEREAS psychotherapy is rooted in and enhanced by a therapeutic alliance between therapist and client/patient that involves a bond between the psychologist and the client/patient as well as agreement about the goals and tasks of the treatment."

This immediately raises the question of who is doing psychotherapy to whom, and under what conditions. The APA Statement above assumes that the therapist is a "psychologist," which might be somewhat more accurate for the situation in America, but is less so with the professional situation in Europe. Common factors that demonstrate effectiveness across the many different forms of psychotherapy seem to be empathy, positive regard, and genuineness in the therapist, which supports the above.[1]

In the U.S., a psychotherapist or psychologist needs a master's degree or doctorate in psychology, medicine, social work, or a similar field, plus a specific number of supervised practice hours – all as mandated by the practitioner's state licensing board. It is also clear that while psychotherapy is not only effective but longer-lasting since it teaches life skills, it is also underutilized – possibly because big pharma is better publicized, but also because access to psychotherapy is limited: *"Psychotherapies are highly effective, but only when consumers have access to them."*[2]

The situation in Europe is quite different; only a few countries require the practitioner to be a psychologist, medical doctor, or psychiatrist. The European Association for Psychotherapy is proposing a new psychotherapy law to pass through the European Commission that would not only legitimize present practice, but also require four years of postgraduate education and specific training in psychotherapy at a master's degree level – EQF-7 (European Qualification Framework, Level 7). Psychotherapy is also currently listed as a subset of psychology/psychologist in the classification of European Skills, Competences, Qualifications & Occupations (ESCO), with an interesting note at the very end: *"It is an independent occupation from psychology, psychiatry, and counselling."*[3]

Furthermore, the "medicalisation' of psychotherapy and mental health needs to be re-assessed. Not everyone who undertakes – or benefits from – psychotherapy has been diagnosed with a mental illness. Psychotherapy can help people with a number of different life stressors and conflicts that can affect anyone, anytime, anywhere. For example, it can be and often is, effective in the following areas:[4]

- Resolving conflicts with a partner, family member, or someone else in one's life
- Relieving anxiety or stress due to work or other situations
- Coping with major life changes (e.g., divorce, death of a loved one, or loss of a job)
- Managing unhealthy reactions, such as road rage or passive-aggressive behaviour
- Coming to terms with an ongoing or serious physical health problem (such as diabetes, cancer, or long-term (chronic) pain)
- Recovering from physical or sexual abuse or from witnessing violence
- Coping with sexual problems, whether they're due to a physical or psychological cause
- Better sleep when there is trouble with insomnia
- Working with compulsive or addictive behavioral patterns such as gambling, debting, etc.)

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1. Browne, J., Cather, C. & Meuser, K.T. (2021). Common Factors in Psychotherapy. Oxford Research Encyclopedia of Psychology. (www.oxfordre.com/psychology/view/10.1093/acrefore/9780190236557.001.0001/acrefore-9780190236557-e-79).
2. APA 2012: Research Shows Psychotherapy Is Effective But Underutilized. (www.apa.org/news/press/releases/2012/08/psychotherapy-effective)
3. ESCO classifies a 'psychotherapist' (Code 2634.2.4) under 'Legal, social and cultural professionals,' social and religious professionals,' 'Psychologists,' 'psychologist':*"Psychotherapists assist and treat healthcare users with varying degrees of psychological, psychosocial, or psychosomatic behavioural disorders and pathogenic conditions by means of psychotherapeutic methods. They promote personal development and well-being and provide advice on improving relationships, capabilities, and problem-solving techniques. They use science-based psychotherapeutic methods such as behavioural therapy, existential analysis and logotherapy, psychoanalysis or systemic family therapy in order to guide the patients in their development and help them search for appropriate solutions to their problems. Psychotherapists are not required to have academic degrees in psychology or a medical qualification in psychiatry.* ***It is an independent occupation from psychology, psychiatry, and counselling****."*
4. Adapted from The Mayo Clinic website: www.mayoclinic.org/tests-procedures/psychotherapy/about/pac-20384616

The significance of these points is that research that attempts to isolate factors (i.e. using randomized controlled trials (RCTs), which are more suitable for testing the efficacy of medications) is ineffective, as psychotherapy has far too many variables. [5] Despite this, cognitive behavioral therapy – and its derivatives such as mindfulness-based cognitive therapy, dialectical behavioral therapy, acceptance and commitment therapy, and rational emotive behavioral therapy – claim that their use of RCTs makes them "evidence-based therapeutic treatments" with, perhaps, the implication that other methods are not. However, Philips & Falkenström (2020) claim that:

> During the last decades, advanced analytic methods have been developed in psychotherapy process research, which enables investigation of causal connections regarding change mechanisms in psychotherapy. Therefore, we propose that the top of the research evidence hierarchy for psychotherapy should encompass: (1) RCT for circumscribed disorders, (2) cohort studies for complex disorders, and (3) advanced process studies for change mechanisms.

One of the better basic manuals about psychotherapy research is contained in Gelo, Pritz, & Ricken (2015). They clarify four interrelated basic assumptions:

(1) Psychotherapy research and its object of investigation are *social constructs* grounded in the values and beliefs shared by members of a specific community at a certain time and place;

(2) For psychotherapy researchers to be aware not only of what they do, but also of why they do it, they should engage in *explicit* and *self-critical reflection* on the foundational assumptions of psychotherapy research;

(3) *Pluralism* should be considered not only a valuable stance, but also an *a priori* condition of any scientific account of psychotherapy;

(4) Finally, self-reflective and methodologically pluralistic psychotherapy research should be conducted on the *process* and *outcome* of psychotherapy to determine how and why psychotherapy works.

Rather than being seen as an independent profession as claimed by the European Association of Psychotherapy's 1990 Strasbourg Declaration, mentioned above, psychotherapy is currently classified as a subset of psychology by ESCO, not included in the category of "Health professions," but classified in the "Legal, Social, and Cultural professions" category. This further negates the use of research techniques suitable for medical treatments, and reinforces the use of techniques more suitable for social studies.

More than 20 years, ago a colleague and I wrote an article entitled *The scientific 'what' of psychotherapy: Psychotherapy is a craft, not a science!* (Young & Heller, 2020), which argued that the direction of assessing psychotherapy by scientific criteria is fundamentally mistaken, and that, like many other professions, the actual practice of psychotherapy is more of a skill-based craft. There is no doubt that the professional practice of psychotherapy can inform science and can be informed by science, but it is definitely not a science in itself.

So, if psychotherapy is neither a medical, nor a health profession, nor even a scientific one, how can we best assess it? In 2010, the European Association of Psychotherapy (EAP) initiated a project to establish the professional competencies of a European psychotherapist (www.psychotherapy-competency.eu). This clearly identified the competencies a European psychotherapist. A comparison with the professional competencies of a European psychologist reveals significant differences which are now recognized by ESCO, though they yet need to be translated into a different category. The pragmatic approach to professional competencies also fits well with the increasingly popular common factors approach (Wampold, 2015):

> To understand the evidence for the common factors, it is important to keep in mind that these factors are more than a set of therapeutic elements that are common to all or most psychotherapies. They collectively shape a theoretical model about the mechanisms of change

5. RCTs are considered one of the more rigorous and scientific methodologies to determine whether a cause-effect relationship exists between treatment and outcome, allowing researchers to exclude the possibility that the association was caused by an alternative factor.

> in psychotherapy. … The contextual model posits that there are three pathways through which psychotherapy produces benefits. That is, psychotherapy does not have a unitary influence on patients, but rather works through various mechanisms. The mechanisms underlying the three pathways entail evolved characteristics of humans as the ultimate social species; as such, psychotherapy is a special case of a social healing practice. … The three pathways of the contextual model involve: a) the real relationship, b) the creation of expectations through explanation of disorder and the treatment involved, and c) the enactment of health promoting actions. Before these pathways can be activated, an initial therapeutic relationship must be established.

This means we must look in different directions than previously for proper and effective psychotherapy research.

To understand how and why psychotherapy works, it is necessary to focus on both the process of psychotherapy – what takes place during the treatment – and the relationship between this process and its outcome – the treatment's clinical effects. Hardy and Llewelyn, writing in Gelo et al. (2015), introduce psychotherapy process research, which examines not only how psychotherapy works, but also focuses on what happens within the system – the client, therapist and their interactions – that somehow enables change to occur; i.e., what underlies, enables, or drives therapeutic change.

> Client change processes may or may not incur within the therapy session; they may or may not be amenable to verbal description, and events that occur in the therapy session may be helpful or neutral with regard to their impact on client change. As in all areas of research, it is therefore important to provide both theoretical and empirical evidence for the way in which therapy processes or activities are linked to client change processes. Further, research must involve identifying and understanding both client and therapy processes so that as Kazdin (2009) states, we can develop 'evidence-based explanations' of why a treatment works and how changes come about. (p. 184)

A number of quantitative and qualitative methods are used within psychotherapy process research. Pragmatically, quantitative research relies more on numbers to fulfill its research goals, while qualitative research relies more on words and language. However, the severe categorization of a research approach as being either qualitative or quantitative is relatively irrelevant when conducting actual research, especially in the field of psychotherapy.

Qualitative Research

Denzin & Lincoln (2005, p. 3) describe qualitative research:

> Qualitative research is a situated activity that locates the observer in the world. It consists of a set of interpretive, material practices that make the world visible. These practices transform the world. They turn the world into a series of representations, including field notes, interviews, conversations, photographs, recordings, and memos to the self. At this level, qualitative research involves an interpretive, naturalistic approach to the word. This means that qualitative researchers study things in their natural settings, attempting to make sense of, or interpret, phenomena in terms of the meanings people bring to them.

This feels quite appropriate for a social science or a skill-based "craft" like psychotherapy. Some forms of qualitative research appropriate to psychotherapy include:

- Qualitative case studies
- Grounded theory and its variants (thematic analysis, etc.)
- Narrative inquiry/thematic analysis
- Talk & text/conversation & discourse analysis
- Ethnographical studies
- In-depth interviews
- Personal experience methods: heuristic research
- Phenomenological research (interpretive/existentialist-informed/hermeneutic)
- Q methodology

Some of the above methods mix and match, rather than being totally discrete. To describe all these methods is beyond the scope of this paper, however good explanations and analyses of these meth-

ods can be found in McLeod, 2011; Timulak, 2009; Harper & Thomson, 2012.

- ***Quantitative Research***. There are three main quantitative research strategies that may be used to reach an understanding of how and why psychotherapy works. These include:
  - Treatment process research which investigates what takes place during psychotherapy, regardless of its clinical significance.
  - Change process research which investigates what takes place during psychotherapy with regard to its clinical significance.
  - Process-outcome research which investigates the relationship between what takes place during psychotherapy and its clinical effects.

  Quantitative research is essentially the process of collecting and analyzing numerical data. It can be used to find patterns and averages, make predictions, test causal relationships, and generalize results to broader populations. It emphasizes the measurement and analysis of causal relationships of variables, not processes. There are four main types of quantitative research which attempt to establish cause-and-effect relationships among the variables: descriptive, correlational, causal-comparative/quasi-experimental, and experimental.

  Quantitative research methods are frequently applied in healthcare and social care research, and use objective measurements with statistical methods, mathematics, economic studies, or computational modeling to enable a systematic, rigorous, empirical investigation. This objectivity and numerical complexity can only be done on a large scale – perhaps less relevant or applicable to psychotherapy. Some psychotherapy mixed methods research uses both qualitative and quantitative.

- ***Qualitative Research***. A consensual qualitative research which is based on data collected through interviews involving open-ended questions and a semi-structured format. This method is particularly good for investigating the inner experiences that are not easily observable to outsiders, such as clients' perceptions of therapists' feelings, therapists' perceptions of relational interventions.

- ***Outcome Research***. Outcome research, quantitative and qualitative, shows more directly how well psychotherapy works over time. Quantitative outcome research is mostly conducted in the social sciences using statistical methods to collect quantitative data. Researchers and statisticians deploy mathematical frameworks and theories that pertain to the quantity under investigation. However, the cooperation of individual psychotherapists is needed, and perhaps for large cohorts, that of their professional associations.

  Borrowing a phrase from evidence-based medicine, psychotherapy outcome research often uses empirically-supported treatments (EST) that describe a controversial recent health-care policy that "restricts the services of psychotherapists to such therapies that have demonstrated efficacy for a given disorder." Treatment manuals play a central role in this particular definition. But, these and other elements, such as disorder-specific treatments, are aspects of research that have been seriously criticized by psychotherapists, as they do not reflect patients/clients who may present with two or three different categories: i.e., anxiety and depression and erratic behavior brought about by work stress and (say) recent grief issues.

As with many disciplines, a considerable gulf exists between research and practice, making it difficult for psychotherapists intently focused on their practice to conduct research, and for researchers to understand the complexity of the psychotherapeutic process.

> The tension between science and practice in psychotherapy has been described as a war or a "bad marriage" (Greene, 2014). Some writers on the research side of the divide characterize clinicians as lacking in knowledge and skill in empirically supported interventions (Karlin & Cross, 2014), while others suggest that clinicians are romantics when it comes to psychotherapy practice, and that they may be subject to cognitive biases when making clinical decisions (Lilienfeld et al., 2013). Writers on the clinical side of the divide argue that randomized controlled trials represent a limited form of evidence (Westen et al., 2004), and that there may be a feeling of resentment among practitioners that researchers dissem-

> inate their findings upon clinicians (Greene, 2014). The result is that patients may not be receiving the best of evidence-based care.[6]

Attempts to bridge this gap have not been very successful, though practitioner research networks hold some hope of producing practice-based evidence of their clinical work. Collecting client feedback and outcome questionnaires are a couple of research methods accessible to the working psychotherapist that can also improve their practice (Lambert & Shimokawa, 2011).

Scott Miller (Miller et al., 2015; Prescott et al., 2017; Maeschalck et al., 2019) is one of the main proponents of feedback-informed treatment (FIT), whereby the client is invited to give direct, real-time feedback to the therapist, using structured yet flexible measures that identify what is and what is not working in a therapy sessions. The therapist is thus prompted as to how to better meet the client's needs. This grass-roots approach to research seems to be quite effective in improving outcomes. While the use of the word "treatment" harkens back towards a medical model, the direct response built into the therapeutic relationship avoids much of the inherent medicalization and depersonalization.

Finally, Gaudiano & Miller (2013) introduce a special issue on evidence-based therapy research, and practice and develop the proposition that traditional psychotherapy is on the decline, while medical use and the over-medicalization of psychotherapy and mental health issues are rising, as is increasing tension between these two approaches. The authors also address issues like diagnosis, treatment development, and training – as always, from the viewpoint of U.S. psychotherapy done primarily by clinical psychologists.

> These factors hold potential opportunities but also major pitfalls that will need to be carefully navigated related to implementation/dissemination issues, interdisciplinary collaborations, and psychosocial versus biomedical perspectives related to the nature and treatment of psychopathology. In addition, we review and comment on the other articles contained in this special issue pertaining to the future of evidence-based psychotherapy (p. 814).

They conclude: "One issue that will be critical is the need for greater and more effective evidence-based psychotherapy advocacy efforts" (p. 821).

This short introduction to current issues in psychotherapy research is designed purely as an introduction to Part 2, which examines the evidence base and appropriate research techniques for a particular (mainstream)[7] type of psychotherapy, long since marginalized but increasingly relevant: Body Psychotherapy or body-oriented psychotherapy.

6. www.societyforpsychotherapy.org/what-clinicians-want-from-psychotherapy-research/
7. The wider field of psychotherapy is often classified into (a) different "mainstreams"; different "modalities" within the mainstreams; and different methods or techniques within modalities. For example, Gestalt therapy (a modality) is usually placed within the humanistic and integrative mainstream, and sometimes uses the empty chair technique. Similarly, the mainstream of psychoanalytic psychotherapies includes Jungian, Lacanian, Freudian, and Adlerian approaches (modalities), which often use the methods of dream analysis, free-flowing conversation, transference analysis, interpretation, and free association.

PART 2
Definition of Body Psychotherapy

First of all, for those unfamiliar with the field, body psychotherapy is a distinct mainstream branch with a very long history [8] (Young, 2012) and a large body of knowledge based upon a sound theoretical position. It involves a different and explicit theory of mind-body functioning that takes into account the complexity of the intersections of and between the body and mind, with the common underlying assumption that a functional unity exists between mind and body. Although many other approaches within psychotherapy touch on this issue, body psychotherapy considers this principle to be absolutely fundamental.

As a mainstream, body psychotherapy involves a developmental model, a theory of personality, hypotheses about the origins of psychological disturbances and alterations, as well as a rich variety of diagnostic and therapeutic techniques used within the framework of the therapeutic relationship.

There are many different types (methods or modalities) of body (or body-oriented) psychotherapies and/or somatic psychotherapies. [9] While some methods/modalities have developed independently, some are "intervention" techniques or body therapies that have added on (or integrated) a psychotherapy training component. [10] However, not many of these body psychotherapy methods or modalities have been subjected to any form of proper scientific evaluation (i.e., their efficacy and effectiveness have not been fully established). However, this does not mean that they are not effective or efficacious – just that the full evidence base has been lacking until relatively recently.

However, body psychotherapy itself (as a mainstream branch of psychotherapy) has been scientifically validated and recognized as a sufficiently "grounded" form of psychotherapy by the European Association of Psychotherapy (EAP), and several of the body psychotherapy modalities have also independently gone through the EAP's scientific validation process. [11]

This scientific validation process involves offering substantive responses to the EAP's "15 Questions on Scientific Validity." This validation of body psychotherapy (as a mainstream) does not differentiate between the different types of body psychotherapy – although some studies refer to just one modality (e.g., Bioenergetic Analysis, or Biodynamic Psychotherapy). Nor does it differentiate between qualitative or quantitative research, or different types of research; both were considered valid if the design were appropriate and applicable to body psychotherapy in general. "Science" just requires the establishment of measurable standards and values.

Nearly all the different theories, methods, and modalities of body psychotherapy (in Europe) now have similar standards of training (see EABP Training Standards [12]), with increasingly core el-

8. Boadella, D. (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*. (2), 1, 45-56.
9. It should also be noted that all methods or modalities of Body Psychotherapy are very different and distinct from the wide variety of (bodily-oriented) physical therapies (e.g. massage, yoga, Feldenkrais, Rolfing, Alexander Technique, Hellerwork, etc.), which do not incorporate any training in psychotherapy.
10. Bloch-Atefi, A. & Smith, J. (2015). The effectiveness of body-oriented psychotherapy: A review of the literature. *PACJA*, 3, 1.
11. For generalized information about the Scientific Validity of Body Psychotherapy (in accordance with the EAP's 15 Questions about Scientific Validity) (see www.eabp.org/wp-content/uploads/2022/01/15-Questions-EABP-2.pdf): and for the (1999) responses from EABP about the Scientific Validity of Body Psychotherapy - as a mainstream branch of psychotherapy (see www.eabp.org/wp-content/uploads/2022/01/15-Questions-EABP-2.pdf).
12. EABP Training Standards: www.eabp.org/training-standards/

ements in their curricula, common theoretical grounds (Marlock, Weiss, Young, & Soth, 2015), and support through research (The Evidence-Base for Body Psychotherapy [13]). They are also in the process of developing similar professional competencies, though these are, at present, undifferentiated between the different modalities. [14]

This listing of the Evidence Base of Body Psychotherapy [15] is the result of an extensive and informed research strategy of members of the EABP's Science & Research Committee (SRC), with submissions from EABP members and others. It is not based upon a systematic review of all available literature; we may have therefore missed some publications. Obviously, many other body psychotherapy research articles exist (many in non-English languages; many confined to specific universities or training schools). This is a work in progress, though at some later point in time, sufficient data may be gathered for a Cochrane Review. [16]

Different and sometimes quite separate approaches (modalities) are found within body psychotherapy, as there are within other main branches of psychotherapy. However, as distinct from being a medical treatment, body psychotherapy bases itself more on being a skill, rather like an art or craft, which is informed by science, and – it is hoped – even informs science. In seeking to understand how people work, body psychotherapy has developed over the past 75 years based on the results of active research in biology, anthropology, proxemics, ethology, neurophysiology, developmental psychology, neonatology, perinatal studies, and many more disciplines.

A wide variety of methods are used within the practice of body psychotherapy, including those involving touch, movement, and breath. There is, therefore, a link with some body-oriented therapies, somatic practices, and complementary medical disciplines. Although these may also involve touch and movement, they are very distinct from body psychotherapy, which recognizes the continuity and deep connections that all psycho-corporal processes contribute, in equal fashion, to the organization of the whole person. There is no hierarchical relationship between mind and body, between psyche and soma. They are functioning and interactive aspects of the whole person.

As it exists today, body psychotherapy is a loose but consensual amalgamation of a number of different types of body-oriented psychotherapies that have, in common, the principle that what happens in the mind also happens in the body. As such, they form an almost indivisible whole. Mind-body dualism is often ascribed to Descartes ("I think therefore I am"), but possibly goes back much further – even to the onset of patriarchy and the beginnings of the hegemony of reason over emotion. Body psychotherapy rejects this dualism and assumes the indivisibility of mind and body. Some body psychotherapy methods include a spiritual component.

The Evidence Base for Body Psychotherapy

Unfortunately, there is no proper, fully scientific evidence base for body psychotherapy – yet! There is, however, a large selection of articles that deal with research aspects of body psychotherapy. These are listed on the EABP website, under that title. [17] There is also a Preamble, worth noting, which states:

> Psychotherapy research in general terms is a relatively young and fairly controversial scientific discipline; the questions as to whether the notion of "Empirically Supported Treatments / ESTs" or even "Evidence Based Treatments" can be applied remains a subject for intensive debate within the psychotherapy community. Lambert (2011) emphasized major goals of psychotherapy research as an applied clinical science, namely, "protecting and promoting the welfare of the client by identifying the principles and procedures that enhance positive outcomes." The literature on the history of psychotherapy research usually distinguish-

13. The Evidence Base for Body Psychotherapy: www.eabp.org/research/the-evidence-base-for-body-psychotherapy/
14. Body Psychotherapy Competencies: www.eabp.org/body-psychotherapy-competencies/
15. The Evidence Base for Body Psychotherapy: www.eabp.org/research/the-evidence-base-for-body-psychotherapy/
16. Cochrane Review: www.cochranelibrary.com/about/about-cochrane-reviews
17. www.eabp.org/wp-content/uploads/2021/12/The-Evidence-Base-for-Body-Psychotherapy-Nov.-2021.pdf

es between four phases, beginning with the systematic case study approach introduced by Sigmund Freud in the 1920s. The first systematic outcome studies were conducted by Carl Rogers and team in the 1950s with an emphasis on psychotherapy processes, as well as conceptual issues in psychotherapy. From 1970 onwards, the focus shifted towards establishing specific effects of psychotherapy interventions in treatment-outcome studies, culminating in the famous 'Dodo-Bird-Verdict': "At last the Dodo said, 'Everybody has won, and all must have prizes" (from Alice in Wonderland). This verdict considers decades of large-scale, so-called "meta-analytic" studies, suggesting that although psychotherapy is effective, no single approach is consistently more effective than another (Luborsky et al., 1975; Smith & Glass, 1977; Wampold & Imel, 2015).

Other researchers, predominantly those representing Cognitive-Behaviour Therapy, concluded their studies as supporting modality-specific evidence (e.g., Chambless & Ollendick, 2001). From about the mid-1980s however, the perspectives in psychotherapy research shifted, and is now characterized by an intensive effort to distinguish general and specific psychotherapy process and change factors in the context of mixed-method (qualitative and quantitative) research approaches (see Laska et al., 2014). The contemporary discourse in psychotherapy research has therefore emphasized the importance of context factors such as: intercultural issues, client-therapist interaction, the matter of choice (matching of therapist/client perspectives), as well as the transfer of experiences from psychotherapy into day-to-day life.

From the perspective of Body Psychotherapy, it is furthermore important to acknowledge the growing influence of a theoretical paradigm that shifts towards a notion of embodied cognition in psychology, philosophy and corresponding findings in (affective) neurosciences (e.g., Panksepp, 2004) and neuropsychology (e.g. Schore, 2012), emphasizing the crucial role of creative, embodied engagement as well as emotional regulation and corresponding resource-oriented, approaches in psychotherapy. Some additional dimensions have to be considered for Body Psychotherapy: the embodied and experiential nature at the core of the psychotherapeutic process in Body Psychotherapy, the interactive, participatory therapeutic relationship as well as the interface between subjective feeling states/affect regulation and movement behaviour – all these aspects, specific for the work in Body Psychotherapy, make it difficult to apply EST criteria to determine an evidence-base for efficacy and effectiveness. Tantia (2019) accordingly suggested to extend the research perspective in Body Psychotherapy and introduce a "somatically informed paradigm".

For the purpose of defining the Evidence-Base for Body Psychotherapy on the EABP website, we however decided to group the literature according to a standard approach, because we came to the view that the EABP website, as an outward facing information platform, and for those who are not familiar with the specific Body Psychotherapy modality, will benefit from a summary that can be compared with other psychotherapy modalities. We would like to however clearly state, that we agree with the critical appraisal of the state of the art in psychotherapy research, i.e. supporting the notion that a wider and methodologically equivalent perspective should be considered whilst determining as to how and to what extent Body Psychotherapy "works" for the people that come to seek support and help provided by our Body Psychotherapy colleagues. After all, and as emphasized by Leichsenring et al. (2018): "Plurality and Diversity Matters", not only in psychotherapy research but also for clinical practice.

All this is not to say that body psychotherapy (and its various modalities) is ineffective; nor is it unscientific, or *only* theoretical. There are a few excellent research studies and a number of good case histories, or more accurately, case "vignettes" [18]. However, it is impossible to count these as proper evidence: they are more indications of efficacy.

18. Vignette: a brief evocative description, account, or episode

From the myriad of case examples, there is no doubt that something works somehow. This important fact cannot be denied but further explored. We must be more precise and accurate. To this end, there are the "5 Ws" of science: who, what, when, where, why – and, some would add, how. Who does it work for; what is it that works; when does it work; where does it work; and – most importantly – why and how does it work?

Systematic research is needed to evidence the effectiveness of each modality. The best evidence would be a multi-centered (i.e., conducted at a number of different locations) outcome study, where the same measurements are used at the beginning and at various intervals throughout the course of treatments. Then the dynamics of progress or factors of therapeutic change – however these are measured – could be better identified. Ideally, there would also be a three-month and six-month follow-up to see if changes are retained over time. This comprehensive type of outcome research has unfortunately not yet been done. Such studies, supported by additional research, would form a reasonably solid evidence base.

There are seemingly obvious connections between what is done to a client, particularly in terms of the body psychotherapy method used, and a client's physiology, psychological, and emotional states. The connections with neuroscience are incredibly important, but need to be better evidenced. Peter Mackereth (2018) quotes a good randomized controlled trial outline which compares Biodynamic Massage with other holistic treatment options for people with multiple sclerosis. However, this must be contrasted with the classic use of scientific findings to support theories of body psychotherapy and the therapeutic process, as in Reich's *Character Analysis* (1980), the work of Gershon in *The Second Brain* (2020) on gut instincts and the functioning of the enteric nervous system; Stephen Porges's Polyvagal work (2011) and the massive amount of work being done on the psychophysiological aspects of trauma. While it is wonderful to find sound scientific support for one's empirical findings, this does not constitute proper evidence. There may well be some correlation, but, as the saying goes, "correlation does not imply causation." [19]

Instead, we could, for example, give a particular type of body psychotherapy to a number of people who all hook up to an EEG [20] (or some other instrument) to demonstrate that the particular technique creates an increase in Alpha waves or a reduction in galvanic skin response [21] giving a measurable, physiological response associated with levels of anxiety or relaxation. We would need to demonstrate that people who receive this technique regularly not only benefit immediately, but also retain those benefits over time. This sort of attention to detailed research and the measurable effects of the therapy would help back-up the demonstrable, beneficial claims for body psychotherapy work by better indicating the how and why.

Most psychotherapy practitioners – body psychotherapy or otherwise – are not trained in science, are not qualified to do research, are often unable to understand scientific findings, are too busy helping clients, and do not have access to laboratories and equipment. As clinical psychotherapy practitioners, we have not been properly educated in the science and research of psychotherapy. Unfortunately, all these points help perpetuate the gulf between research and practice that exists not only in psychotherapy, but which is also widespread in other sciences.

In the early 2000s, after the European Association of Body Psychotherapy (EABP) established the scientific validity of body psychotherapy with the European Association of Psychotherapy (EAP) by answering their "15 Questions" at length, a number of other body psychotherapy modalities also answered the same 15 Questions. Biodynamic Psychology was one of these modalities. The EAP's "15 Questions" can be found **here** [22], and EABP's response, about the whole of body psychotherapy

19. Correlation tests for a relationship between two variables. However, seeing two variables moving together does not necessarily mean we know whether one variable causes the other to occur. This is why we commonly say "correlation does not imply causation."
20. EEG: electro-encephalogram, which tracks and measures electrical activity in the brain.
21. Galvanic skin response (GSR) measures the electrical potential on the skin (minute changes in sweat gland activity), which can indicate the intensity of emotional arousal (and relaxation).
22. EAP's 15 Questions on Scientific Validity: www.europsyche.org/app/uploads/2020/06/EAP_15_Questions.pdf

as a mainstream branch of psychotherapy can be found **here**.[23]

Currently, there is no access to the submission answers which were about the scientific validity of the psychotherapy modality: i.e., that there is a basis in science, and is not purely a belief system, or even worse, a sect. This is only the first step. Once it has been established that there is some scientific validity, one needs to look more closely at the details: i.e., the 5Ws and building up the evidence base for that particular method.

Some good work was done when the European Association for Psychotherapy (EAP) required all European organizations representing different psychotherapy modalities answer the EAP's "15 Questions on Scientific Validity"[24] with substantive responses. In 1999, Michael Heller and I answered the questions on behalf of mainstream of body psychotherapy. Then, most of the other body psychotherapy modalities within that mainstream in Europe – e.g., Biosynthesis (David Boadella), Psycho-Organic Analysis (based on Paul Boyesen's work), Hakomi (based on Ron Kurtz's work), Concentrative Movement Therapy (based on Helmut Stolze's work), Bioenergetic Analysis (based on Alexander Lowen's work), Emotional Re-Integration (developed by Peter Bolen), Character Analytic Vegetotherapy (a combination of original work by Reich & Raknes, then developed by Federico Navarro, Clorida Lubrano-Kotulas, and others), Biosystemic Psychotherapy (originated by Jerome Liss), Functional Psychotherapy (based on Luciano Rispoli's work), Core Energetics (originally developed by John Pierrakos), Psychotherapeutic Postural Integration (Eliane Jung-Fliegans & Claude Vaux), etc. – all answered the 15 Questions for their modalities.

In addition to the various modalities of body psychotherapy, the European Association for Body Psychotherapy (EABP), the European Association for Biosynthesis (EABS), the European Association for Psycho-Organic Analysis (EAPOA) and the European Association for Concentrative Movement Therapy (EAKBT), the EAP's 15 Questions on Scientific Validity have also been answered by the European Association for Integrative Psychotherapy (EAIP), the European Confederation of Psychoanalytic Psychotherapies (ECPP), the European Federation of Centres for Positive Psychotherapy (EFCPP), the European Association for Hypno-Psychotherapy (EAHP), the European Association for Gestalt Therapy (EAGT), the European Federation for Psychosynthesis Psychotherapy (EFPP), the European Federation for Bioenergetic Analysis-Psychotherapy (EFBA-P), the European Association for Neuro-Linguistic Psychotherapy (EANPt), the European Association for Reality Therapy (EART), the European Family Therapy Association (EFTA), the Federation of European Psychodrama Training Organisations (FEPTO), and the European Network for Person-Centered and Experiential Psychotherapy and Counselling (PCE Europe). The compilation of these submissions could help work out the similarities and differences between the body psychotherapy methods.

However, even if a psychotherapy has established its scientific validity does not mean that it is effective. Nor does it mean that it has demonstrated that people in treatment get better and stay better. There are several other standards that psychotherapies and psychotherapists must meet.

In 2010, the EAP began a project to establish the Professional Competencies of a European Psychotherapist. By 2013, the Core Competencies were established. This process has been useful in establishing that psychotherapists and clinical psychologists have different professional competencies. Up till then, psychotherapy was seen as a subset of clinical psychology: different competencies established a significant difference. To continue this work , we need to differentiate the specific competencies of each body psychotherapy modality.

Developing a research study or project, is not easy – especially if one is also trying to earn a living from one's private massage or psychotherapy practice. However, joining with others, as in a practitioner research network, is an easier possibility. It could be useful, perhaps, to start a Biodynamic (or Biosynthesis, or Bioenergetic) practitioner research network (PRN) in the UK, parallel and/or liaising with the UKCP's PRN, and maybe being part of the

23. EABP's Response to the 15 Questions: www.eabp.org/wp-content/uploads/2022/01/15-Questions-EABP-2.pdf
24. www.europsyche.org/app/uploads/2020/06/EAP_15_Questions.pdf

EABP's PRN.[25] A bid for research funding coming from such a network, backed by relevant professional associations, is often more successful than an individual or a small group obtaining funding, unless they are backed by a reputable (university-based?) institution.

I have written about the increasing necessity for the different psychotherapy, and especially body psychotherapy modalities, to establish a proper evidence base that demonstrates its efficacy and effectiveness.[26][27] Frank Röhricht and I have established a fairly comprehensive compilation of research for body psychotherapy in general on the EABP website.[28] However, the various modalities need to participate by contributing massive amounts of proper research and scientific work if we are to establish a widely accepted and recognized evidence base. Leading the way in research are such organizations as Biodynamic Psychotherapy, Gestalt Psychotherapy, and Transactional Analysis whose body of research is much larger and far better established.

Developing Research Standards

Before launching into any research, there are a number of points to consider. As the research will involve other people (or animals), most research studies, before they begin, must submit their protocols and a description of their research methods for ethical approval. EABP's Science and Research Committee (SRC) is developing a set of standards to help researchers ensure that their work is ethical. For example, case studies today need written permission from the subject, who, in turn, will need to be shown a final draft before publication. This was rarely the case for the early case studies or vignettes. Simply changing names and details is no longer sufficient.

In the EAP Statement of Ethical Principles,[29] there is a section on research (which may be in need of updating). If touch is involved, the USABP Code of Ethics has a specific statement about ethical touch (§ VIII).[30] I have also written quite extensively about the ethics of professional touch[31].

To lay the groundwork before starting a research project, practitioners, need backup from their training institutes. Training institutes need to be working closely with post-graduate research students in psychology departments and universities. This is the only way evidence base can become established in our field

When a research project is complete, the journal chosen to publish in must have an impact factor. It is important to seek out a properly peer-reviewed, scientific journal, such as *Psychotherapy Research*[32], or the journal of *Body Movement & Dance in Psychotherapy*[33], or EABP and USABP's very own *International Body Psychotherapy Journal*[34]. Other traditional psychotherapy journals may well be interested if the research is well-established and well-written.

In the early days of publication of original body psychotherapy articles in journals like *Energy & Character* or specific to a modality of body psychotherapy, like the *Bioenergetic Analysis Journal* or the *Hakomi Journal*, there was no peer review; there was no research; there were a few case histories and vignettes. Those were the early days. Now, much more is needed!

25. UKCP: United Kingdom Council for Psychotherapy's, Practitioner Research Network is described here: www.tavistockandportman.nhs.uk/research-and-innovation/research-centres/family-therapy-systemic-research-centre/practitioner-research-networks/
26. Young, C. (Ed.) (2012). *About the Science of Body Psychotherapy*. Stow, Galashiels: Body Psychotherapy Publications.
27. Young, C. & Grassman, H. (2019). Towards a Greater Understanding of Science & Research within Body Psychotherapy. *International Body Psychotherapy Journal*, 18(1). (www.ibpj.org/issues/IBPJ-Volume-18-Number-1-2019.pdf)
28. The Evidence-base for Body Psychotherapy: www.eabp.org/research/the-evidence-base-for-body-psychotherapy/
29. EAP: Statement of Ethical Principles: www.europsyche.org/quality-standards/eap-guidelines/statement-of-ethical-principles.
30. USABP Code of Ethics: www.usabp.org/USABP-Code-of-Ethics
31. 'About the Ethics of Professional Touch': www.courtenay-young.co.uk/courtenay/articles/The_Ethics_of_Touch_v.3.2.pdf
32. *Society of Psychotherapy Research Journal*: www.psychotherapyresearch.org/page/SPRJournal
33. *Body Movement & Dance in Psychotherapy*: www.tandfonline.com/toc/tbmd20/current
34. *International Body Psychotherapy Journal*: www.ibpj.org

Some of the articles about body psychotherapy are good pieces of background research, but they do not carry the proper weight of evidence needed to demonstrate the effectiveness of the body psychotherapy. They are indicative, rather than evidential. These articles also need to be published in a well-established, peer-reviewed and indexed journal.

All these points are increasingly important, if not absolutely necessary when we consider establishing a solid evidence base for body psychotherapy. It might even be a good idea to build a body psychotherapy research network so that individuals can collaborate to support and enhance each other's research work.

There are also other forms of research that can help validate a method or modality – I am **not** here considering randomized controlled trials (RCTs), which are usually an unsuitable form of research for most psychotherapies, and absolutely unsuitable for body psychotherapy, especially when involving touch. The structure of a randomized controlled trial puts no emphasis on, and even denigrates, the (almost unmeasurable) person-to-person contact that most psychotherapies are based on. It emphasizes a form of manualization requires the treatment be the same for every client and done by any therapist. Unfortunately, cognitive behavioural therapy (CBT) and its many derivations have based their authenticity on this form of science, which is far better suited to the pharmaceutical industry.[35] This emphasis has skewed the field of psychotherapy away from more suitable scientific research.

There is a hierarchy of scientific research. For example, case studies are forms of qualitative research, as opposed to quantitative research. At best, they indicate and support different ways of working, and they may lead to other research studies, but they are also not really part of a proper evidence base and therefore they do need to be used judiciously.[36]

The Pillars of Research

Efficacy. The need for proper research is to establish, beyond any doubt, the **efficacy** of a treatment method: its ability to produce the desired result consistently, or its level of success in achieving a desired goal. It is **not** good science to say: "I did this and it worked with this person at this point in time." Instead, we need to be able to say that when this number of people were treated by this method – people in different countries, of different ages and social backgrounds, with different presenting conditions, and treated by this type of therapist – we had these results. On that basis, we can make a reasonable prediction as to the efficacy of a method and honestly show that it works.

Effectiveness. The effectiveness of a treatment method assesses the following criteria: how well it works; how quickly it works; how long the effects last; and the possible side effects or conditions that may be counterproductive or contraindicated. Data for effectiveness must be derived from a number of long-term and wide-ranging studies. This is a very different type of research and almost certainly needs external funding.

The professional associations of psychotherapy and body psychotherapy would need to involve themselves in raising and/or seeking such research funding. Such funding for many types of research is available, possibly from the European Union, or from health bodies seeking research grants, but obtaining such funding is not easy, and certainly not for everyday practitioners trying to live off their professional practice. Such research would also need to be validated by outside support such as a university. Few individual body psychotherapists have access to these facilities, have the knowledge and expertise to develop a research study, the time and energy to devote to it unless there is an ulterior motive like a PhD, nor the support and resources of an institute. But this does not mean that one shouldn't try or give up.

35. The founder of behaviorism, John B. Watson, advised parents not to touch their children, other than a pat on the head when they had done something well.
36. EABP SRC Guidelines for Writing A Body Psychotherapy Case Study: www.eabp.org/eabp-guidelines-for-writing-a-body-psychotherapy-case-study/

One simple way to do this is to join up with other like-minded practitioners and form a practitioners research network (PRN). This form of collaboration can, over time, really strengthen and develop peoples' practices, as well as strengthen the field for that particular method or approach. Again, professional associations can and should play a significant role here.

The Science and Research Committee of EABP has tried, and will continue trying, to develop a PRN for body psychotherapy practitioners, but there is also room for body psychotherapy practitioners from a particular modality to form their own PRN, and focus on developing relatively simple research studies in that modality.

One of the more recently published bibles about psychotherapy research is by Omar Gelo, et al. [37] In it, they describe the different kinds of research that are appropriate to psychotherapy, both quantitative and qualitative. However, unsurprisingly, they don't mention touch, and maybe this is where we body psychotherapists need to become more specific.

For more general research about touch, the reader is strongly advised to begin with the work of Tiffany Field, a dedicated researcher, professor at the University of Miami School of Medicine, and director of the Touch Research Institute in Florida. Her books include *Infancy*; *The Amazing Infant*; *Touch*; *Touch Therapy*; *Complementary and Alternative Therapies Research*, and *Massage Therapy Research*, as well as many published articles and essays in edited volumes. These sorts of books should (in an ideal world) be compulsory reading for all body psychotherapy students. There are several other neuroscientists, like Antonio Damasio, author of *Descartes' Error* (2006), who are also candidates for such compulsory reading.

A massive amount of research work has been done recently on the neuroscience of touch [38], and also on the neuroscience of trauma – all of which is very pertinent to body psychotherapists (as trauma is largely stored in the body). Indeed, as Bessel van der Kolk, a world-renowned trauma expert, has frequently stated, one really needs to be a body psychotherapist to work with trauma. This is very relevant, as is Allan Schore's (1994, 2003, 2003) series on attachment theory; Daniel J. Siegel's *The Developing Mind* (1999), *The Mindful Therapist* (2010), *The Whole-Brain Child* (2011), and *Pocket Guide to Interpersonal Neurobiology* (2012). Siegel's other books also form a significant body of work in this field, as does Jaak Panksepp's *Affective Neuroscience* (2004) and Louis Cozolino's *The Neuroscience of Psychotherapy* (2017). Steven Porges has already been mentioned; Candace Pert's *Molecules of Emotion* (1999) is also very relevant. The research work of Kerstin Unvas-Moberg, author of *The Oxytocin Factor* (2011) and other books, is equally significant to body psychotherapists. All of these authors have presented at various body psychotherapy conferences.

However, all the theories of these eminent researchers only provide supporting evidence for body psychotherapy; they do not prove anything about it. Body psychotherapists will need to do a bit more proper research work until there is sufficient material for a full Cochrane Review – or similar.

However, if other body psychotherapists want to engage in a wider and more significant outcome research project, then perhaps they should ask about a proposal I made to the EABP SRC.

■ ■ ■

37. Gelo, O. C. G., Pritz, A. and Rieken, B. (Eds). (2015). *Psychotherapy Research: Foundations, Process & Outcome*. Vienna: Springer.
38. *The Science of Touching & Feeling*: David Linden, Professor of Neuroscience at John Hopkins University: www.youtube.com/watch?v=lW8pJ7E9taQ

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In Search of Factors That Inform How Clients Experience Somatic Experiencing® Therapy

An Interpretive Phenomenological Analysis

Gregory James

ABSTRACT

Background: While current Somatic Experiencing studies have produced impressive outcomes and biological rationales for treatment, there is a lack of client-centered research attending to the lived experience of those attending the therapy. Learning from clients about their therapeutic experience can illuminate a multitude of factors that help and hinder therapeutic outcomes in order to conceive of or reform interventions, advance our understanding of therapeutic change, and gain insight into clients' hidden processes. These might include unexpressed fear, dissatisfaction, and avoidance, as well as what they most value about the therapy.

Method: Participants were interviewed using a semi-structured schedule. Interpretive phenomenological analysis (IPA) was used to process the data. The sample size was necessarily small to align with IPA guidelines.

Findings: Two superordinate themes were abstracted: communication and pacing. Subordinate themes: Intake assessment, expectation, and psychoeducation are situated under the superordinate theme of communication.

Conclusion: Hidden processes illuminated in qualitative research of this kind can greatly benefit Somatic Experiencing Practitioners (SEPs) in better understanding how their therapeutic approach is experienced by their clients.

Keywords: Somatic Experiencing, client perspective of therapy, trauma therapy, common factors

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> ***... important implications for practice in the realms of client safety, expectation, retention, communication, and service delivery.***

The importance of finding treatments that are effective in combating the insidious effects of trauma cannot be overstated. The impact of this phenomenon can be far-reaching, and include stressful and involuntary memories of the event, chronic avoidance, and physiological hyperarousal (Breslau, 2002, Kuhfuss et al., 2021), resulting in the survivor living a tortured life, tainted by the past, which seeps unavoidably into the fabric of the society within which they live (van der Kolk et al., 1996). In the last two decades, widespread coverage in books, films, and TV has increased public awareness of trauma-related mental health to the point where the demand for accessible and effective treatment has surged (Forbes et al., 2020). Studies indicate that up to 94% of individuals seeking therapy will have experienced some form of trauma (Bride, 2004; Kilpatrick et al., 2013; Foreman, 2018) regardless of their presenting issues (Trippany et al., 2004; Bober & Regehr, 2006; Foreman, 2018). The prevalence of primary exposure to traumatic events in the general population is said to range between 70% and 90% (Breslau, 2002; Benjet et al., 2016), while others would assert that the experience of trauma visits us all (van der Kolk et al., 1996; Levine, 1997; Frazier, 2012).

Formally introduced in the seminal book *Waking the Tiger* (Levine, 1997), Somatic Experiencing (SE), is an emerging approach to the treatment of trauma that does not yet enjoy an overabundance of research, as compared to psychotherapy (Almeida et al., 2020; Kuhfuss et al., 2021). Though the current literature boasts impressive outcomes, it is not yet widely recognized in the current literature related to the accepted treatments for post-traumatic stress disorder (PTSD) (De Jongh et al., 2016; Forbes et al., 2020). However, Bisson et al. (2020) point to the increasingly robust base of evidence being developed that supports viable alternatives to pharmacological or psychological interventions for the treatment of PTSD, and include SE in their recommendations.

"Where information about meaning and value of therapy are sought, clients may be the only accurate source of information." (Elliott & James, 1989, p. 445)

Most of the current SE research is limited to therapeutic outcomes (Brom et al., 2017; Andersen et al., 2017; Almeida et al., 2020; Kuhfuss et al., 2021). Even where case studies are presented, the perspective is focused on the therapist's perception (Hays, 2014; Payne et al., 2015; Levit, 2018). Human relational variables are arguably essential to identify and include when assessing the effectiveness of any therapeutic intervention, and research that includes the client perspective can illuminate a multitude of factors that help and hinder therapeutic outcomes in order to conceive of or reform interventions, advance our understanding of therapeutic change, and gain insight into clients' hidden processes. These might include unexpressed fear, dissatisfaction, and avoidance, as well as what they most value about the therapy (Bowie et al., 2016; Levitt et al., 2016; Timulak & Keogh, 2017).

Review of the literature

Trauma definition, recognition, and treatment have had a checkered history dating back to the early 1800s (Monson et al., 2007), and have been the subject of decades of academic and professional debate (Friedman et al., 2007). The concept of shell shock, for example, was a linguistic touchstone of the scale of the First World War, and entered the zeitgeist of the early part of the 20th century (Winter, 2000, p. 7). Postwar trauma diagnosis and treatment underwent rapid shifts through World War II and beyond, in part due to political and/or military pressures (Jones & Wessely, 2006; Monson et al., 2007). Also a factor was the reconceptualization of hitherto seemingly disparate symptoms that were folded into a single definition of PTSD (Friedman et al., 2007) as part of the *Diagnostic and Statistical Manual for Mental Health Disorders* (DSM-III); American Psychiatric Association, 1980; Jones & Wessely, 2006). It was not until PTSD was included in the DSM-III that causation was linked to the traumatic event, rather than the disposition, willpower, or family history of the sufferer (Jones & Wessely, 2006). More recently, the focus has again begun to shift to a more nuanced understanding that while the event is a trigger, trauma is in the nervous system, and not in the event itself (Levine, 1997; Heller & Heller, 2004). An exponential increase in scientific knowledge that indirectly and directly informs the understanding and treatment of trauma has led to a variety of interventions being available to practitioners today (van der Kolk, 2014; Forbes et al., 2020).

SE is predicated on the increasingly accepted notion that trauma is held in the body (Levine, 2015), and its treatment focus on interoceptive awareness and somatic responses is supported by a growing and persistent body of literature showing that somatic therapies have an important role to play in trauma treatment (van der Kolk, 2014; Grabbe & Miller-Karas, 2018). Despite this, the contention persists that PTSD is primarily a disorder of the mind (van der Kolk et al., 1989; Horwitz, 2018), resulting in the somatic resolution of trauma being left out of mainstream psychotherapeutic modalities (Ogden et al., 2006), despite the increasing acceptance in trauma research of the link between mind and body (Leitch, 2007), and the view that "that much of a person's traumatic past isn't accessible to verbal recall." (van der Kolk, 2009, 11:10). The client's perception of trauma resolution is consequently skewed toward talking therapies, for, as Angelo et al. (2008) point out, when people believe they have a psychological issue, they seek psychological interventions.

What is Somatic Experiencing?

SE is described by its originator Peter Levine as a resiliency-based model and "gentle step-by-step approach to the renegotiation of trauma" (Levine, 1997, p. 90). SE recognizes trauma as the result of a chronic increase in nervous system activation (van der Kolk et al., 1996; Riordan et al., 2017) that cause the overwhelmed mind and body to continue reacting long after the traumatic event has passed (Herman, 1992; van der Kolk, 2014). SE attempts to restore balance, in part, by the action of titration and pendulation (Levine et al., 2018; Levine, 1997), whereby attention is drawn to small amounts of nervous system activation while pendulating back and forth between this activation and downregulation, thus allowing the body to spontaneously restore a natural balance to the nervous system (Olssen, 2013; Payne et al., 2015). SE is consequently heavily reliant on interoceptive awareness (Winblad et al., 2018) – the awareness of internal sensations. Orienting, completion of defensive responses, resourcing, tracking sensation and involuntary movements, and therapeutic touch are among the interventions used to reintegrate traumatic experience, along with an intimate understanding of how trauma impacts the nervous system (Nickerson, 2015; Winblad et al., 2018).

Despite consistently impressive study outcomes (for example Parker et al., 2008; Leitch et al., 2009; Payne et al., 2015; Winblad et al., 2018;), SE has not found its way into the general consciousness of trauma research, as shown not only by the lack of approach-specific studies, but also by its omission in the literature concerned with the review and analysis of current treatment options for PTSD (Wampold et al., 2010; Reisman, 2016; Watkins et al., 2018; Forbes et al., 2020). This is not an indication of poor results relative to other approaches, but rather a reflection of the fact that body-oriented therapies for the treatment of trauma and PTSD are still considered revolutionary (Rothschild, 2017; Fisher, 2017).

Research that robustly attends to the effectiveness of SE is scarce, as compared to the many decades of research into psychotherapeutic modalities. Studies that explore the factors and variables that contribute to outcomes in psychotherapy have resulted in a consensus of efficacy for these approaches (Kazdin, 2009; Cuijpers et al., 2019), which has led to their legitimacy among practitioners, researchers, and the public alike (Levitt et al., 2016; Mahon, 2023). The author contends that SE needs a larger body of literature, healthy discourse, and perhaps more years in the public domain to reach the point at which consistent research is being conducted that may allow for such determinations to be made. It is hoped that this study plays a role in fulfilling that aim. Due to the scarcity of research into SE, it was necessary to look to the plethora of studies that focus on what does and does not work in psychotherapy in order to gain an understanding of how future studies could benefit from decades of critical review and public discourse.

What can psychotherapeutic research tell us?

Research into the processes that contribute to psychotherapeutic outcomes has a long history (Timulak & Keogh, 2017), producing a wealth of information that has helped broaden access to funding (Levitt et al., 2016) and inform new and more effective interventions (Elliott & James, 1989) while also highlighting poor training, practice standards, and negative outcomes (Bowie et al., 2016). While it is generally accepted that psychotherapy works (Silberschatz, 2017; Cuijpers et al., 2019), the mechanisms by which it does, and the orientations

that may deliver results, are still widely debated (Cooper, 2008; Tzur Bitan & Lazar, 2019). One such debate is between common factors (CF), elements of therapy shared by many modalities), and "empirically supported therapies" (EST) (Roth, 2005, p. 50), which emphasize more orientation-specific techniques (Mulder et al., 2017; Tzur Bitan & Lazar, 2019) aimed at the remediation of any given mental disorder (Laska et al., 2014).

EST refers to specific factors within a modality that are proposed to be the initiators of change, regardless of client context (Laska et al., 2014; Mahon, 2023). While considered by proponents as more scientific, more easily manipulated for research, and easier to disseminate among practitioners, the EST approach does not purport to do away with common factors. For example, the therapeutic alliance has long been considered one of the primary catalysts of change (Rogers, 1957; Noyce & Simpson, 2018; Norcross & Lambert, 2018) and a headline factor in the CF argument. EST supporters do not deny that this is a factor shared by all psychotherapies (Laska et al., 2014). At the same time, common factors do not deny that there are "specific ingredients" that play an important role alongside common factors (Joyce et al., 2006; Wampold, 2015b, p. 270).

Wampold (2015a) posits a contextual model of "common factors" (Cuijpers et al., 2019; Wampold, 2015b, p. 270) that have both common and specific elements, but whose emphasis on the specific differs from that of the EST model. In recognition of the diversity of human beings as social creatures, the contextual model describes three pathways for psychotherapeutic benefit. They are:

- The "real relationship" (Wampold, 2015b, p. 270), where each person meets the other in congruence.
- Management of client expectations via dissemination of information regarding the client's presentation and treatment.
- The implementation of healthy strategies, where the client actively engages in something that promotes their well-being (Wampold, 2015b; Rousmaniere et al., 2017).

While the implementation of these latter strategies is considered a common factor, the strategies themselves are specific to any given approach. As alluded to above, these specific ingredients differ from techniques in EST in that the emphasis is not on treating the psychological deficit. Instead, its focus is on finding contextual, individually relevant, and acceptable interventions that create a positive and plausible expectation of healing within the client, and initiate actions that are beneficial to them (Wampold, 2015b).

Whether SE might benefit from engaging in the common factors debate is unclear. SE's interventions are predicated on the fact that nervous system responses to threat are universal (Levine, 2010a; Payne et al., 2015). The approach is replicable, easily disseminated, and manualized (Winblad et al., 2018; Almeida et al., 2020; Somatic Experiencing®, 2023), and common factors such as relationship building, empathy, and listening skills, for example, are not part of the training (Somatic Experiencing®, 2023). All would suggest a leaning toward EST. However, SE is nuanced and necessarily open to interpretation because of its suitability for integration into other approaches (Levine et al., 2018;, Levit, 2018; Blakeslee, 2023). Furthermore, a SEP can address certain elements of trauma-related symptoms without having any contextual information, which may further imply a leaning toward an EST model. However, it could also be argued that the necessity to work without context is often the result of a client who is unable to express their experience in words (van der Kolk, 2009). This would be considered a contextual factor necessitating a contextual, approach-specific intervention which would again lean toward the CF model. Regardless of where SE may sit within current psychotherapeutic frameworks, SE researchers can learn from the successes and pitfalls of such research, and one way in which to do so is to begin focusing more intentionally on how clients' experience can inform practice.

Research method

Interpretive Phenomenological Analysis (IPA) was chosen to ensure that the subtleties of the human experience were captured. It is well-suited to qualitative research, as it facilitates the expression of lived experience by a research participant (Gyollai, 2020) while explicitly acknowledging the role of researcher interpretation in the process (Smith, 2004). It is a phenomenological methodology widely used in the field of counseling and psychology (Smith, 2004; Brocki & Wearden, 2006; Eatough & Smith, 2017), and was originated for this purpose (Smith, 2004).

Participants

PA necessitates the use of purposive sampling (Rostill-Brookes et al., 2011),a deliberate choice to ensure that potential research participants have knowledge that is relevant to the study (Cohen et al., 2018). This is particularly important in IPA because the approach is characterized by small sample sizes (Smith et al., 2009). Individuals who had attended at least four SE sessions for the treatment of trauma were sampled in this way.

Procedure

Semi-structured interviews (SSI) were chosen for their suitability in generating rich data. Questions were intentionally broad to elicit authentic responses to each participant's experience of their therapy. Interviews were conducted online, and audio recorded with permission.

Analysis

Following the method suggested by Smith et al. (2009), descriptive, linguistic, and conceptual notes were made while reviewing interview recordings. Descriptive notes attend to content – what the participant is saying. On a second pass, attention is given to linguistic notes – words the participant uses, how they articulate their views, pauses or hesitations, use of metaphor, etc. Finally, conceptual notes are made, representing a wider view or interpretation of what the participant may be saying in the context of the full interview (Smith et al., 2009).

These comments were then reviewed for each interview individually, and emerging themes were noted. Each interview was then summarized under emerging themes specific to that interview. Lastly, these summaries were cross-referenced and compiled by a process of abstraction, whereby similar themes are clustered under a superordinate theme. It is these superordinate themes that are being presented in this paper.

Results

Two superordinate themes emerged from the analysis: communication and pacing. Communication encompassed three subordinate and interrelated themes; intake assessment, psychoeducation, and expectation.

Communication

Communication emerged as a superordinate theme as a result of all participants expressing a desire for, or appreciation of, a sense of collaboration and open communication between therapist and client. This is represented by the following subthemes:

- *The value of an intake assesment*[1]

Of the eight research participants, three were offered assessment sessions before beginning weekly therapy. For these three participants, there was a general sense of their assessments having been an opportunity to discern safety and comfort with their potential therapist.

> *"It was helpful for me just to meet her first and to see whether I felt comfortable with her." (Ella)*

Having attended two other counseling assessments, at his third assessment, Noah reported breaking down in front of the therapist with whom he ultimately decided to attend regular sessions. This initial time together in the assessment was the point at which he knew the therapist was offering what he needed.

> *"I just knew that if I could let go like that in front of him then a) something was wrong, and b) that was probably the person who was gonna help me. I had to be challenged and pushed. He did both of those things." (Noah)*

While Noah needed to know that his therapist would be strong enough for him, Alex had different needs in assessing the suitability of the therapist with whom she was thinking of working. She reports a feeling of being heard and validated by her therapist during the initial assessment, which resulted in an immediate initiation of trust:

> *"There's just always something very validating about someone going, 'Gosh, that is a lot, and we can absolutely be with that.' It gave me some confidence in the therapy itself. It gave me confidence in her as a practitioner." (Alex)*

The above quotes suggest that participants appreciated the opportunity to assess, for themselves,

1. The author refers to an intake assessment as being an initial consult prior to establishing regular sessions.

the suitability of a therapist in order to ensure that they felt safe, and that their treatment expectations matched what the therapist and therapy could provide before committing to regular sessions.

There was a mix of opinions about the value of an assessment from the remainder of the participants, and not all mentioned it explicitly. However, comments made further into the interviews in relation to trust and expectation allude to issues that may have, at least partly, been resolved in an intake assessment, had it been offered. These were centered mostly around the issue of psychoeducation and goal communication.

> *"I think there was possibly an assumption that I already knew what was going to happen in the session. Going a little bit more slowly and just explaining a little bit more about the session and what to expect and how it might feel… Those types of things I think would've been helpful." (Olivia)*

Furthermore, not having asked Olivia about her intentions for therapy, her therapist made assumptions about what would be best to work on. Olivia describes how her therapist picked up on something she said while they were chatting at the start of their first session, and ran with it. This left her feeling disempowered and that she had no choice but to follow the therapist, despite being unsure about whether it was a subject she wanted, or needed, to spend time on.

> *"I don't know if that's what I wanted to talk about or not. There was not really any 'What would you like to talk about today?' It was a bit like, 'Okay, well let's work with that'… I didn't know what to expect, so I just sort of went with it." (Olivia)*

Phillip had a similar experience, which suggests that an assessment would have given the work some much needed direction. There is an audible frustration in his tone and his words.

> *"I wanted an assessment. I would've liked him to have asked me what I wanted to get from the therapy, what my goals were, what I was struggling with… I think that would've helped me to also further define what it was that I was looking for." (Phillip)*

One could argue that Phillip's desire for an assessment may be a result of an expectation based on past experiences, rather than a current need. However, listening to his tone and responses to questions further on in the interview, the lack of this initial session would appear to have led to genuine frustration and misattunement with his therapist.

> *"After the first session, and certainly at the beginning of the second session, he [the therapist] had no idea why I was there. He hadn't asked me what my issues were that I wanted to work on." (Phillip)*

Raya was keen to express her disappointment at not having been given an opportunity to address her needs and intentions for therapy at the start. She describes how this may have helped her to ease into the therapy, to get a feeling of being heard, and, much like Olivia, more information about the therapy itself and what to expect.

Had she attended an assessment, Raya feels that:

> *"I would've got the chance to express what I wanted to express in words first. And then presumably she would've explained a bit more about what SE is, and what she would likely do, and so I would've felt more comfortable because I would've known a bit more what to expect." (Raya)*

The consequence of not offering an explicit space to address questions, expectations, and uncertainties was felt by three of the participants as a rupture, and a hindrance to any further relationship with their therapist. While the lack of an assessment is not always explicitly cited, all three reported choosing to end therapy prematurely, and without feeling that they got what they needed from it.

> *I don't think I got to focus on the issue that I actually wanted to focus on… I didn't feel like the therapy was working" (Raya)*

> *"I feel like it fell short of what I needed. There was not enough sense of what we were trying to achieve" (Phillip)*

Olivia did not explicitly mention terminating therapy, but did report seeing her therapist only once before moving to another SEP, with whom she remained. Her subsequent experience was quite different from the outset:

> *"We did more of an intake. And so she was asking me about my trauma history and things like that… And also even at that very light level, there were emotions coming up talking about certain things, and there was a lot of space given for each." (Olivia)*

When asked how she experienced this assessment session with the new SEP:

> *"I think feeling a greater sense of safety." (Olivia)*

In contrast to the participants who had no intake assessment and a negative experience, Mia and Andrew report successful relationships despite having had no such session, suggesting that the assessment can initiate, but is far from a prerequisite for, an effective therapeutic relationship.

> *"I just felt that she was really with me, and understood where I was without any kind of judging... I think that's what made it feel really safe." (Mia)*

> *[She was] "one of my favorite therapists that I've ever had." (Mia)*

Andrew felt that over time, an allegiance with his therapist grew. He describes it thus:

> *"There's an allegiance here, we're in this together. It felt like a joint exploration. It was more than just relational... there's a sense of going on that journey together." (Andrew)*

- *Role expectations: Am I talking too much?*

An uncertainty arises for participants that is seemingly a result of previous experience in talking modalities, or the public perception of SE not being a talking therapy. Consequently, Phillip, Raya and Ella express unease around how much or how little talking was expected, or allowed, in their sessions.

> *"I remember reading [that] this is not talking therapy. And so that was always in my mind... am I talking too much?" (Ella)*

Despite her uncertainty, her therapist embraced Ella's need to talk about issues, resulting in a long-standing and successful therapeutic relationship. However, as much as her therapist may have been able to hold the way in which Ella chose to use her sessions, what she had read about SE made it hard for her to believe that she was engaging in the therapy correctly.

> *"So, there were times I would end up just talking more or telling a story... She listened really well, but there was just something in me that was telling myself that I was doing it wrong." (Ella)*

A similar disquiet around talking was also expressed by Phillip and Raya, which indicates their need, and perhaps their expectation, of talking being integrated with SE:

> *"I didn't know how much talking was involved with SE. I think probably my impression was that there was not a lot of talking in SE at all because it wasn't talking therapy. So I almost kind of apologetically said, 'I feel like I need to tell you my story.'" (Phillip)*

Raya's experience illustrates how one's presuppositions can lead to disappointment and disengagement from the therapy. While she knew that SE was largely body-based, she felt that there would be more integration with talking therapies, despite knowing that her practitioner was not a counselor or psychotherapist.

> *"It [the therapy] was very strictly body-focused, and there wasn't any room for actually having a conversation about the thing that I felt caused my body to react in the way that it did." (Raya)*

Unfortunately, after four sessions, Raya reports, through tears, feeling like a failure despite really wanting the therapy to work for her. Ultimately, she ended the sessions.

> *"[I] just felt like I was failing because I didn't feel like the therapy was working, or [I] wasn't able to connect with it." (Raya)*

Finally, Phillip succinctly illustrates the need for "role induction" (Swift et al., 2012, p. 55), the intentional act of establishing the role of both client and therapist early in the relationship.

> *"I think I got the sense in the first session that I had to lead it in some ways, certainly at the beginning, because there was no kind of offering of explanation of how things would work ,and what his [the therapist] expectations of me were." (Phillip)*

- *Process expectations*

For some participants, the contrast between previous talking therapy and their experience of SE facilitated a new understanding of how positive therapeutic change can be achieved. Both Alex and Ella were pleasantly surprised with their experience of SE. It showed them how different these sessions can feel as compared to previous counseling experiences. With less talk, they felt they could drop the need to make meaning, and focus almost exclusively on their senses.

> *"There's like a freshness and a sense of aliveness I think that comes from it. … The process itself just leads to less grip on finding meaning." (Alex)*

> *"I could just stay with what was happening in my body, and just felt really understood as that being an important part of my experience." (Ella)*

Despite having worked on his trauma experiences with multiple counselors, Noah reports having no prior knowledge of SE. He states that at first he was resistant to doing body-oriented work, and when asked to spend some time with his internal sensations he was not keen.

> *"To start with, I didn't like it. I think I tried to resist what was going on." (Noah)*

Noah may have experienced here what Andrew expresses in his interview when talking about his therapist making observations about his body language. It speaks to a vulnerability that is needed on the part of the client to be willing to follow difficult sensations, and allow the body to speak about what the mind is not necessarily ready to reveal:

> *"In talking therapy you can hold back what you want to say for as long as you want to until you trust them [the therapist]." (Andrew)*

Alex describes the way in which somatic work took her in unexpected directions. The fluidity of the work was experienced as a benefit, not as something to be feared.

> *"We ended up kind of working in quite a dynamic way where we had this overarching intention to work with the trauma. We started there and sort of diffused some of that. But then other things came in, and some of the other things that came in were actually really profound things to work with." (Alex)*

Ella has a similar view. She approached SE therapy not for specific trauma work, but as a result of having done a short workshop that she found helpful in settling her nervous system. She soon realized that the process of regular somatic work allowed her to see where the issues were that she needed to work on.

> *"It was through the process of SE that I even really figured out what the trauma was." (Ella)*

Expectation and psychoeducation are closely linked, with the latter having a potentially significant influence on the former.

- *Psychoeducation*

In support of the assertion that psychoeducation can help to normalize one's somatic responses (Parker et al., 2008), Ella reports a feeling of relief at understanding her internal biological processes.

> *"When she did explain things, that helped me feel less alone in what I was experiencing. 'Oh, it's just a normal nervous system response to that experience'… There was just a relief in that." (Ella)*

One gets the sense that this work, without an explanation of what is happening, and why, leads to discomfort in being in the dark about somatic responses.

> *"Just doing the body bit would've been like, 'Well, I don't know what's going on.' The talk and the body need to happen together so that you have an understanding of it." (Noah)*

Process expectations seem to be interwoven with psychoeducation, with some of the participants reporting unease at not knowing what to expect from the therapy itself. Both Phillip and Raya suggest that more education around what was happening in their sessions, both preemptively and at the time, would have increased their level of comfort with the therapy itself. Speaking about what he may have needed, Phillip suggests:

> *"More openness about what they're [the therapist] doing, why they're doing it, and when they're doing it. Not all the time, but just like a preemptive thing. Like the first session, or an assessment session going, 'This is what it's about, or why we'll be doing these things,' etc." (Phillip)*

Raya similarly expresses unease with not understanding the reason for doing certain things in the therapy, and speaks to a general disquiet with, and difficulty in, connecting with the therapeutic process:

> *"When somebody says we're gonna do this, this is what it's likely to look like, and this is why, then you understand the benefit to yourself of doing it." (Raya)*

> *"If you don't know why that's important, then it does feel more like you're performing for them, because they hold the cards, they have the knowledge in their head of why that might be good for you, or where they might go with that, but you are left not knowing." (Raya)*

Here, Raya introduces a powerful example of how an imbalance of knowledge and power in a relationship can be difficult for a client to navigate. The use of the phrase "holding all the cards" and the word "performing" suggests that Raya may have felt subjugated as a consequence of the therapist's lack of communication. While there is no evidence that another participant, Ella, felt subjugated in what she describes as a collaborative process, the use of the phrase "I could get this wrong" suggests a concern about the potential consequences of not engaging in the therapy correctly:

> *"The SE practitioner knew what the process was and I didn't, even though actually it was always a collaborative process, but just a belief somewhere in there that she knows what's happening. I don't, and I could get this wrong." (Ella)*

The following quote could reveal the perceived consequence that Ella is concerned about when she suggests that getting it wrong would mean she would not benefit from the treatment. This concern is also shared by Raya.

> *"I'm gonna do this really well, and I'm going to heal myself and fix myself and get this right." (Ella)*

> *"I suppose I just felt like I was failing because I didn't feel like the therapy was working, or I wasn't able to connect with it, and therefore I wouldn't get better." (Raya)*

- *Pacing*

Six participants mentioned the pace of the therapy as an initial source of frustration, either too slow or too fast. While the pacing of SE stood out for Phillip, it was not something that bothered him at first:

> *"The slowness I think stood out for me. There was a part of me that appreciated the slowness of it. It was quite nice, and curious and interesting, to kind of drop into body and go, 'Okay, what's happening there?'" (Phillip)*

After several sessions, however, Phillip's annoyance with the lack of communication and psychoeducation collided with this slower pace, and became a source of frustration.

> *"There was not enough forward motion. There was not enough sense of what we were trying to achieve." (Phillip)*

Andrew notes that he found he had to adjust his expectations to meet the pace of the therapy, and that his initial desire to do more was replaced by an appreciation of the nuances of SE:

> *"I think maybe I adapted my expectations as we were going along. I think I maybe had quite high expectations to begin with. Over time, I think my experience was that even the small things that we did do – grounding, resourcing, saying, okay, 'Let's take a pause there,' or 'What do you notice now?' – an easily be missed. It did give me an appreciation of how much value there is in those really simple things." (Andrew)*

Andrew speaks further to adjusting to the pace of therapy, and how trust can grow over time. He also touches on letting go of his role expectation, and allowing the therapist to bring to his awareness anything that he might have missed.

> *"I started to feel more comfortable in knowing what we were doing... letting my body just do whatever it wanted to do and knowing that that was okay, and if there was something interesting there, that she would pick up on that and we might follow it." (Andrew)*

Andrew was not alone in frustration eventually turning to appreciation. Mia reports her first few sessions feeling disjointed. Living her life at speed, she found these first sessions too slow and frustrating. However, over time, the slowness became a source of comfort and safety, ultimately allowing more vulnerability in the process.

> *"I sort of started to know what to expect. I think probably as she [the therapist] began to understand my nervous system and I began to understand the therapy, it just started feeling like something that was really safe and reassuring. And it actually let me go a little bit deeper than I think I would've if I'd had counseling." (Mia)*

The pacing was challenging in opposing ways for the participants, with those already mentioned feeling that they wanted to go faster at first. However, one participant recalls their therapist not going slowly enough. Recounting her first session, and alluding to previously mentioned issues that may have been alleviated by an intake assessment, Raya speaks about diving into somatic work before establishing a connection with the therapist, or the therapist knowing anything about her personal history.

> *"I think it just dipped into it too quickly for me. I think I would've liked to have had some time to chat and feel like I had a kind of cognitive connection with the therapist, rather than straight away just being about me and my body, because my body is what I have a problem with." (Raya)*

> *"Within the first three or four minutes, she asked about putting her feet on my feet and I found that really uncomfortable, and she sensed that... I did say I didn't find that comfortable, and then she didn't try and do anything like that again." (Raya)*

Further exploring what she felt she might have needed instead, Raya again touches on her desire for a better connection with her therapist, and for more opportunities to communicate her issues before beginning the somatic work.

> *"It would've been nice for it to just have been a bit more of a relaxed entry into the room... it was literally, we didn't have a conversation at all. Immediately we were into something. There wasn't a kind of conversation about what SE is, and what she was likely to do in the session, and why, and that sort of thing." (Raya)*

Discussion

Communication with its three subordinate themes, emerged as a powerful factor in client retention for three of the study participants, and nonetheless essential for the remaining five, who appreciated the results of good communication with their therapists. These findings show the importance of sharing information with clients through psychoeducation to normalize somatic responses, and alleviate any uncertainty about role or process expectations. Psychoeducation is effective and common across a variety of trauma treatments (Schnyder et al., 2015; Mahoney et al., 2019) including SE (Kuhfuss et al., 2021), and the study's findings support this. This is especially important as SE is relatively new to the field of PTSD recovery, and differs from generally accepted treatments (see Forbes et al., 2020). The consequent comparison, specifically with talking therapies, had an impact, both positively and negatively, on the expectations of all participants.

Role expectation refers to the behaviors that are expected of both the client and therapist during sessions; their role in therapy (Wang et al., 2022). The uncertainty that arises around role is illustrated by the unease expressed by almost half the participants with how much talking is involved in the approach. Process expectations refer to presumptions made by clients as to what may occur during sessions (Tzur Bitan & Abayed, 2020). Most participants were pleased with their experience of SE, but it did take time and a willingness to trust in a largely unknown process to get to a point where they were comfortable to fully engage with it. This is arguably true of most, if not all, therapeutic approaches, but the findings do suggest that this unease may have been partly alleviated by better communication, be it through psychoeducation, management of expectations, or intake assessments.

Intake assessments which in these findings were shown to precipitate trust and safety, have been shown elsewhere to considerably influence a better connection and stronger alliance between therapist and client in subsequent sessions (Hilsenroth & Cromer, 2007). However, findings also show evidence of a strong, longstanding relationship developing over time for some participants who were not offered an intake assessment. This suggests that the relationship and/or alliance is not exclusive to those who attend these sessions. Therapy can be successful and even flourish without the need for assessments. The findings do suggest, though, that there are elements, such as expectation and goal setting that, if not discussed early in the relationship, can have a detrimental impact on client retention. Furthermore, while assessments are opportunities for a therapist to assess a client (Hilsenroth & Cromer, 2007), Alex and Ella show how they are also opportunities for the client to assess the suitability of a therapist, ensuring that they feel safe and that their treatment expectations match what the therapist can provide.

The intentionally slow pace of SE is central to creating an experience in the body that is counter to the experience of trauma (Levine & Kline, 2011; Olssen, 2013; Levine et al., 2018), which overwhelms the body's ability to effectively respond or cope with the demand on it (Olssen, 2013; Payne et al., 2015). Six participants mentioned the pacing of the therapy as an initial source of frustration, be it too slow or too fast. For all those who found it too slow, a strong appreciation was later felt for the positive impact of pausing to allow their sensory experience to be part of the healing process. Conversely, when

the pacing was too fast, and the focus on the body was initiated too soon, a sense of unsafety, shame, and overwhelm was reported. This experience is supported by Levine (2010b, 37:35) who states:

> *"Traumatized people come to view their bodies as the enemy. Any sensation in the body becomes a harbinger, a trigger, for the overwhelming helplessness and terror and shock that they experienced. So you gradually have to bring the people to their body sensations… If you do it too fast then the person can easily become overwhelmed."*

While there were elements that may have initially made them uncomfortable and may not have met their expectations, five of the eight participants had a positive overall experience of SE therapy, and a subsequent effective and longstanding therapeutic relationship. For the three who terminated their therapy early, the gap between expectation and reality, often not bridged by sufficient communication, expectation management, or attention to pacing, made the process unsustainable. However, there was no indication that they had lost their faith in SE as an effective approach, with two of them going on successfully to other therapists and training professionally in the modality themselves. The remaining participant, Raya, a non-therapist, remains open to SE in the future, and her experience may simply illustrate the fact that finding the right therapist is not always straightforward:

> *"(I'd) still be willing to try SE again with another therapist if I knew that the therapist worked in a different way. It's not like I've totally sworn off SE forever [laughter]. I could still see the value of it. I just didn't… I felt uncomfortable with her, I think." (Raya)*

Ethics: Protection of human subjects

Ethical approval was granted by the Bath Spa University research ethics committee. Interview questions were deliberately broad, and the participants were told ahead of time that they would not be asked to, nor should they, share personal trauma history or the content of what was discussed in their therapy sessions. It was stipulated that the study was only concerned with their experience of the therapy, and not with any session content or therapeutic outcomes. Pseudonyms have been used to maintain participant anonymity. Participants were recruited for their relevant experience in accordance with the aims of the research, and not for any other characteristic such as ethnicity, age, religion, or gender.

Limitations

Due to confidentiality held by practitioners, participants were sourced through social media channels that were largely frequented by mental health professionals. Consequently, six of the eight participants were mental health or holistic therapists themselves, and had a basic understanding of SE. This doesn't appear to have compromised their ability to remain objective about their experience. However, if further research is undertaken, members of the general population with little knowledge of SE or other therapeutic approaches would provide responses that may more accurately represent most service users.

Further research

The SE research that exists boasts impressive outcome statistics, and the neurobiological mechanics of the approach are being attended to with some regularity (Levine, 1997; Nickerson, 2015; Reoch, 2017), though this could be improved upon (Payne et al., 2015). This author contends that more, and larger, studies of the lived experience of those attending SE therapy would help in determining the non-biological elements involved in the success or failure of the approach.

It was not the author's intention, or one of the stated research aims, to situate SE within a recognized theoretical framework from which efficacy can be assessed. However, the author would be remiss not to explore SE's suitability to either the CF or EST framework, as elements thereof have emerged unexpectedly from the findings. Alignment with either of these frameworks may assist in future research efficacy. The body reacts to external stressors in relatively predictable and well-understood ways (Levine et al., 2018), and SE's interventions aim to take advantage of the fact that one's natural biological resources, embodied by the nervous system, are universal (Levine, 2010a; Payne et al., 2015). This may suggest that it could be a one-size-fits-all approach to the treatment of trauma, which would fit comfortably within the EST model that emphasizes specific treatment

protocols aimed at remediating any given mental health issue, regardless of client context (Laska et al., 2014; Tzur Bitan & Lazar, 2019). The findings, however, suggest that there are enough similarities with Wampold's (2015b) CF model to posit, at the very least, a connection, and to suggest the possibility of further research. The participants' desire for, or appreciation of, bilateral communication, role induction, expectation management, psychoeducation, and trust within a therapeutic relationship align with the CF model. Furthermore, SE is a holistic modality that recognizes the importance of the context around which a traumatic event occurred, as well as the unique resilience and nervous system capacity of each individual. As use of pacing considers these individual circumstances and actively supports the resolution of trauma (Levine and Kline, 2011; Riordan et al., 2017), it could be considered a modality-specific intervention; the last of the constituents of the contextual model.

Implications for practice

Although the sample size is necessarily small to align with IPA guidelines, this study provides valuable insight into what Elliott (2008) describes as "covert processes" (p. 239), and what Blanchard and Farber (2016) refer to as "secrets" (p. 91) that may not otherwise be expressed, if not for studies like this. Role and process expectations detailed here may be examples of hidden processes whereby a client's expectations of their role in the therapy, and what may happen in the sessions, remained unspoken. The clients were consequently left to navigate these things on their own. Secrets are things that, in this study, hide shame, frustration, and a sense of failure that were not expressed to the therapists themselves, but which resulted in some participants terminating therapy prematurely.

For all participants, an opportunity early in this relationship to sense safety through questioning, learning, and personal resonance with the therapist was, or would have been, helpful. The author suggests that SE practitioners may need to help clients and potential clients understand what they might expect from sessions, express their needs, collaborate on their goals, and help them find their role in the therapy before they begin.

Conclusion

This study's primary aims were to facilitate the expression of the subjective voices of those who have experienced SE therapy, and to better inform therapists about elements of the approach that may and may not work for clients, and the human variables that may impact outcomes. The findings have important implications for practice in the realms of client safety, expectation, retention, communication, and service delivery. Studies of the lived experiences of those attending SE therapy could help in determining what non-biological elements are involved in the success of the approach, and what, if any, common factors are shared with psychotherapeutic modalities, e.g., the working alliance or therapeutic relationship. Alignment with a recognized theoretical framework, such as CF or EST, may assist in future research efficacy. Perhaps this shared experience, and a language more familiar to those for whom psychological concerns are more highly rated, will allow SE to enter the fold of accepted trauma therapies.

SE is considered to be a complimentary modality, with many ways to interweave the wisdom of the nervous system, be it through psychotherapy, dance therapy, life coaching or teaching, for example (Blakeslee, 2023). This study has shown the importance of listening to and acting upon the hidden processes present in the client experience of SE, regardless of the modality within which it is practiced. We cannot change what we are not aware of, and so this research, and others that attend to the client perspective of SE, will hopefully help inform best practice, creating, over time, a strong foundation upon which an already proven-effective modality can rely.

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Translation, Cultural Adaptation, and CFA of Nepali Version of Somatic Symptoms Scale (N-SSS-8)

Yubaraj Adhikari & **Birgit Senft**

ABSTRACT

Background: The Somatic Symptoms Scale (SSS) was developed as a brief assessment and screening tool for evaluating the somatic burden of individuals. Nepal lacks a culturally adapted Nepali version of a brief measure of somatic symptoms scale (SSS) for clinical and research use. This research covers translation, cultural adaptation, testing, and applicability of the tool through psychometric analysis. Confirmatory factor analysis (CFA) was applied to test the reliability and validity of the tool.

Aim: To examine the validity and reliability of translated and culturally adapted versions of SSS-8 through the use of CFA.

Methods: A non-experimental survey design was used to examine the distress of Nepali doctors (n = 547) using online and paper-and-pencil methods with the use of SSS-8. Translation, cultural adaptation, pilot testing, confirmatory factor analysis (CFA), and other applicable psychometric tests were carried out.

Results: The reliability score of Cronbach alpha (α) of the construct was 0.804. All items, except one for stomach or bowel problems to represent gastrointestinal symptoms, were retained with adequate factor loadings. Construct validity was established, as the fitness level of indices of the model met the acceptance criteria. Convergent validity could not be established, as the average variance extracted was below 0.5 for each subscale. The discriminant validity of the scale was confirmed. Post-hoc CFA verified the Nepali version of N-SSS-7, confirming a tri-factor model – pain, cardiopulmonary, and fatigue – with model fit indices (SMRs, RMR, and RMSEA) all below 0.08. The model fit scores of NFI, TLI, AGFI, and CFI were above 0.94.

Conclusions: CFA confirmed the Nepali version of the Somatic Symptoms Scale (N-SSS-7) is a valid and reliable tool to quickly assess the somatic burden in the Nepali population.

Keywords: Somatic Symptoms Scale, Nepali Version, Cultural Adaptation, Confirmatory Factor Analysis

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> ***... multiple methods are used when translating and adapting psychological tools from one language to another, with no consensus among scholars on a single approach.***

The Somatic Symptoms Scale (SSS-8) is a self-administrated somatic symptoms tool derived from the Patient Health Questionnaire (PHQ-15), which was originally developed by Kroenke et al. (1997) and later validated by Gierk et al. (2014). The SSS-8 captures an individual's perceived somatic burden, and is widely used in both clinical and non-clinical settings and validated in many languages. In Nepal, a brief tool to assess the somatic burden in the general population was not available. In the past, the Bradford Somatic Inventory (BSI) with 46 items was used with torture survivors (Emmelkamp et al., 2002). The PHQ-15 was tested to measure the somatic burden of medical students (Adhikari et al., 2017). Tol et al. (2009) selected seven somatic symptoms from the Symptom Checklist-90-R (SCL-90-R) to measure the somatic experiences of Nepali-speaking torture survivors in Bhutanese refugee camps. The SSS-8 is included in the new control trial of van't Hof et al. (2020), but researchers failed to explain whether they used an English version or if any translation/cultural adaptations were made. Nepali mental health and psychosocial practitioners (MHPSS) needed a brief somatic symptom tool for use in clinical practice and research. The adaptation and validation process of the Nepali version of the Somatic Symptoms Scale (N-SSS) was both applicable and necessary in the Nepali context. This study presents the detailed process of translation, adaptation, and validation of the N-SSS with a confirmatory factor analysis process.

Method

Study Design

A cross-sectional design was applied to measure the somatic symptoms of Nepali doctors. Online data was collected through a Google doc and paper-pencil methods. Doctors registered with the Nepal Medical Council were included, whereas doctors who discontinued their practice due to mental health or other reasons were excluded.

Tools

The SSS-8 has eight self-reported items ranked on a 5-point Likert scale (0 = Not at all, 1 = A little bit, 2 = Somewhat, 3 = Quite a bit, and 4 = Very much). The SSS-8 had good reliability as measured with Cronbach alpha (α = 0.81) and good internal consistency (Gierk et al., 2014). Tests of the confirmatory factor analysis (CFA) confirmed that somatic symptoms lie in four clusters: gastrointestinal, pain, cardiopulmonary, and fatigue-related factors (Gierk et al., 2014; Gierk et al., 2017). The content validity of the SSS-8 was good. The SSS-8 is culturally adapted, and used in the English, Japanese, Korean, German, Portuguese, and Greek languages (Gierk et al., 2014; Matsudaira et al., 2017; Yang et al., 2020, Toussaint et al., 2020; Pollo, 2020; Petrelis & Domeyar, 2020).

Translation and cultural adaptation process

The SSS-8 was culturally adapted and translated into Nepali by using forward-backward translations, consultations with experts in receiving feedback, and pilot testing before the final data collection. The first translation from English to Nepali was done by two Nepali bilingual psychologists. Both translated versions were checked by the researcher, and a single list was prepared. That list was given to an expatriate bilingual psychologist to carry out a lexical back-translation, which was then reviewed by an expatriate bilingual psychologist before a final draft was prepared. Then both the English and Nepali versions were shared with 23 Nepali psychologists and consultant psychiatrists, who had both clinical and research experience in the mental health and psychosocial fields for their feedback.

Fifteen experts out of 23 responded to the request. In response to SSS-1, they advised to add "wa" in between two optional words, rather than using brackets. In SSS-2, there was a suggestion to use "dhad" instead of "pittyu." In SSS-6, the word "samasya" was found missing and was adjusted. In SSS-8, they advised to phrase "trouble sleeping" as "nidauna garho hune wa nidrama biujhine." They advised framing the sentence as "bhayo" and "diyo" instead of "bhaeko chha" and "dieko chha." Last, the reviewers recommended that the researchers conduct psychometric testing through a pilot study, rather than use the translated version directly with the study population. The researcher had already planned such a step. The translated and culturally-adapted Nepali version of the SSS-8 was then reviewed by a Nepali language expert for

grammatical errors before the pilot test. The final Nepali version of the SSS-8 was piloted with 55 medical doctors. The test results and statistical properties of the SSS-8 Nepali pilot version were calculated before the final study.

Ethical aspects of the study

Two institutions, the Austrian Academy of Psychology (AAP) and the Nepal Health Research Council (NHRC), provided ethical approval before the data collection process. The participants received announcements with a detailed explanation of the research, which included voluntary participation, informed consent, the possibility of withdrawal at any stage without any explanation, potential harms (psychological and mental health-related) due to their participation in the research, and a debriefing note with contact details of institutions providing free counseling and therapeutic support in case of need. No personal data, such as names, addresses, emails, and phone number, were collected. Therefore, the anonymity, privacy, and confidentiality of the respondents were well respected in all steps of the research.

Data analysis

After the data collection process, the data were coded, cleaned, and analyzed using the SPSS-25 and SPSS AMOS-25 versions. Normality, homogeneity of the variances, linearity, multicollinearity, and co-variances were tested before detailed analysis. Apart from the correlations among the variables, Levene's test for the homogeneity of variances was also conducted. Descriptive statistical analysis was applied to measure the means and standard deviations of continuous variables. Significance testing for normality followed the distribution checks via scatterplots, box plots, kurtosis, and skewness. A Pearson's product-moment correlation was analyzed after testing the relevant assumptions for the correlation.

Results

Pilot study on Nepali version of the Somatic Symptoms Scale

The final draft of the Nepali version of the scale was piloted with the intended population and the first 55 online responses collected via a Google form were considered. The responses were coded, and data cleaned. No missing data were found. The Cronbach alpha for the Nepali version of the SSS-8 was 0.864, which showed good internal consistency among the eight items. The internal consistency, with any item deleted, was over 0.833 for all items. When bivariate correlations of each item were tested, all items, except the N-SSS-2 and N-SSS-5, were found to be significantly correlated (p <.001). Additionally, the dimensionality of the scale was examined by investigating the factor structure using the pilot data. After conducting the principal CFA, the commonalities were calculated, and the results indicated that all items, except the N-SSS-2 and N-SSS-8, had commonalities above 0.4. The extraction of loadings through total variance explained why the eigenvalues of two components were more than 1. The two components with eigenvalues over 1 comprised only 65.26% of the cumulative variance. The outcome of KMO and Bartlett's Test for adequacy of sampling was 0.838, and the variance of each item was significantly correlated (p <0.001).

The analysis suggested conducting a confirmatory factor analysis (CFA) to test the model of the SSS-8. When Gierk et al. (2014) tested a higher-order general factor analysis of the English version of the SSS-8, the results suggested using four factors. The suggested frame includes a) the SSS-1 for gastrointestinal symptoms, b) the SSS-2, 3, and 4 for pain, c) the SSS-5 and 6 for cardiopulmonary symptoms, and d) the SSS-7 and 8 for fatigue. A CFA was applied with the four-dimensional model of the SSS-8 (see Figure 1). The CFA of the Nepali version of the SSS-8 showed a maximum reasonably good fit. All items had strong and significant correlations (< 0.56). The fit indices are presented in Table 1.

The results of the fit indices of the CFA for the pilot test of SSS-8 were reasonably in line with a good fit. For convergent validity, composite reliability (CR) was found to be > 0.7, and the average variance extracted (AVE) > 0.5 was measured. For other measures, CR = 0.84 and AVE = 0.78 for pain; CR = 0.73 and AVE = 0.57 for cardiopulmonary, and CR = 0.61 and AVE = 0.44 for fatigue were measured. Each score of AVE was greater than MSV and ASV. The test further confirmed that it would be fruitful to carry out full-scale administration of the Nepali version of the SSS-8 to the chosen population for study in Nepal.

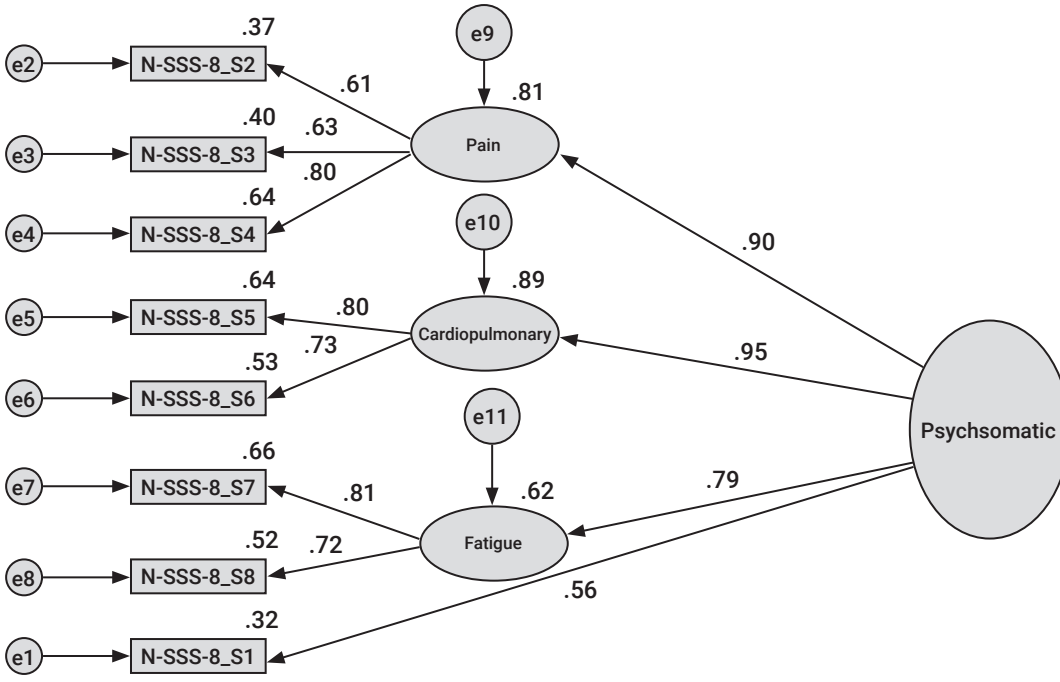

Figure 1. *Results of Confirmatory Factor Analysis of Pilot Test for SSS-8-N*

Main Study Findings and Prevalence of Somatic Symptoms

A total of 557 doctors responded to the survey, with 415 males (75.90%) and 129 females (23.60%), yielding a response rate of 62.80%. Of these, 400 responses were received online, while the remaining were collected via paper forms. The somatic symptoms were calculated based on five severity categories: none to minimal (0-3), low (4-7), medium (8-11), high (12-15), and very high (16-32). The prevalence of psychosomatic measures among respondents was as follows: medium = 20.80%, high = 13.70% and very high = 6.80% (Adhikari & Senft, 2022). A cut-off score of 11 was applied, as suggested by Gierk et al. (2014). The somatic burden as per socio-demographic variables of the studied population is presented in Table 3.

Confirmatory factor analysis of the Nepali version of the SSS-8

CFA process and outcomes

Descriptive statistics of the N-SSS-8 showed very good reliability, with a Cronbach's alpha of 0.802. The mean score of SSS-8 for the overall data was $M = 11.90$ ($SD = 6.42$). The static values of skewness

Table 1. *Fit Indices from CFA with Four-Factor Model of SSS-8-N* ($N = 55$, $p = 0.002$)

Model	CMIN/df	NFI	TLI	GFI	CFI	RMR	SMRs	RMSEA	P-Close	Hölter Kriterium
SSS-8	2.077	0.770	0.823	0.849	0.861	0.118	0.053	0.141	0.010	48

Note: NFI = Normed-Fit Index, TLI = Tucker-Lewis Index, GFI = Goodness-of-Fit Index, CFI = Comparative-Fit Index, RMSR = Root mean square residuals, SMRs = Standardized root mean Square Residuals, RMSEA = Root mean square error of approximation, Hölter Kriterium for numbers of samples in $p = 0.01$

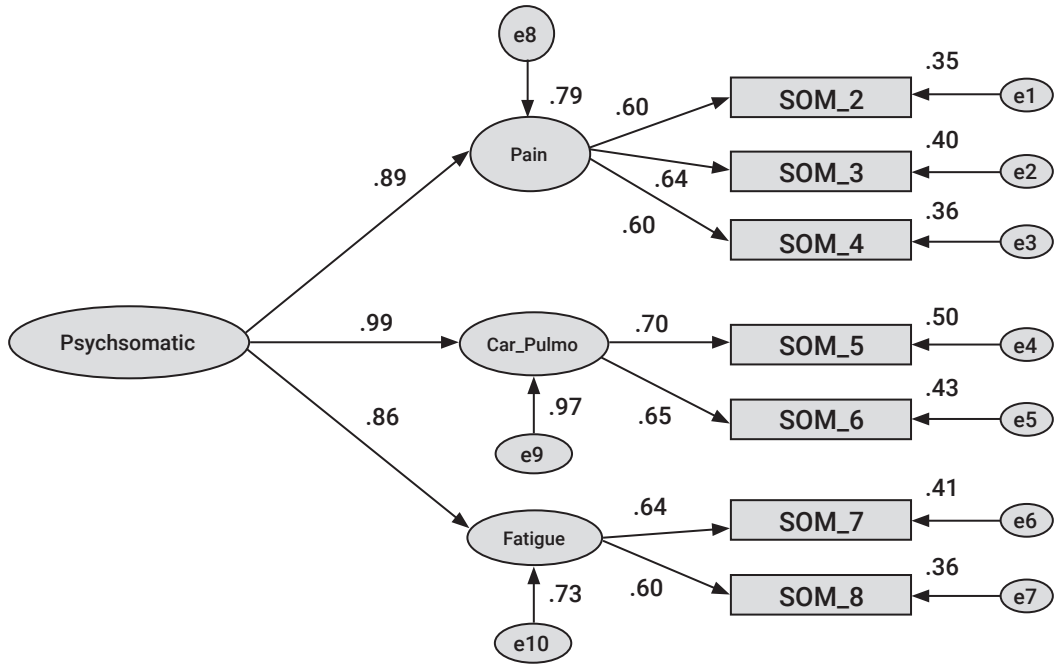

Figure 2. *Confirmatory Factor Analysis of N-SSS-8 with Three-Factor Model*

and kurtosis were 0.603 and 0.440 with standard errors of 0.104 and 0.209 respectively. Histograms, normal Q-Q plots, box plots, scatter plots, Mahalanobis' distances for the DVs, and residuals further demonstrated that the data were normally distributed. Shapiro-Wilk and Kolmogorov Smirnov tests were conducted for all items of the SSS-8, and no significant deviations from normality were found.

CFA was conducted on the N-SSS-8 to evaluate a four-factor model. The four-factor model of the SSS-8 includes three items to represent pain – SOM-2 (back pain), SOM-3 (pain in arms, legs, or joints), and SOM-4 (headaches); two items to represent cardiopulmonary symptoms – SOM-5 (chest pain or shortness of breath) and SOM-6 (dizziness); two items to represent fatigue – SOM-7 (feeling tired or having low energy) and SOM-8 (trouble sleeping); and a single item – SOM-1 – to represent gastrointestinal symptoms (stomach or bowel problems). The CFA results showed that SOM-1 had a factor loading of only 0.55, with an error variance of 0.28. This factor loading was below the required threshold, so SOM-1 could not be retained. Consequently, the CFA was conducted for a three-factor model without SOM-1. The measurement model is presented in Figure 2.

Table 2. *CFA Fit Indices for Three-Factor Structural Model of N-SSS-8* (*N* = 547, *p* <.001)

Model	CMIN/df	NFI	TLI	GFI	CFI	RMR	SMRs	RMSEA	P-Close	Hölter Kriterium
SSS-8	4.461	0.922	0.918	0.965	0.938	0.072	0.0529	0.080	0.005	245

Note: NFI = Normed-Fit Index, TLI = Tucker-Lewis Index, GFI = Goodness-of-Fit Index, CFI = Comparative-Fit Index, RMSR = Root mean square residuals, SMRs = Standardized root mean square residuals, RMSEA = Root mean square error of approximation, Hölter Kriterium for number of required sample, with *p* = 0.01

CFA fit indices of structural model of the N-SSS-8

The overall model fit for the structural model of the N-SSS-8 was examined using the same set of fit indices applied to the measurement model of the SSS-8. The model fit indices are presented in Table 2.

Factor loading and summary of construct of measurement model of the N-SSS-8

A recursive model was tested, with 28 distinct sample moments and 12 distinct parameters to be estimated. The chi-square value of the default model was 71.379 with 16 degrees of freedom with a significant level of probability (p <.001). The measurement model of the current study shows an adequate model fit for the empirical data. The normed chi-square (CMIN/df) was measured as 3.699, which is an acceptable value. The values of NFI, TLI, GFI, and CFI were all above 0.90, the required level. The values of RMSR, RMSR, and RMSEA were 0.071, 0.53, and 0.070 respectively; all were at the acceptable threshold of 0.08. In conclusion, the CFA analysis of the N-SSS-8 was fit and supported by the data. The construct related to gastrointestinal symptoms had only a single item by which to measure the construct. This item, for gastrointestinal symptoms, was not used in the measurement model. A summary for all constructs is presented in Figure 3.

The factor loading for all items of each construct was above 0.62, except for one item: the SOM-4. Positive and strong correlations (> 0.82) among the three measures were found. A summary of the fitness indices of the measurement model is presented in Table 4. All the fitness indices for the

Table 3. *Distribution of Distress Measures across Socio-Demographic Variables*

Characteristic	Sub-Heading	*N*	%	SSS-8	
				M	*SD*
Overall	Medical/Dental Doctors	547	100	11.9	6.42
Gender	Male	415	75.9	11.92	6.35
	Female	129	23.6	11.91	6.73
	Unknown	3	0.5	9.67	1.15
Position	General Physician/Dental Doctor	291	53.2	11.37	6.8
	Consultant	153	28	12.03	6.26
	Senior Consultant	39	7.1	11.64	4.79
	Director	9	1.6	13.78	6.08
	Resident Doctor	55	10.1	14.29	5.35
Qualification	MBBS	288	52.7	11.9	6.6
	Master's in Medicine	199	36.3	12.95	6.12
	Doctorate in Medicine	60	11	8.47	5.33
Experience	0-2 Years	188	34.4	12.54	7.09
	2-5 Years	183	33.46	11.23	5.75
	5-10 Years	109	19.93	11.62	7.08
	10+ Years	67	11.88	12.4	4.78

Characteristic	Sub-Heading	*N*	%	*M*	*SD*
Type of Institution	Government Hospital	242	44.24	11.71	6.03
	Private Hospital	175	31.99	10.29	6.96
	Teaching Hospital	97	17.73	14.44	5.58
	Private Practice	20	3.66	13.95	4.94
	NGO/Public	13	2.38	15.31	6.92
Location of Job	Home-Based	303	55.39	11.95	6.35
	Out of Home	244	44.61	11.85	6.52
Rural/ Urban/ Aboard	Out of Kathmandu Valley	224	40.95	13.71	6.02
	Kathmandu Valley	289	52.83	10.56	6.48
	Working Abroad	34	6.22	11.44	5.78
Age Group	18-25 Years	67	12.25	12.87	7.88
	26-45 Years	451	82.45	11.82	6.21
Age Group	46-60 Years	26	4.75	11.31	5.97
	60+ Years	3	0.55	8.67	7.02
Type of Service	Emergency Service	97	17.73	13.31	6.6
	Outpatient	36	6.58	5.25	4.56
	Surgery/Post-Op.	225	41.13	12.74	5.78
	Private Clinic	89	16.27	8.7	6.5
	Other	74	13.53	13.74	5.87
	All of the Above	26	4.8	14.42	5.01
Caseload per Week	Below 25	124	22.67	8.44	5.98
	26-49	153	27.97	10.48	6.89
	50-75	120	21.94	14.68	5.4
	76 or above	150	27.42	14	5.23
Clinical Supervision	Not Heard of	62	11.33	15.08	6.41
	Yes	169	30.9	13.25	5.75
	No	316	57.77	10.56	6.42
Self-Care Training	Not Heard of	50	9.14	13.86	6.07
	Yes	30	5.48	9.37	6.39
	No	467	85.37	11.86	6.41

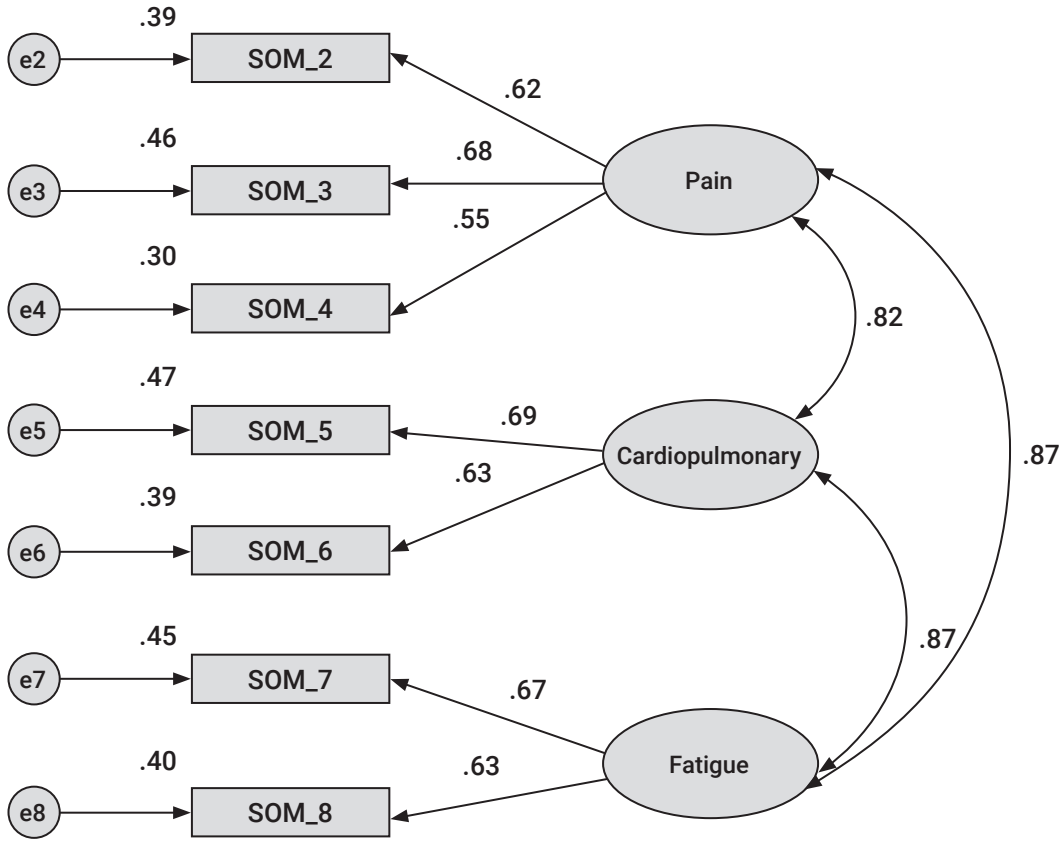

Figure 3. *Measurement Model of N-SSS-8*

measurement model of the N-SSS-8 achieved the required level.

Unimodality, reliability, and validity of N- SSS-8

Unimodality: To achieve unimodality, there should be acceptable factor loadings for all measuring items, and acceptable loadings of items for respective latent variables. Each item with a low factor loading must be deleted. Unimodality has to be analyzed before calculating and presenting the reliability and validity of any construct. Positive factor loadings of 0.50 or above are an acceptable level to demonstrate the unidimensionality of a scale. Positive factor loadings above 0.60 for each measured item of the N-SSS-8 were measured (refer

Table 4. *CFA Fit Indices for Three-factor Measurement Model of SSS-8* (*N* = 547)

Model	CMIN/df	NFI	TLI	GFI	CFI	RMR	SMRs	RMSEA	P-Close	Hölter Kriterium
SSS-8	3.456	0.947	0.942	0.976	0.961	0.048	0.0396	0.067	0.078	329

Notes: NFI = Normed Fit Index, TLI = Tucker-Lewis-Index, GFI = Goodness-of-Fit-Index, CFI = Comparative Fit Index, RMSR = Root mean square residuals, SMRs = Standardized Root mean Square Residuals, RMSEA = Root mean square error of approximation, Hölter Kriterium for the number of required samples, with $p = 0.01$

Table 5. *Factor Loadings and Reliability Scores of SSS-8 (N = 547)*

Construct	Item	Factor loading	Cronbach α	CR	AVE
Pain	SOM_2	0.60	0.64	0.64	0.38
	SOM_3	0.64			
	SOM_4	0.60			
Cardio	SOM_5	0.70	0.60	0.63	0.45
	SOM_6	0.65			
Fatigue	SOM_7	0.64	0.60	0.55	0.38
	SOM_8	0.60			

Note: AVE = average variance extracted, CR = composite reliability

to Figure 3). Therefore, it is acceptable to proceed with calculating the reliability and validity of the scale.

Reliability: A summary of each construct and item with its factor loading, CR, and AVE is presented in Table 5 above.

Validity: The validity of any instrument or measure is its ability, to a certain extent, to measure whatever it is supposed to measure. In any measurement model, three types of validity (convergent, construct, and discriminant) are measured through CFA. Table 6 presents the internal reliability and validity indices of the N-SSS-8.

Discussion

The present study evaluates the reliability and validity of the translated version of the SSS-8 into the Nepali language within a sample of Nepali doctors. Since the author was unaware of any similar studies conducted in Nepal, a rigorous process of translation and cultural adaptation process was therefore followed. Maneesriwongul and Dixon (2004) outlined that multiple methods are used when translating and adapting psychological tools from one language to another, with no consensus among scholars on a single approach. The recommended steps include drafting a direct translation, writing a lexical back-translation, collecting feedback from practitioners and experts, finalizing a draft version, and piloting the tool with the target population before its final use (Davis et al., 2013; Sousa & Rojjanasrirat, 2011; Van Ommeren et al., 1999). This study followed the exact process recommended by the scholars.

Gierk et al. (2014) carried out a confirmatory factor analysis of the SSS-8 in which the three-factor model was superior to the one-factor model, and recommended its use. The Korean version of the SSS-8 is equally suggested for the three-fac-

Table 6. *Internal Reliability and Validity Indices of N-SSS-8 (N = 557)*

Construct	AVE	CR	MSV	ASV
Pain	0.38	0.64	0.76	0.71
Cardio	0.46	0.63	0.76	0.71
Fatigue	0.38	0.55	0.76	0.76

Note: AVE = average variance extracted, CR = composite reliability, MSV = maximum shared variance, ASV = average shared variance, N/A = not applicable

tor model, instead of one. In the CFA process, each item of the SSS-8, except SSS-1, had a factor loading above 0.60 at the 0.05 significance level.

For construct reliability, composite reliability (CR) values should be greater than 0.6 and average variance extracted (AVE) values should be above 0.5. In addition, the Cronbach alpha (α) for each construct should be above 0.7. Therefore, the N-SSS-8 did not achieve scores demonstrating reliability for each sub-scale. However, the overall reliability (α) of the construct was 0.804. The reliability (α) score is higher than that of the English and German versions (Gierk et al., 2014; Toussaint et al., 2017), but lower than the Korean version of the SSS-8 (Yang et al., 2020).

Convergent validity can be verified if the AVE value for each item is 0.5 or above (Fornell & Larcker, 1981). The AVE scores for all factors of the N-SSS-7 are below 0.5 (see Table 6), so convergent validity of the tool was not achieved. That said, AVE scores probably did not reach acceptable levels because there were fewer than three items for each factor.

Construct validity is established when the fitness level of indices meets the acceptance criteria. Ping (2009) suggested that AVE scores below 0.50 be considered if a study is being conducted for the first time. Hair et al. (2005) claimed that convergent validity can be explained and verified through computing and analyzing the CR and AVE values of each measure, and that convergent validity is achieved if the CR values of each construct are above 0.7, and the AVE scores of each construct are above 0.5. The CR score for each measure should be greater than the AVE score (Hair et al., 2013). All measures of the N-SSS-7 met the acceptable level of fit criteria (Awang, 2014).

Discriminant validity is confirmed when both maximum shared variance (MSV) and average shared variance (ASV) are greater than AVE (Hair et al., 2005; Hair et al., 2013). The scores of AVE, ASV, and MSV measured in this study prove that MSV < AVE and that ASV < AVE; therefore, the discriminant validity of the scale is confirmed. Discriminant validity can also be achieved in situations where the measurement model and all items of the model are free from redundancy (Ahmad, Zulkurnain, and Khairushalimi, 2016). There was no redundant item in the model, confirming its discriminant validity.

Conclusions

The study concludes that the translation, cultural adaptation, and confirmatory factor analysis of the SSS-8 have been successfully completed. The reliability and validity indicators for the three-factor model of the N-SSS-8, excluding SSS-1 for Gastro, have been justified. The analysis of the psychometric properties of the N-SSS-7, presented below in Preeti font, suggests that it should be used for further clinical and research purposes.

Conflict of interest

None

Authors' contribution

This research provides researchers and clinicians with a validated and reliable Somatic Symptoms Scale for use in the Nepali context.

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Nepali Somatic Symptom Scale (N-SSS-7)

म तपाईलाई विगत एक हप्ता भित्रमा तपाईले महसुस गर्नु भएका कठिनाईहरू बारे प्रश्न गर्दैछु । प्रत्येक प्रश्नको लागि तपाईलाई विगत एक हप्तामा कति धेरै कठिनाइ भयो भन्ने बारेमा म प्रश्न गर्दैछु ।

कठिनाईहरू (N-SSS-7)		(हुदै भएन) ०	(कहिले काँही भयो) १	(अकसर भयो) २	(धेरै भयो) ३	(एकदमै धेरै भयो) ४
S2	तपाईलाई कम्मर दुख्ने समस्याले कत्तिको दुःख दियो?					
S3	तपाईलाई हात-पाखुरा, खुट्टा दुख्ने वा जोर्नी दुख्ने समस्याले कत्तिको दुःख दियो?					
S4	तपाईलाई टाउको दुख्ने समस्याले कत्तिको दुःख दियो?					
S5	तपाईलाई मुटु (छाति) दुख्नेवा श्वास फेर्न गाह्रो हुने समस्याले कत्तिको दुःख दियो?					
S6	तपाईलाई टाउको झन्न हुने, रिंगटा वा चक्कर लाग्ने समस्याले कत्तिको दुःख दियो?					
S7	तपाईलाई शरीरमा कमजोरी वा थकित हुने समस्याले कत्तिको दुःख दियो?					
S8	तपाईलाई निदाउन गाह्रो हुने वा निन्द्रामा बिंउझिरहने भयो कि भएन? यस्तो कत्तिको भयो?					

Water As An Affective Medium

Eleonore ten Thij, Moniek van Slagmaat, Truus Scharstuhl

ABSTRACT

Introduction: Clinical observations suggest that haptotherapy in water improves clients' capacity to experience positive affect. Water is considered an affective affordance (Fuchs 2013); it is used to facilitate bodily awareness, and thus enhances awareness of embodied affectivity. As a result, touch can be used more subtly and sparingly in therapy, which may be beneficial for clients who have difficulties experiencing safety in closeness and with affective touch. The current study constructs and explores a method to make these observations researchable.

Methods: We hypothesized that improving sensory awareness will lead to experiencing more positive affect. We constructed a questionnaire to link base embodiment and field of affective resonance to experiencing specific affects such as vitality and existential feelings. Forty students of the STH Water completed this questionnaire before and after a learning event.

Results: The results indicate that the questionnaire was highly reliable, and that sensory awareness and positive affect had improved.

Discussion: The approach seems feasible for a subsequent research step using the questionnaire with different subjects, testing the model underlying the questionnaire, comparing the effects of haptotherapy in water with the effects of other haptotherapeutic interventions, and adding a therapy effect measurement.

Appendix: questionnaire (QWAM-22).

Keywords: sensory awareness, affect, haptotherapy in water

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> ***Water facilitates bodily awareness and thus enhances awareness of embodied affectivity.***

In the Netherlands, a new therapeutic concept emerged in the 1950s: haptonomy. Theoretically, it was based on the work of Merleau-Ponty, Buytendijk, Prick, Calon, Duynstee, and Terruwe, among others (Verhoeven, 2013). The concept originated from Frans Veldman, who researched the principles of touch and feeling phenomenologically. He developed affective touch to appeal to our bodies-as-subjects (to be discriminated from our bodies-as-objects). He considered our tactile sense as closely connected to our capacity to feel and connect – to experience affect and share emotions (*International Journal of Haptonomy and Haptotherapy* (IJHH), (WIH), website July 2021).

Haptonomy developed into a specific form of body and touch or contact-oriented therapy, called *haptotherapy*. It is based on the idea that developing awareness of bodily experienced affects, connectedness, attachment, and autonomy allows for change, growth, and an increase of feelings of wellbeing (Klabbers, 2018, 2022; Wibbels-Pancras, 2021). Its tools are conversation, affective touch, and experiential exercises as means to appeal to a client's embodied, affective abilities.

In the context of haptotherapy, affective touch is a way of touching during which the therapist expresses the intention to acknowledge, accept, and appreciate clients and their affects. Thus, clients are invited to acknowledge and experience affects in their body in a constructive manner. Touch may be used to improve awareness of how clients relate to others. It may help change patterns of responding to fear or stress, and, as a resource for furthering bodily awareness and connection, help improve resilience (Elbers, 2021).

A promising new approach within haptotherapy is haptotherapy in water. Water facilitates bodily awareness and thus enhances awareness of embodied affectivity. As a result, touch can be used more subtly and sparingly. This may be especially beneficial for clients with control issues, trauma, and attachment problems, who have difficulty experiencing safety in closeness and affective touch. Haptotherapy in water may help trigger and heal early childhood trauma. Being carried by, and in, warm water may invoke and address perinatal bodily memories.

There is currently extensive interest in embodiment and affective touch within the fields of phenomenology, empirical research, and therapeutic work. Our body provides us with a sense of self, other, and reality (Fuchs, 2013; Rathcliffe, 2012; Fugali, 2016; Körner, Topalinski, & Strack, 2015; Bekrater-Bodmann, Azevedo, Ainley, & Tsakiris, 2020). Research shows that interoception codetermines our capacity for homeostasis (Neto, Bicalho, & Bortolazzo, 2021). Touch influences our bonding with others (Ellingsen, 2014), our performance and judgment of social situations, our hormonal balance, sleep, immune response, and experience of pain – in other words, our health and feelings of wellbeing. Additionally, touch can communicate intentions in a basic, direct way (Linden, 2016; McGlone, Wessberg, & Olausson, 2014; Kraus, Huang, & Keltner, 2010; Ackerman, Nocera, & Bargh, 2010, as cited in Linden, 2016). According to Field et al. (2005), touch therapy has been noted to have immediate and long-term effects on the body's biochemistry, including decreased levels of the stress hormone cortisol, and increased levels of the neurotransmitters serotonin and dopamine, which play roles in mood regulation, movement, impulse control, and more.

As the subject of touch and its connection with the limbic and vagal systems became more widely researched, touch also found its way into the treatment of both physical and psychiatric conditions, cancer, psychological trauma, and autism spectrum disorders (Porges, 2009; Geller & Porges, 2014; Ogden, 2006; Gene-Cos et al., 2016; Levine, 2010; Brom et al., 2017; Van der Kolk, 2014; Field et. al, 2005; Krieger et al., 1979; Weze et al., 2007).

Research question

Experimental quantitative research in haptotherapy is still relatively new (*IJHH* website July 2021), and has yet to be developed for haptotherapy in water. In this study, we aim to take a first step in this direction.

As within other body-oriented therapeutic approaches, awareness of sensory information and affect are considered linked (Price & Hooven, 2018). Enhancing sensory awareness is thus considered one of the basic working mechanisms in body-oriented therapy (Tarsha, Park, & Tortura, 2019). Haptotherapy in water operates from the same assumption, and our research question based on this link asks: Does haptotherapy in water enhance sensory awareness and the experiencing of more positive affect?

To assess our research question, we constructed a questionnaire in which we specified sensory awareness and positive affect. Below we illustrate how we derived this questionnaire from relevant literature and clinical observation.

Constructing the questionnaire – affects

The way affects are understood in haptotherapy appears closely related to the work of Fuchs (2013, 2016), who explains that affects are not to be regarded only as inner individual states. Rather, they

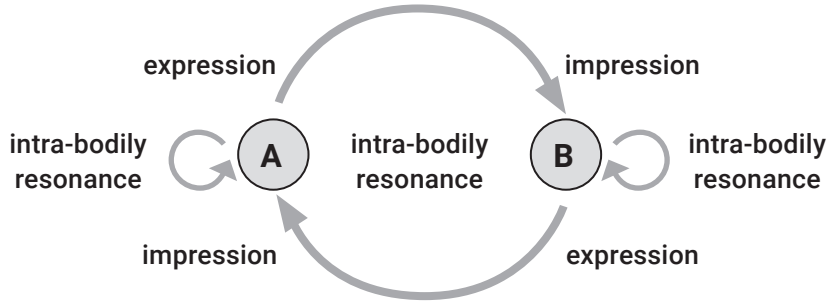

Figure 1: *Inter-affectivity*

From *Phenomenology and the Cognitive Sciences*, 11(2), 2012, pp. 205-236, "The Extended Body: A case study in the neurophenomenology of social interaction," by T. Froese and T. Fuchs.

are considered to be primarily shared states that we experience through inter-bodily affection; they are felt from the inside, but also visible in expression and behavior. For example, we feel our vitality in our posture and movement, our anger in our body arousal. The resonance of affects in our bodies – in arousal, posture, and movement – is a simultaneous expression of affect. As such, our affects become externally perceivable and their expression produces an impression, by triggering corresponding or complementary bodily feelings in our interaction partners. Likewise, our interaction partners' affects cause bodily feelings in our bodies, and so on (after Fuchs 2013, also see Figure 1).

Fuchs states:

> "We do not live in a merely physical world. The experiential space around us is always charged with affective qualities. We sense an interpersonal climate of atmosphere. Feelings emerge from situations, persons, and objects. Affective space is essentially felt through the medium of the body, which widens, tightens, weakens, trembles, shakes, etc." (Fuchs, 2013)

According to Fuchs, the word *affects* denotes five different phenomena that differ from each other in qualities like directedness, propositional content, polarity, manner of awareness, duration, and perceived distinctive cause, to name a few:

1) Vitality feelings
2) Existential feelings
3) Affective atmospheres
4) Moods
5) Emotions

Not only does phenomenology direct our attention to the inherently social character of affects, but experimental neuroscience suggests that mirror neurons are involved in understanding emotions (Motluk, 2008; Rizolatti & Caruana, 2017). Shared representations enable vicarious pain and vicarious touch (Gallese, 2018, 2005; de Vignemont, 2014).

From a body-oriented therapy perspective, positive affect may contribute to our ability to engage in processes of change (Stalikas & Fitzpatrick, 2008; Coombs, Jones, & Coleman, 2002). In our study, we focus on vitality and existential feelings, which seem to be the most basic affects that color the way we experience ourselves in the world, as well as the way we experience the other affects.

Vitality feelings

We consider feelings of vitality as non-intentional – they are not "about" anything. Here we agree with Fuchs (2013) that vitality seems related to fitness and feeling healthy (de Jong-Bouwmeester, 2016). It relates to experiencing internal vital processes – and as such may be both sustained and periodic, but does not entirely coincide. Vitality is also associated with mental attitudes, like lust for life, motivation, and resilience (Strijk et al., 2015; De Jong-Bouwmeester, 2016). We agree with Fuchs (2013) that vitality appears as a continuum between two poles.

We constructed "vitality" partly on Fuchs (2013), and partly on Vita-16 (Strijk et al., 2015), and the Subjective Vitality Scale (Ryan & Frederick, 1997) as found in De Jong-Bouwmeester (2016). These two questionnaires are reasonably well-researched. We thus considered vitality as a concept that can be measured on three dimensions, and added these ten questions to the instrument:

- *Energy:* the extent to which someone is feeling fit, energetic, calm, or tired.
  - I feel fit and energized
  - I feel active and purposeful
  - I am tired
  - I feel calm and relaxed
- *Resilience:* the degree of pain or discomfort, of feeling able to handle unexpected events well, of feeling that you can take on the world.
  - I suffer from pain or discomfort
  - I feel like I can take on the world
  - I now feel that every experience in life will make me stronger
  - I now feel I can handle unexpected events well
- *Motivation:* the extent of feeling motivated to take on challenges and feeling energized by plans for the future.
  - Next week I will immediately take on a new challenge
  - I get energized by my plans for the future

Existential feelings

The term *existential feelings* was first used in 2005 by Ratcliffe, who was concerned with making sense of altered experiences of reality in states of depression. He used the concept to name feelings that are not intentional, like emotions or moods; feelings that are somehow related to our felt sense of belonging to the world, to our sense of reality; and affective experiences that constitute how we locate ourselves in the world and with other people. As such, these feelings permeate all our experiences, thoughts, and activities. They are essentially feelings of possibility – what can possibly be felt, and how one can be in the world with oneself and others, etc. (Ratcliffe, 2012). For our purposes. and loosely following Fuchs (2013), we measure existential feelings on the following dimensions, adding nine items to the questionnaire:

- *Affectability* or *affective potential:* the degree to which you are capable of experiencing affects and to what extent you feel present, open, and lively
  - I feel present
  - I feel a lot of space (openness, freedom) in myself
  - I feel lively
- *Connectedness with self / feeling in harmony with self:* the degree to which you have faith in yourself, feel good about yourself and your life
  - I have faith in myself
  - I feel good about myself and my life
- *Connectedness with the world (others) / feeling in harmony with others:* the degree to which you feel involved and at home with others, or in need of control of your environment and the opinions of others
  - I now feel involved in my environment
  - I feel at home in this company
  - I leave nothing to chance
  - I wonder what others will think of me

Constructing the questionnaire – bodily awareness

Field of affective resonance

Water contact can be both a physical and affective means of being in contact with ourselves and with others. Water becomes an affective medium both through the intrinsic qualities of the warm water itself and through explicit guidance.

According to Scharstuhl, specific qualities of water appeal to us:

> "Water, especially warm water, can bring us in contact with our bodies: it encloses us like a second skin. The touch of water is so complete that the connection with our tactile senses and our feelings is made instantly. The body softens and becomes receptive. There is also a physiological impact; pleasantly warm water has a subduing effect on the involuntary vegetative nervous system, rendering us calm. The buoyancy of water makes us feel lighter and thus float. The amount of air we have in our lungs strengthens our buoyancy further. The water carries us (and also enables you to be carried by others quite easily). Due to the hydrostatic pressure, water also has a supportive quality. Because of this pressure, which causes the pressure of the water to be equally divided over all parts of our bodies, we feel the water very evenly and uniformly. Water supports and surrounds us and keeps us balanced." (Scharstuhl 2020a: Scharstuhl, van Banning, 2020b)

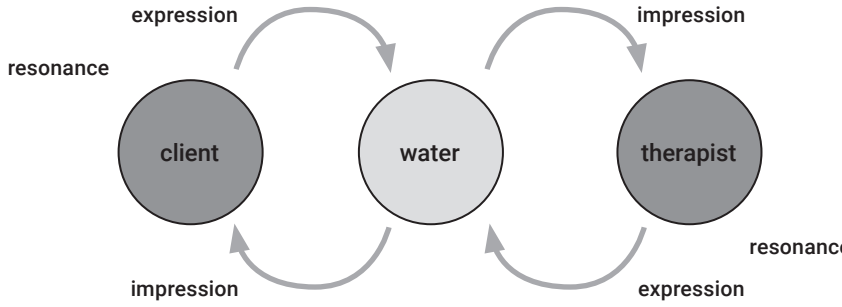

Figure 2: *Water as an affective affordance for embodied inter-affectivity*

Typically, a haptotherapy session in water starts with specific basic guidance that aims to further two types of sensory awareness: awareness of the field of affective resonance, and base embodiment. It generally includes four steps:

1. Direct the client's interoception, and the affects that are conveyed.
2. Enhance the client's proprioception and exteroceptive awareness of the qualities of the space surrounding them and the feelings these denote.
3. Direct the client's awareness of the inter-affectivity that the qualities of this surrounding space facilitate, and how this contributes to the client's (inner) movements and the meaning they attribute to the interaction. Therapists also activate their field of affective resonance. As a result, clients are also, by means of embodied inter-affectivity, implicitly guided to activate their affective field of resonance (See Figures 1 and 2).
4. Help the client get awareness of base embodiment (see below).

Fuchs (2013, 2016) argues that the body serves as the *medium* of our affective engagement in a given situation. Actions, feelings, and emotions are visible through our bodily expressions. Intercorporality and interaffectivity emerge when the bodies of several individuals are intertwined in a process of bodily resonance.

Similarly, neuroscientific research assumes that mirror neurons help us to experience and understand other people's actions, emotions, and sensations. Innamorati, Gallese, Ebisch, and Saggino (2019) show that *vicarious experience* – the phenomenon of intersubjective emotion, which consists of participating in the emotion of another through affective responses to the other's emotional state – describes a fundamental quality of empathy and social understanding. Keysers, Kaas, and Gazolla (2010) show that similarly, somatosensory input is probably linked to our visual and auditory social perception.

In haptotherapy, when participating fully and autonomously in this interaffectivity, it is important to discern between sensing and feeling our own actions, sensations, emotions, and those of the people surrounding us. Therefore, we help clients develop an awareness of sensations stemming from their own experiences, and those stemming from others' experiences – their *vicarious sensations*. Grouped together, we call interoception, exteroception, proprioception, and vicarious sensations the *field of affective resonance* (FAR). Originally the technical term 'transsensus' was used in haptotherapy meaning the haptic capacity to be perceptively and affectively aware of others in the space around you (Veldman, 2007). We instead use *field of affective resonance* to align with the terminology borrowed from Fuchs to denote these three modes of sensory awareness, together with the peri-personal space in which people are aware of their mutual vicarious feelings.

The basic guidance aims to raise awareness of water as an affective affordance (Fuchs, 2016, see Figure 2) that furthers a client's FAR.

> "They become aware of the warm water enhancing their sense of boundaries. On the one

> hand, this results in elucidating and intensifying their interoception, more than what they sense in themselves outside the water. They tend to feel more 'collected', more as a whole, or more complete. On the other hand, this results in being more aware of the water that envelops them. They are more aware of their skin, and thus of how they move. The more they are aware of the water space enveloping them, the less they feel hindered by the counter pressure of the water, and the more the hydrostatic pressure allows them to move smoothly; they move 'with' the water, instead of against it." (Scharstuhl, 2020a)

Additionally, the movement of the water contributes to the awareness of how they experience others in their water space. They experience the water physically and *inter-affectively* embedding them (see Figure 2). As a result, they get a better sense of where other people are in relation to themselves, and how they could attune themselves to others. We assume that this enhanced sense of FAR in water (or aquatic field of affective resonance) will help further the awareness of the FAR outside the water.

With the help of an interview group of experienced haptotherapy in water instructors, we formulated eight items that query FAR.

- *Interoception:* the degree to which you can feel the surrounding space
  - I can sense my skin
  - I feel a little skittish
- *Exteroception:* the degree to which you are attuned to the physical world outside yourself.
  - I can sense the space around me
- *Proprioception:* the degree to which you are aware of your position in space
  - I can sense the position of my body in this space
  - (I sense) I have clenched my jaws somewhat
- *Vicarious sensations:* the degree to which you are attuned to others in your peri-personal space.
  - I can sense where others are around me
  - I can sense how I can tune in to others

Constructing the questionnaire – base embodiment

Another point of attention in the basic instruction is invoking a feeling of being well-balanced physically, mentally, and emotionally. This experience of being well-balanced can invoke feelings of being at home with yourself, feeling secure, and being present in the moment.

According to haptotherapists, feeling well-balanced depends on how aware you are of the sub-abdominal and lower back area of your body, specifically the pelvic, iliac and hypogastric regions. We call this *base embodiment* (Figure 3).

Veldman, the founder of haptonomy, stresses the importance of *basic presence* for representing authenticity in relating to others. He describes it as expressing the way a person is present with the experience of the authentic fundamentals of one's being in the world.

> "Being present in one's basis can be observed in muscle tone that allows for a coordinated, effective and smooth pattern of moving. Feeling complete in one's base corresponds to a person feeling secure, open and aware of herself." (Veldman, Soler, 2013, p. 15)

Since this research tries to differentiate between sensory information and affect – to examine whether they are indeed linked – we use the term

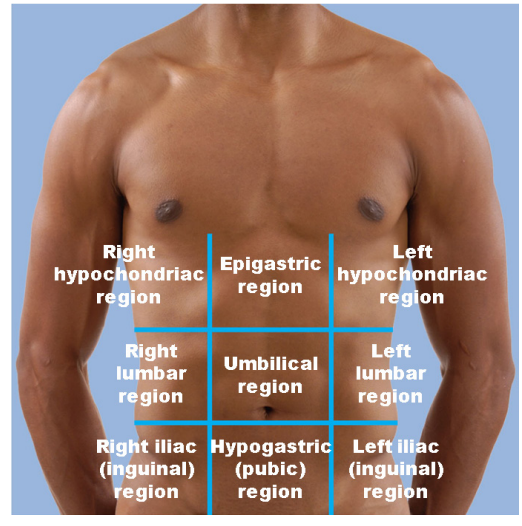

Figure 3: *Base embodiment through awareness of pelvic, iliac, and hypogastric regions*

base embodiment. We adhere to the technical definition of embodiment based on Niedenthal (2007): the perceptual, somatovisceral, and motoric experiencing of feelings, emotions, and actions.

In the basic guidance, helping clients become aware of how they embody their base consists largely in:

- Directing client awareness to the buoyancy of water
- Helping clients balance posture in water in such a way that clients are optimally aware of this area of their body
- Breathwork combined with movement from the lumbar regions

With the help of our interview group, we operationalized the notion of base embodiment by asking what it means to embody one's base. Subsequently, we compared our findings with those found in the literature.

The haptotherapists agreed about seven base embodiment characteristics that could be categorized into three dimensions, with seven questions to add to the questionnaire.

- *Support:* the degree to which you feels yourself, literally, supported
  - I feel close to myself
  - I can sense the chair / the earth supporting me
  - I am firmly standing on my legs
- *Movement:* the degree of moving smoothly, and as a whole
  - I am moving as a whole
  - I am moving smoothly
- *Interoception base:* the degree of awareness of one's physicality as a subject, and calm breathing
  - I am breathing calmly
  - I can sense my body (physical reactions) clearly

Methods

Participants

In this study, we focus on the effect of the basic sensory awareness and affect guidance. When a client engages in a water haptotherapy session, the therapist usually starts with a specific basic guidance. Mastering basic guidance is an important part of the curriculum a haptotherapist must complete to become competent in counseling in water. Both the first therapy session and the first module in the therapy curriculum are mainly dedicated to this basic guidance. Later sessions and modules generally begin with a shortened version of this guidance. We invited forty-two students from the Scholingscentrum voor Toegepaste Haptonomie in Water (STH Water) / School of Applied Haptonomy in Water to participate in this study. Students were at varying stages of training. Two students turned in incomplete questionnaires, which were excluded from the analysis.

The curriculum of the STH Water consists of six modules. The first module provides an extensive program on the basic guidance. Advanced modules follow human developmental phases of attachment and autonomy, providing some specific process work on these subjects. More extensive learning takes place in therapy sessions, and in applied collaborative learning within a network of therapists. However, the basic guidance is part of every course and learning session.

Sixteen students (40%) came from the first module, eight (20%) from the second, nine (22.5%) from the fifth module, and seven students (17.5%) from the learning network. Most students, 95% (38), were female, the mean age was 57.6 (SD = 6.26), and all had at least a degree in higher vocational education. All students were haptotherapists.

Instruments

We operationalized our key concepts by constructing a 33-item questionnaire consisting of seven-point Likert scales. The items were phrased as propositions. The Likert scales ranged from "I do not agree at all" to "I agree completely." The questionnaire was randomized, avoiding a response bias by placing questions belonging to a specific concept together. The questions were based on literature study wherever possible, and clinical observations, as described above. For clinical observations, we interviewed two very experienced and two beginning haptotherapy-in-water instructors, all of them experienced haptotherapists. For the actual questionnaire, please refer to the appendices.

Procedure

At the beginning of the course / learning session, students were asked to participate in a research study on haptotherapy in water. Students were asked to complete a questionnaire before and after a course / learning session. The researcher was not present during these courses / learning sessions. The questionnaire provided a short explanation stating the objective of the study in general terms, and how to complete the questionnaire. Age and level of education were asked, but not names. Students participated voluntarily, and received no reward for participating

Data Analysis

We used the open source and cross-platform JASP Team (2022) to conduct statistical analysis. Questions containing a negation were recoded before entering the statistical analysis.

For reliability analysis, we used Cronbach's Alpha, McDonald's Omega, and Guttman's Lambda-2. Although Cronbach's Alpha is quite commonly used in research, methodological literature criticizes it as a measure of reliability (Sijtsma, 2009; Crutzen & Peters, 2015; Mcneish, 2017). Therefore, we offer all three scales here.

We then used the paired samples t-test, which compares the mean values of two measurements, to examine the relationships between pre- and post-session values of the variables.

Consecutively, we used Spearman's correlations test to examine coherence within and between the two measurements, or, in other words, the link between awareness of sensory information and affect.

Results

Reliability

As we can see in Table 1, the reliability of the questionnaire was very good.

Hypothesized effect of haptotherapy in water

We hypothesized that the basic instruction of haptotherapy in water increases clients' vitality, positive existential feelings, base embodiment, and field of affective resonance.

To test this hypothesis, we first added up the values of the variables (answers to the questions) of each concept (or subscale) and compared pre- and post-session values:

We then used the paired samples t-test, which compares the mean values of two measurements, to examine the significance of the relationships between pre- and post-session values of the variables.

Table 2 shows the general tendency of the data. Table 3 shows that our tentative hypothesis appears confirmed.

Link between awareness of sensory information and affect

As we can see in Table 4, there is a strong positive, highly significant correlation between:

- Base Embodiment and Existential ($rS = 0.77$, $p < 0.001$);
- Base Embodiment-2 and Existential-2 ($rS = 0.812$, $p < 0.001$);
- Base Embodiment-2 and FAR-2 ($rS = 0.734$, $p < 0.001$).

Table 1. *Frequentist Scale Reliability Statistics*

Estimate	McDonald's ω	Cronbach's α	Guttman's $\lambda 2$
Point estimate	0.912	0.912	0.919
95% CI lower bound	0.873	0.864	0.872
95% CI upper bound	0.952	0.946	0.949

Note: Of the observations, pairwise complete cases were used. CI = confidence interval

Table 2. *Descriptives*

	N	*Mean*	*SD*	*SE*
Vitality	40	46.025	7.213	1.140
Vitality-2	40	54.200	7.680	1.214
Existential	40	45.375	6.997	1.106
Existential-2	40	54.000	5.542	0.876
Base embodiment	40	35.825	5.602	0.886
Base embodiment-2	40	43.725	3.883	0.614
FAR	40	38.075	4.281	0.677
FAR-2	40	45.175	3.734	0.590

There was a mediocre positive, strongly significant relationship between:

- Existential and Vitality ($rS = 0.664$, $p < 0.001$);
- Base Embodiment and Vitality ($rS = 0.505$, $p < 0.001$);
- FAR and Existential ($rS = 0.587$, $p < 0.001$);
- FAR and Base Embodiment ($rS = 0.587$, $p < 0.001$);
- Existential-2 and Vitality-2 ($rS = 0.648$, $p < 0.01$);
- Base Embodiment 2 and Vitality-2 ($rS = 0.559$, $p < 0.001$);
- FAR-2 and Existential-2 ($rS = 586$, $p < 0.001$).

There was a weak positive significant relationship between FAR and Vitality ($rS = 0.447$, $p = 0.004$) and between FAR-2 and Vitality-2 ($rS = 0.315$, $p = 0.048$). There are no significant correlations between the pre-and post-session values of the variables; the two measurements are clearly distinguished. This indicates that there indeed might be a relationship between sensing your body and experiencing affect, as is supposed in haptotherapy in water.

Discussion

Our aim with this study was to make the effect of haptotherapy in water researchable; does haptotherapy in water improve the capacity to feel – to expand sensory awareness – and to experience positive affect?

Our approach indeed seems promising. It seems to confirm that sensory awareness is linked to experiencing affect, one of the basic assumptions of haptotherapy and other body psychotherapy approaches, which is already confirmed in previous research (Ciofi, 1991; Kitayama, 1991; Mehling et al., 2009; Price & Hooven 2018; Linzarini et al., 2021). More specifically, it indicates that base embodiment and field of affective resonance are linked to feelings of vitality and positive existential affect. It also suggests that the basic instruction of haptotherapy in water helps ameliorate both affects. This is relevant to both haptotherapists and their clients. The better the haptotherapist's capacity to feel, the better they may help clients become aware of what they feel. If enhanced awareness of sensory information increases positive affect, clients may thus be more able to engage in processes of change (Fitzpatrick & Stalikas, 2008; Coombs, Jones, & Coleman, 2002).

However, it is too early to draw this conclusion, since the sample was too small to test the model contained in the questionnaire. Moreover, the results of this study may have been affected by some bias. Although the basic instruction is part of every course, the courses also differ from each other. We used a sample of convenience, instead of a random one. We constructed a questionnaire to operationalize specific ways of feeling and specific affects. The questionnaire turned out to be highly reliable, in relation to the sample of haptotherapists. Although we did not use specific jargon, haptotherapists are schooled to ask and answer questions about feeling and affect. Future research is necessary to investigate if the questionnaire is also reli-

Table 3. *Paired Samples T-Test: significant differences pre-test and post-session conditions*

Measure 1		Measure 2	*t*	*df*	*p*	*Mean*	*SE*	Cohen's *d*
Vitality	–	Vitality-2	−5.213	39	< .001	−8.175	1.568	−0.824
Existential	–	Existential-2	−6.320	39	< .001	−8.625	1.365	−0.999
Base embodiment	–	Base embodiment-2	−7.906	39	< .001	−7.900	0.999	−1.250
FAR	–	FAR-2	−7.189	39	< .001	−7.100	0.988	−1.137

Note: Student's t-test.

Table 4. *Spearman's Correlations: link between sensory awareness and affect*

Variable		Vitality	Existential	Base embodiment	FAR	Vitality-2	Existential-2	Base embodiment-2	FAR-2
1. Vitality	rS	—							
	p	—							
2. Existential	rS	0.664 ***	—						
	p	< .001	—						
3. Base embodiment	rS	0.505 ***	0.777 ***	—					
	p	< .001	< .001	—					
4. FAR	rS	0.447 **	0.558 ***	0.587 ***	—				
	p	0.004	< .001	< .001	—				
5. Vitality-2	rS	0.038	−5.179e4	−0.010	−0.062	—			
	p	0.818	0.997	0.953	0.703	—			
6. Existential-2	rS	−0.032	0.237	0.134	−0.117	0.648 ***	—		
	p	0.845	0.141	0.410	0.472	< .001	—		
7. Base embodiment-2	rS	0.125	0.288	0.202	−0.217	0.559 ***	0.812 ***	—	
	p	0.443	0.071	0.212	0.178	< .001	< .001	—	
8. FAR-2	rS	0.215	0.243	0.168	−0.120	0.315 *	0.586 ***	0.734 ***	—
	p	0.183	0.130	0.299	0.460	0.048	< .001	< .001	—

* $p < .05$, ** $p < .01$, *** $p < .001$; p = p-value, rS = Spearman's ρ

able in random (client) samples. Further research may show whether parts of the questionnaires can be used to guide clients in their awareness of base embodiment and field of affective resonance, and to assess treatment effect. Other body awareness questionnaires seem either too general for our purposes (Shields, Mallory, & Simon, 1989) or not adapted to specific capacities to feel, relevant to haptotherapy and haptotherapy in water (Mehling et al., 2009).

When we look at the outcome of the correlation analysis, the results seem almost perfect. The results may have been partially influenced by a combined recall and expectancy bias. The time between the first and second completion of the questionnaire was about four and a half hours on average. Students may have had some memory of how they had answered some of the questions earlier. However, since the instrument contained 33 questions, we expect this effect to be limited.

Nevertheless, we think we are justified to consider our approach adequate to use in an experimental design that allows us to compare the effects of the basic instruction of haptotherapy in water with the effect of other haptotherapeutic interventions, or of other activities in water. Further research should thus assess a causal relationship between haptotherapy in water, enhanced sensory awareness, and experiencing more positive affect. Also, it should assess whether this form of therapy contributes to a more lasting improvement of the capacity to feel, or the extent to which it brings about positive outcomes in the treatment of specific client groups.

■ ■ ■

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Appendix

Questionnaire water as affective medium (QWAM-22). In our research, the Dutch version was used.

1. I feel fit and am energized

|_____|_____|_____|_____|_____|_____|_____|

I do not agree at all I agree completely

2. I have faith in myself

|_____|_____|_____|_____|_____|_____|_____|

I do not agree at all I agree completely

3. I am moving as a whole

|_____|_____|_____|_____|_____|_____|_____|

I do not agree at all I agree completely

4. I can sense the space around me

|_____|_____|_____|_____|_____|_____|_____|

I do not agree at all I agree completely

5. I feel active and purposeful

|_____|_____|_____|_____|_____|_____|_____|

I do not agree at all I agree completely

6. I (now) feel involved in my surroundings

|_____|_____|_____|_____|_____|_____|_____|

I do not agree at all I agree completely

7. I am firmly standing on my legs

|_____|_____|_____|_____|_____|_____|_____|

I do not agree at all I agree completely

8. I suffer from pain or discomfort

|_____|_____|_____|_____|_____|_____|_____|

I do not agree at all I agree completely

9. I feel present

|_____|_____|_____|_____|_____|_____|_____|

I do not agree at all I agree completely

10. I feel close to myself

|_____|_____|_____|_____|_____|_____|_____|

I do not agree at all I agree completely

11. I can sense my skin

|_____|_____|_____|_____|_____|_____|_____|

I do not agree at all I agree completely

12. I feel I can take on the world

|_____|_____|_____|_____|_____|_____|_____|

I do not agree at all I agree completely

13. I am tired

|_____|_____|_____|_____|_____|_____|_____|

I do not agree at all I agree completely

14. I can sense where the others around me are

|_____|_____|_____|_____|_____|_____|_____|

I do not agree at all I agree completely

15. I feel a lot of space (openness, freedom) in myself

|_____|_____|_____|_____|_____|_____|_____|

I do not agree at all I agree completely

16. Next week I will immediately take on a new challenge

|_____|_____|_____|_____|_____|_____|_____|

I do not agree at all I agree completely

17. I feel at home in this company

|_____|_____|_____|_____|_____|_____|_____|

I do not agree at all I agree completely

18. I am breathing calmly

|_____|_____|_____|_____|_____|_____|_____|

I do not agree at all I agree completely

19. I feel a little skittish

|_____|_____|_____|_____|_____|_____|_____|

I do not agree at all I agree completely

20. I leave nothing to chance

|_____|_____|_____|_____|_____|_____|_____|

I do not agree at all I agree completely

21. I now feel that every experience in life will make me stronger

|_____|_____|_____|_____|_____|_____|_____|

I do not agree at all I agree completely

22. I am moving smoothly

|_____|_____|_____|_____|_____|_____|_____|

I do not agree at all I agree completely

23. I can sense the position of my body in this space

|_____|_____|_____|_____|_____|_____|_____|

I do not agree at all I agree completely

24. (I sense) I have clenched my jaws somewhat

|_____|_____|_____|_____|_____|_____|_____|

I do not agree at all I agree completely

25. I feel calm and relaxed

|_____|_____|_____|_____|_____|_____|_____|

I do not agree at all I agree completely

26. I feel lively

|_____|_____|_____|_____|_____|_____|_____|

I do not agree at all I agree completely

27. I can sense how I can tune in to others

|_____|_____|_____|_____|_____|_____|_____|

I do not agree at all I agree completely

28. I can sense the chair / the earth supporting me

|_____|_____|_____|_____|_____|_____|_____|

I do not agree at all I agree completely

29. I can sense my body (physical reactions) clearly

|_____|_____|_____|_____|_____|_____|_____|

I do not agree at all I agree completely

30. I wonder what the others will think of me

|_____|_____|_____|_____|_____|_____|_____|

I do not agree at all I agree completely

31. I feel good about myself and my life

|_____|_____|_____|_____|_____|_____|_____|

I do not agree at all I agree completely

32. I get energized by my plans for the future

|_____|_____|_____|_____|_____|_____|_____|

I do not agree at all I agree completely

33. I now feel I can handle unexpected events well

|_____|_____|_____|_____|_____|_____|_____|

I do not agree at all I agree completely

Polyvagal-Informed Therapeutic Drumming for Victims of Interpersonal Violence

A Feasibility Study

Jessica Hoggle, Debra Nelson-Gardell, Nancy Rubin

ABSTRACT

The inclusion of therapeutic modalities for trauma survivors that integrate the brain, mind, and body is essential for addressing the range of physiological responses and symptoms caused by interpersonal violence (van der Kolk, 2014). Neglecting to include the body in therapy leaves out an essential component necessary for healing. The polyvagal theory helps explain the physiological responses to trauma from the perspectives of biology and neuroscience (Porges, 2018). An emerging method used as a therapeutic tool has been the incorporation of rhythm and drumming. This intervention integrated concepts from polyvagal theory into therapeutic drumming exercises, such as exploring the different nervous system states through sound and rhythm. Therapy clients were invited to participate in five individual therapy sessions incorporating rhythm and drumming, with the final session using drumming to create the client's trauma story. Participants were then interviewed about their experiences, and the recorded interviews were transcribed and coded for thematic analysis. Five main themes emerged from the interviews: connecting with sound, insights gained, sense of agency, sense of safety, and social connection. As an initial feasibility study, this project's aim was to discover what participants liked and gained from the drumming sessions. All participants mentioned movement from a sense of isolation to a sense of connection. The drumming sessions also offered a creative and safe outlet for expressing difficult emotions and memories that may otherwise be too difficult to discuss using words.

Keywords: trauma, rhythm, drumming, polyvagal, feasibility study

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> ***... rhythm can be seen as a co-facilitator within therapy.***

The inclusion of therapeutic modalities for trauma survivors that integrate the brain, mind, and body is essential for addressing the range of physiological responses and symptoms caused by interpersonal violence (van der Kolk, 2014). Neglecting to include the body in therapy leaves out an essential component necessary for healing. The polyvagal theory helps explain the physiological responses to trauma from the perspectives of biology and neuroscience (Porges, 2018). Stephen Porges used this theory to explain the nervous system's three states as a reaction to perceived threat:

dorsal vagal (shutdown), sympathetic (fight/flight), and ventral vagal (safety and connection). While this perspective has been useful in helping to normalize the reactions of trauma survivors, therapists specializing in trauma have used it in countless ways to help clients feel safer with themselves and when interacting with others (Dana & Grant, 2018). Polyvagal-informed therapists have used various modalities to help traumatized individuals reconnect to their bodies and re-establish feelings of safety with others, including yoga, music, and dance (Gray, 2018; Ogden, 2018). An emerging method used as a therapeutic tool has been the incorporation of rhythm and drumming. Research studies involving drumming interventions have found many positive impacts, including enhanced immune system responses, decreased stress-related arousal, and increased feelings of empowerment and connection to others (Bittman et al., 2001; Fancourt et al., 2016; MacIntosh, 2003; Pelletier, 2004).

Building on previous research, the intervention described in this paper integrated concepts from polyvagal theory into therapeutic drumming exercises, such as exploring the different nervous system states through sound and rhythm. Therapy clients were invited to participate in five individual therapy sessions incorporating rhythm and drumming. Topics included safety, boundaries, exploring fear and anger, strengths, as well as drumming through their trauma narrative and their healing journey. Participants were then interviewed about their experiences, and the recorded interviews were transcribed and coded for thematic analysis.

Trauma's effects on the brain and body

To understand the importance of involving the body in trauma-focused therapy, it is first essential to understand some of trauma's impacts. Survivors of trauma, specifically due to sexual assault, often have a constellation of symptoms, many of which are physiological and have major impacts on the body. One study examined a population of college females, and found that those with a history of trauma had more difficulty regulating their nervous systems and engaging with others, leading to physiological symptoms such as heart rate irregularities (Dale, et al., 2018). The very nature of interpersonal violence is a violation against one's own body, and many survivors experience a disconnect between the body and mind (Levine, 1997). Because of the physiological responses and symptoms related to trauma, it is essential to implement holistic treatments that integrate the whole person, including the brain, mind, and body.

Re-establishing feelings of balance and stability are essential in order to recover a sense of safety that is compromised after trauma. In *The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma* (2014), van der Kolk discusses the role of the brain's amygdala as the essential component for distinguishing situations as either safe or dangerous. This area of the brain is also responsible for processing emotions, and is activated when trauma survivors see, hear, or smell a stimulus that reminds them of their trauma – even years later when the danger has passed (van der Kolk, 2014). Sounding an internal alarm, the amygdala decides whether or not something is a threat even before we become conscious of danger. The sympathetic nervous system is activated, leading to a rise in blood pressure and heart rate. What originated as a survival response becomes maladaptive for those who have experienced trauma, as the nervous system signals a threat even when the danger has long passed. Because interpersonal trauma is often perpetrated by someone known or even trusted by the victim, other relationships can become distorted, resulting in survivors having immense difficulty engaging in these relationships, and leading to worsening isolation and shame.

Survivors of trauma are left feeling disconnected not only from others, but can often also feel disconnected from themselves, including feeling numb or disengaged from activities (Levine, 1997). Developing a sense of connectedness to their own bodies can be a powerful step to manage the overwhelming emotions that accompany trauma. Because of the connection between body and mind, emotions are often experienced as intense physical sensations (van der Kolk, 2014). For example, anxiety may be experienced as sweaty palms or a racing heart, embarrassment as a flushed face, and anger as a clenched jaw and fists. Levine's (2015) book *Trauma and Memory* contains a diagram of different bodies representing different emotions, in which scientists have "mapped" where in the body a certain emotion is felt. This is a helpful illustration of how trauma and its resulting emotions are quite literally held in the body. Since trau-

ma is stored in the body, neglecting to address its physiological effects on survivors will ultimately leave many aspects of the trauma untreated. Healing can take place only when individuals are able to feel safe in their own bodies, rather than operating from a constant fear of impending danger.

Drumming as a therapeutic intervention

Interest is growing surrounding the use of body-oriented approaches in the treatment of trauma. Drumming has been studied in various populations as a modality to connect the body and mind (MacIntosh, 2003). The approach of using therapeutic drumming as a complement to talk therapy may serve to supplement more cognitive or dialectical methods by including the body as an essential component within treatment. This review will explore the potential benefits of drumming relevant to trauma recovery, including establishing a sense of connection, safety, and empowerment.

The body's response to music

Research has shown that music not only has the power to elicit an emotional response, but it can also have positive biological effects on the body. In a meta-analysis of 22 quantitative studies examining the effects of music on the body, a statistically significant decrease in stress-related arousal was found for those who participated in music therapy activities (Pelletier, 2004). Further studies have specifically examined the biological impact of drumming, including enhanced immune system and anti-inflammatory responses (Bittman et al., 2001; Fancourt et al., 2016). These studies highlight the positive health benefits of drumming, and the potential for drumming interventions to affect biological processes within the body. Although further research is needed in this specific area, these results have implications for treating physiological symptoms related to the trauma of interpersonal violence.

Research on group drumming

As an emerging field, current research studies examining the affective impacts of music therapy or therapeutic drumming tend to involve a relatively small number of participants for pilot studies. Because of the often unique and personal impact that music and drumming can have on an individual, most researchers studying therapeutic drumming have used a qualitative approach to capture a more in-depth understanding of participant's experiences. Findings from group drumming studies included significant decreases in anxiety, feeling more connected with others in the group, fostering feelings of belonging and safety, and feeling more supported in the learning process (Bensimon, Amir, and Wolf, 2008; Deraney et al., 2017; Perkins et al., 2016; Plastow et al., 2018). Developing a sense of connectedness rather than isolation can be particularly important for victims of trauma, who often feel isolated and alone (van der Kolk, 2014).

Because trauma is processed in nonverbal areas of the brain, using words to describe the emotions and effects of a traumatic event can be very difficult for survivors (van der Kolk, 2014). Interventions involving music can facilitate the healing process by allowing survivors to convey experiences that words cannot express. MacIntosh (2003) discussed the effects that various music interventions can have on sexual assault survivors. She has explored the impact of music and developed interventions specifically for sexual assault survivors termed "music and healing workshops." In a group setting, survivors are first taught grounding and relaxation techniques, including the use of their own voices to pick a tone in which to musically ground themselves. They are then invited to share their favorite song or piece of music, as well as the emotions felt when listening to it. Additionally, MacIntosh integrated drumming circles and other rhythmic exercises into the workshops. Even without words, communication took place from one drum to another, and rhythm was used to express emotions such as anger, fear, vulnerability, or sadness (MacIntosh, 2003). While these emotions can be difficult for victims to express in words, drumming can allow a safe space for these emotions to be heard and felt.

Trauma and polyvagal theory

A theory that has been studied and applied to trauma therapy is polyvagal theory. It describes the three "systems" of the autonomic nervous system that are essential for survival: the dorsal vagal complex (collapse/freeze response or immobilization), the sympathetic nervous system (fight/flight response or mobilization), and the evolutionarily newest ventral vagal system, which Porges has also named the social engagement sys-

tem (Porges, 2018). When potential danger is detected, the body's defense system responds in one of two ways. It can be mobilized to take action via the sympathetic nervous system, or, in an attempt to conserve energy, or when the fight/flight response is unconsciously deemed ineffective, the dorsal vagal complex responds by shutting down, freezing, or even by playing dead (Porges, 2018). The higher-level survival system, via the ventral vagus nerve, was developed as the social engagement system in mammals. This shows how social engagement and interaction are necessary not only for mammals to survive, but also to thrive as a species. Importantly, this pathway connects the brainstem to muscles associated with the face and heart, giving mammals the ability to communicate safety through mechanisms such as eye contact, smiling, and voice intonation, as well as the ability to co-regulate with others (Porges, 2018).

Applications of polyvagal theory

The polyvagal theory has been applied specifically to interventions incorporating music. Dr. Deveraux (2017) describes Stephen Porges insights into the effects that music can have on one's physiological state, noting that listening to calming music can activate a sense of safety. Porges also discussed drumming circles as an intervention that combines the physiological effects of music with spontaneous social engagement. According to Deveraux, features such as rhythm, tone, and frequency of sounds can support both a sense of internal safety and connection to others. Establishing a sense of safety between client and therapist is a central component of therapeutic methods applying polyvagal theory. Polyvagal therapist Bonnie Badenoch (2018) emphasized the importance of safety in re-establishing a sense of trust and interpersonal connection with clients by titling her chapter, "Safety *is* the Treatment." She notes that if a sense of safety is not fostered within the client's body, and between the therapist and client, progress will be significantly hindered.

Rhythm itself can encourage connection, and bring the social engagement system online. Dance and movement therapist Amber Gray (2017) has incorporated rhythm and movement into treatment for trauma victims, and used a polyvagal perspective to show how the social engagement system is activated. Polyvagal-informed dance movement therapy (DMT) has been used with the most traumatized individuals in helping them express what they could not through words, assisting in reorienting them to their bodies (Gray, 2018). One goal of this approach is to use movement and rhythm as resources to move more flexibly between the different physiological states, rather than becoming stuck in hyper- or hypoarousal (Gray, 2017). In a case study working with a victim of torture, rhythm and movement helped the client progress from a state of complete shutdown, isolation, and dissociation to becoming more open physically, and more able to verbalize her experience (Gray, 2018). Through this approach, clients can discover their inherent right to take up space and use their "voice" through movement, sound, or rhythm when they may otherwise feel unsafe to speak.

Gray (2017) suggests that drumming can be both a tool that may feel safer than dance or body movement for clients who have experienced an assault on their body, as well as a means to enhance the social engagement system. The use of various call-and-response techniques in drumming can be used to engage clients and develop the therapeutic relationship, such as the therapist or facilitator drumming a simple rhythm, and the client responding with the same or a complementary beat. In this sense, rhythm can be seen as a co-facilitator within therapy.

Intervention development

For this intervention, techniques were chosen based on various polyvagal-informed exercises, as well as the Rhythm 2 Recovery Model (Faulkner, 2017). Based out of Australia, Rhythm 2 Recovery is evidence-based, cited by various researchers for its use in the practice setting, and boasts that over 4,000 professionals have received training in the model (Faulkner, Wood, Ivery, & Donovan, 2012; Martin & Wood, 2017; Wood & Faulkner, 2014). It combines principles of evidence-based therapy methods with strategic drumming exercises focusing on specific themes, such as identifying strengths, clarifying values, or overcoming adversity. Key components of rhythm and reflection allow for creative expression using drums or other rhythm instruments, as well as thoughtful reflection and application of the exercises (Faulkner, 2017). In his work with trauma survivors, Faulkner discusses the critical element of creating a sense of safety for the participants. As with other modalities of trauma work, if victims do not feel safe, then

the intervention will not be effective, no matter how intricate or well-planned it may be. Related to safety is comfort in engaging with difficult feelings. Faulkner discusses the role that drums can have in facilitating a "discussion" without using words. If talking about how an experience felt proves to be too difficult, participants can instead play how they felt, or how they would imagine the feeling would sound. This can be a less threatening way for survivors of trauma to begin to reconnect and re-engage with intense emotions. Core concepts from the Rhythm 2 Recovery Model, including safety and connection, were adapted for this intervention. However, the actual activities and exercises differed in order to take a more polyvagal-informed approach. Additionally, while Rhythm 2 Recovery often uses a group drumming format, this intervention utilized individual sessions with the client and therapist. Although some of the benefits of a group may be lost, such as connecting with other survivors of trauma, an individual model was chosen due to the ability to focus more on each client's specific needs and issues, as well as the ability to tailor each session to that individual. Five drumming sessions were conducted with each client, using a specific theme for each session (see Table A for an overview of sessions and objectives). Discussion and feedback took place after each activity, and related specifically to the client's own trauma. Exercises such as playing a steady "grounding" rhythm were used at the end of each session, as well as a closing discussion to ensure the client felt safe leaving the session.

Methodology

Sample

The first author of this manuscript worked as a therapist at a university counseling center at the time of the research. Their client load served as the source of the sample for this study. Clients initiated contact with this particular counseling center because of a history of trauma related to interpersonal violence. This circumstance made them suitable for the study. Relying on purposive sampling, inclusion criteria required participants to be students, faculty, or staff members of the institution or its affiliates, and to have been victims of interpersonal violence, including sexual assault, dating or domestic violence, stalking, sexual harassment, or adult survivors of childhood abuse. Clients of all genders and gender identities were eligible. Exclusion criteria included having an arrest or criminal charge related to any form of interpersonal violence, or having been found responsible for a sexual assault or harassment-related violation in a Title IX investigation.

Based on research detailed below, it was expected that six to ten participants would be sufficient for this study. This range allowed for both saturation and feasibility. As used in qualitative studies, saturation describes "the point in data collection and analysis when new incoming data produces little or no new information to address the research question" (Guest et al., 2020, p. 2). Several researchers who have relied on qualitative interviews for their data collection have found that the majority of new information had been discovered within the first six to ten interviews (Morgan et al., 2002; Guest et al., 2006; Francis et al., 2010). Therefore, fewer than six participants for this study would likely have been insufficient to generate significant and meaningful data for a thematic analysis. Consistent with this number, Guetterman (2015) discussed differences in sample size needed depending on the methodology used, and determined that as few as six could be adequate for a phenomenological approach examining participant experiences. Additionally, more than 10 participants would likely not be feasible due to time constraints and limitations within the agency, including the time required for the researcher to transcribe each interview and code the data. A total of nine participants were initially recruited, with one dropping out.

Procedures

Before any participants were recruited for the study, Institutional Review Board (IRB) approval was obtained. The administrative assistant of the counseling center in which clients were recruited gave clients the recruitment flyer and told them that if they were interested, they could inform the researcher at their therapy appointment. In order for any further recruitment efforts to take place, the client had to initiate the conversation about study participation in order to avoid even the appearance of possible coercion. Once clients expressed interest in the study during their therapy session, the researcher engaged them in the informed consent process before starting the intervention. Potential participants were given a handout with a brief description of the drumming sessions as part of the

informed consent process before agreeing to participate. As mentioned previously, this study involved the integration of drumming activities into five individual therapy sessions between the participant and researcher. Each session focused on a different theme, culminating with the participant's use of rhythm to tell their trauma experience.

Interview protocol

This study used a feasibility approach (Bowen et al., 2009) to determine the general practicality of the intervention's use, as well as the perceived acceptability and benefits gained by participants. Feasibility studies are often conducted as an initial tactic to determine whether a research project is suitable for future more rigorous research. Various methods of evaluation can support feasibility studies in answering the question "Can it work?" (Bowen et al., 2009). To help answer this question, individual interviews took place with each participant after the five drumming sessions were completed. Interviews lasted between 45-60 minutes and were audio-recorded for transcription. They were semi-structured in nature, and largely guided by the participant's responses. Consistent with the protocol for a feasibility study, participants were guided through the five session exercises, and asked about their experiences in each one. They were also asked about their thought process in choosing which instruments to play, which sounds they chose the therapist to play, and significant rhythms that they developed. Finally, participants were asked about what specific aspects or sessions they benefited from the most, and what they would have liked to see changed. The researcher asked clarifying questions throughout the interview to ensure accurate interpretation of participant accounts. Through this interview method, participants stories were told of their experience with the intervention.

Data analysis

Thematic analysis of transcribed interviews and coding of responses was conducted using a phenomenological approach. This approach is often used in social research to describe the lived experiences as told by the individuals themselves, and aims to portray the perspectives of participants as closely as possible (Denscombe, 2017). Because drumming is a uniquely individual experience, participants who complete the same intervention may come away with different perceptions and impacts. In fact, phenomenology has been applied in several studies involving drumming and music interventions for well-being (Dingle et al., 2012; Perkins et al., 2016; Perkins & Williamson, 2014). Consistent with this methodology, open coding of transcripts allowed for the reality of participant experiences to come through, rather than the researcher relying on their own preconceptions of what might be found. Denscombe (2017) describes the necessity in phenomenology to suspend one's own beliefs about what might be found in order to provide a more accurate and "pure" description of participants' encounters with the intervention. This suspension of beliefs is accomplished by the researcher first acknowledging their own internal biases about the results hoped for, and approaching the interviews without any presumptions of participant responses. The researcher coded participant responses with the use of Nvivo 12, and conducted a thematic analysis to convey the recurring themes and sub-themes generated by the participant interviews. This process of thematic analysis was developed by Braun & Clarke (2008) to provide clear methodological guidance. With the assistance of Nvivo 12, visual representations of the data, such as a word cloud, were used in addition to reporting on themes. A report of the data that emerged from the interviews assisted in exploring the feasibility and acceptability of the study.

Positionality

The three authors of this manuscript engaged with the study in various ways. The first author served as the principal investigator, and it was their clients who served as potential study participants. That author engaged with the analysis first, with the second and third authors contributing to analysis and meaning-making, as well as providing guidance in the overall development of the project and knowledge surrounding polyvagal theory.

First author positionality: I first experienced my own incident of interpersonal violence early in my undergraduate career, which was also the initial catalyst for me to invest my time in sexual and domestic violence as a social justice issue. I first volunteered as a victim advocate at a local rape crisis center. Then, while obtaining my Master's degree in social work, I obtained a part-time job as a sexual assault counselor within a grant-funded community agency. These experiences ultimate-

ly helped in progressing my career to becoming a Licensed Independent Clinical Social Worker at the counseling center where this intervention took place with my clients. Additionally, although I have never been a drummer, I grew up with a love for music, and played violin and piano. The intersection of my personal and professional experiences with interpersonal violence, along with my musical background and passion for rhythm, ultimately helped shape my views of this project.

Second author positionality: I am a seasoned clinician and research-focused scholar with experience in psychotherapy with individuals whose histories include exposure to emotionally traumatic experiences, especially experiences with interpersonal violence. As such, I brought my theoretical awareness associated with attachment theory, systems theory, and polyvagal theory. I began reading and considering the topic of neuroscience in relation to social work practice a number of years ago. Trained in various trauma-specific techniques of psychotherapeutic intervention, including EMDR, along with my personal experiences of having participated in drumming activities in the past, I saw the potential value of the intervention when the project's first author and originator brought it to my attention. My research background includes projects using quantitative, qualitative, and mixed-methods approaches.

Third author positionality: Very early in my professional career as a clinical psychologist, I became aware of the extremely negative impact of the broad range of childhood trauma on my clients. As a recently minted psychologist in 1990, the interventions I had learned were lacking in effectiveness for my clients with the most complex problems. Intrigued and hopeful, I pursued EMDR training. Immensely helpful, but not a panacea, this was the beginning of my exploration, education, and training in what has come to be known as trauma-informed care. Integrating theoretical models such as EMDR, hypnosis, Internal Family Systems, Emotional Freedom Technique/Tapping, and the polyvagal theory with vigilance for dissociation has been crucial to my work. When I learned of drumming and trauma processing, it made sense, particularly given the alternative bilateral stimulation aspect of EMDR and tapping, and the understanding that trauma is stored in the body. When I was asked to join this dissertation project, I was intrigued and very happy to participate.

Trustworthiness / rigor

Credibility was first established by engaging in reflexivity within the memoing process, as well as self-reflection on personal biases that may be present in the study. For example, since the researcher was also the therapist conducting the therapy sessions with participants, there was the potential to seek out or encourage responses that would yield positive results for the research. By being mindful and maintaining active awareness of potential biases, credibility was increased. Additionally, during participant interviews, the researcher engaged participants and asked clarifying questions to ensure their statements were being accurately captured. As previously discussed, using a phenomenological approach in this study allowed the researcher to take a "backseat" to the participants' voices, allowing their stories to be told. Finally, a discussion in this paper of how findings relate to the broader shared human experience contributes to the element of transferability. Although not generalizable in the customarily understood sense due to the size and scope of the study, the findings of this research may be useful for other populations or in similar settings.

Results

Five main themes were generated, along with several sub-themes under each theme. See Table B for a complete listing of each theme and sub-theme. Due to space limitations, only one sub-theme for each main theme was chosen for discussion below. Pseudonyms were used for client names to protect their identity. Participant quotes were placed in italics to highlight their importance as the primary source of results.

Theme 1: Connecting with sound

Due to the nature of the intervention involving experimenting with different rhythms and sounds, it was unsurprising that all eight participants discussed the various ways they connected emotionally to different sounds. Many participants highlighted specific instruments that they connected more to, or that reminded them of specific memories in their lives.

Processing difficult emotions

Participants mentioned the ways that sound and rhythm served as a useful tool in processing emo-

tions that may be too difficult to discuss or process verbally. This finding is supported by research discussed previously, indicating that verbal processing of trauma may be more difficult for survivors due to trauma's impact on the brain (van der Kolk, 2014). Georgia specifically discussed the ways that the instruments helped in exploring feelings of anger: *"You know rain is symbolic of rebirth and growth and stuff like that, and it felt like, that is very comforting, to come out of anger and into a cool place of growth. And that is so helpful with the people I love and trust to see me angry now, that I know that they will be that place for me. It felt cool to be able to voice that, and know that that was happening. It's like doing the thing helps you to realize the feeling, and then you get to talk about the feeling, and then you realize the feeling and it goes back and forth."*

Theme 2: Insights gained

Participants spoke about general insights they gained through the intervention. Some of these insights occurred in the context of the actual drumming, while others happened later when participants processed the experience on their own, or even during the interview. Insights were divided into those related to the participants' sense of self, and those related to their trauma.

Insights related to trauma

One set of insights that participants discussed related directly to how they viewed their own trauma. Of particular interest were the ways that participants mentioned that the drumming helped to facilitate a process of giving themselves permission to feel certain emotions related to their trauma. Blaze stated: *"I remember especially feeling at the end, the word activated, definitely fair. And I remember playing the drum was the first time that I let myself be angry about the situation or like I had called a feeling I was feeling anger, but hadn't actually been, 'I want to externalize this emotional force.' And I remember how pleasant it was, in the aftermath of having done that, of being, 'Wow, hitting a drum feels great.'"*

Theme 3: Sense of agency

Many participants discussed the ways that the sessions helped them develop a sense of agency or empowerment with themselves. This theme was further divided into three sub-themes related to agency: agency after experiencing trauma, agency over the decisions they made in the sessions, and having a sense of ownership of their feelings.

Ownership of feelings

Related to agency and control, participants discussed how the intervention allowed them the space to own their feelings. This points to the process of allowing oneself to feel strong emotions that may have been cut off after trauma. Georgia discussed her process of owning her feelings within the larger context of rhythm: *"Making up the pattern, the beat, the rhythm, the melody for this, was hard, but it was relying back on what I felt, and what I thought, and the kind of rhythms that already exist within being an alive human being. Like a heartbeat, or running, or stuff like that. I think that it was very much like that falling back on myself for those things, that I didn't have to use my head to divine some beautiful creative artistic thing. That it could just be me, what I felt."* This thought also explores the related sense of taking ownership of drumming as a deeply creative experience, and the freedom that comes with allowing oneself to turn inwardly and rely on intuition, rather than solely on reason or rational thought.

Theme 4: Sense of safety

Arguably the most important theme related to participants' feelings of safety. As mentioned before, if survivors of trauma do not feel safe while in therapy, making progress will be much more difficult. Several sub-themes emerged related to safety, which most participants discussed in some way.

Safety in processing trauma memories

Although "Processing Trauma Memories" was listed as a sub-theme under "Connecting with Sound," a distinguishably different sub-theme emerged related to participants feeling safe in sharing, processing, and confronting trauma memories. Katie shared some of her experiences with safety through the intervention, as well as in processing certain aspects of how she responded during one of her assaults: *"So when we talk to the deeper stuff that was probably scarier and harder to talk about, unlike if we were just doing talk therapy, I was able to connect with it more because I felt safer. I had control and there was someone else with me, so if I felt overwhelmed, I could stop. And it was in a controlled environment. I've had issues with, when one of the assaults happened, I couldn't move. And there*

was that catatonic, like not being able to move and it seemed like it always bothered me, and then we started talking about, that's a normal response. And then how it feels and venturing into that scariness, but in a safer place where I don't feel that. And in doing so, it made me feel less responsible for having done it, for that happening. I guess, because it's not something that I could control and being able to explore it again in a safer environment, but not through words."

Theme 5: Social connection

A final theme that appeared relates to the social connection that occurred throughout the sessions. Music has often been described as a social experience, and interpersonal violence can frequently leave survivors feeling isolated, though craving connection. Throughout the interviews, participants described how they felt connected to others in their personal lives, as well as a sense of connection between participant and therapist.

Connection with therapist

Researchers have shown the ways that music and rhythm can facilitate a genuine connection between those participating (Devereaux, 2017). Several participants discussed their feelings of connection within the therapeutic relationship, and their ability to discuss things in the context of drumming that they would not have otherwise. Blaze also spoke about the playfulness that occurred between themselves and the therapist while drumming: *"It's a little bit like when you feel silly dancing, and then you dance, and then it's fun, or like roller skating or bowling. They're these things that feel like there's a jumping-off you have to do into the activity, and then once you're in it, it is fun, and it is nice, and it is cool. And then I think afterwards the feeling was simply, it's called playing drums for a reason. And it felt like I had played, even if we were talking about difficult things. Even though we went deep, I felt like I got to work through it. I didn't feel like I was carrying baggage into the rest of my day."*

Making meaning

Once all the themes were gathered from participant interviews, a visual tool helped in connecting the themes and responses. A word cloud was created using Nvivo 12, which searched the word frequency of nodes (themes) created, and set to the grouping of "specializations," so that it looked for words with similar meaning, creating the words in the cloud. In examining the word cloud, several words stand out that help make meaning of participants' experiences. The more predominant words such as "change," "going," and "activated" signify some type of movement that took place within the sessions. These words highlight participants' awareness of the progress they were able to make through the drumming sessions. The fact that "change" is the largest word in the cloud is significant, as participants identified changes they noticed in themselves as a result of the intervention. Perhaps an over-arching theme emerging from the findings is the change and movement from isolation to connection that participants felt by drumming. This sense of connection may be experienced both as internal connection with themselves and their bodies, and external connection to other people. While these experiences may be felt very differently among individuals and can take on different meanings, previous research has already demonstrated the impact that music and rhythm have on connecting humans to each other (MacIntosh, 2003; Pelletier, 2004; Bittman et al., 2001; Fancourt et al., 2016). This sense of movement may also be experienced as the participants' ability to move *through* their trauma, not just talking around it. As previously mentioned in the results section, several participants noticed a distinguishable difference in what they were able to process, share, and feel with the addition of rhythm that they were not able to experience before in talk therapy. This further reinforces the usefulness of music and rhythm to facilitate discussion without using words.

Discussion

Within the discussion section, we first provide an overview of the project's results, giving meaning to the findings. We then connect this project and its findings to previous research discussed in the literature review, as well as the findings' connection to polyvagal theory. We then discuss some of the project's limitations, and provide some personal reflections engaging with this project. Finally, implications for future research will be discussed.

Discussion of project findings

In taking a phenomenological approach, the themes found were used to tell the story of the participants' experience. Even with only eight par-

ticipants, they all discussed ways in which adding drums and rhythm in the therapeutic space was a beneficial tool within talk therapy. As mentioned in the results section, several participants spoke to the ways that they found the medium of rhythm to be more helpful than talk therapy alone in creating a safe space to process trauma. This finding is supported by previous research indicating that, for some individuals, talk therapy on its own may not be sufficient in addressing deep trauma wounds, due to trauma being stored in nonverbal areas of the brain (van der Kolk, 2014). While each participant had different comfort levels and experiences with music, even those with little or no prior experience mentioned the benefits of trying something new, getting out of their comfort zone, and allowing themselves to be creative. A few participants who seemed somewhat hesitant in the beginning, and unsure of how or what to play, were able to "tap in" to their creative selves throughout the course of the sessions. Several participants spoke to this element of creativity, which supports Amir's (2004) previous findings on improvisational music therapy and its ability to assist survivors of childhood trauma in processing unresolved memories. In one interview, Georgia discussed this aspect of creativity, along with the freedom that it brings: *"I'm a creative person in the sense that I can create knitting or crochet or something like that, but it feels less artistic. But this is a thing that I thought would be very artistic, that ended up being whatever I wanted it to be. So being able to have the physical thing, and kind of think of the tether of, this is knitting, or this is crocheting, the physical aspect of… I can put myself into the instrument. It was very cool, to channel the emotions."*

Another aspect of importance within the intervention was the sense of "lightening" that it brought to therapy. Talking about one's deep traumas can be tremendously difficult and takes incredible vulnerability, courage, and bravery. Having the instruments in the room served as a metaphorical and physical vessel for holding heavy and dark memories and emotions. In fact, one exercise in the intervention invited participants to use the drums as a container for their fears related to their trauma, and imagining themselves placing their fears into the drum with every beat. Having a physical space to hold intense feelings could be a very useful and important addition within trauma therapy. Additionally, this lightening was seen throughout the sessions in the form of play. As reflected in the subtheme of "Freedom to Experiment," participants recognized that there was no right or wrong way to play, which took some pressure off their musical abilities. This degree of expression and freedom may not otherwise exist in traditional talk therapy. This also gives room to explore intense memories and emotions in a way that feels less threatening or dangerous. Talk therapy, especially when trauma enters the room, can often be thought of as heavy and serious. This project demonstrated that it does not necessarily have to be either of those in order to make progress.

Relationship to previous research

Several of the themes and sub-themes that were found in this project share similarities to previous studies mentioned in the literature review. Most notably, Faulkner's (2017) Rhythm2Recovery model stresses the component of emotional safety when engaging in rhythm exercises, as well as rhythm's ability to encourage difficult discussion and communication without words. This model's ability to facilitate participant comfort in sharing intense memories and feelings is echoed in this project.

The theme of social connection is also supported by previous research. MacIntosh's (2003) "music and healing workshops" facilitated increased connection and empathy among participants in group drumming circles. Several other researchers have studied drumming circles among various populations, and their ability to encourage connection and decrease participants' sense of isolation (Bensimon, Amir, & Wolf, 2008; Mungas & Silverman, 2014; Perkins et al., 2016). Although this project used an individual rather than a group therapy approach, several participants reflected on improvements they noticed within their personal relationships, as well as their connection with the therapist.

Connection to polyvagal theory

In addition to the aspect of social connection, this project supported other aspects of polyvagal theory. As previously mentioned, most participants discussed some aspect of safety within the project, both in being free to experiment and play, as well as safety in sharing and processing deep trauma wounds. This element of safety is a central com-

ponent of polyvagal theory. The social engagement system allows humans to connect and thrive as a species, and it can be engaged only within the context of safety (Porges, 2018). When any type of danger is detected, whether real or perceived, feeling safe becomes much more difficult, particularly in the therapy room when vulnerability is often required. Several polyvagal-informed therapists have discussed the use of other creative modalities to re-establish a sense of safety in traumatized individuals, including dance, yoga, and tapping (Gray, 2018; Ogden, 2018). As this intervention shows, rhythm may be another intervention that can facilitate a sense of safety.

Limitations

One limitation related to the research was that the researcher in charge of project design and data analysis was also the therapist conducting the actual project implementation with participants. Therefore, the risk of researcher bias was present due to the potential to seek only "favorable" results. Attempts were made in taking a phenomenological approach to have participants' voices come through, rather than the researcher's own thoughts or opinions. Additionally, as an initial feasibility study, the research questions were more open-ended as a way of seeking what was useful and helpful about the study. A further related limitation was that the researcher was the sole individual who analyzed the transcribed interviews for coding. Due to time constraints, efforts to recruit additional researchers for this task were foregone. However, further studies may be strengthened by having at least two individuals code results, which could then be compared and/or contrasted.

Researcher reflections

As a therapist experienced in treating trauma, all the participants in this study were already established clients of the primary researcher's, some of whom they had worked with for several years before engaging in the project. Therefore, a level of trust and rapport had already been built with clients before they agreed to participate in this project. Due to the level of trust required for trauma survivors to try something brand new in therapy, this project may not have worked as well if it had been conducted with clients who did not have a therapeutic relationship already established with the therapist. Additionally, because the clients had already engaged in some type of trauma therapy before starting the research project, various lengths of time had passed since their traumas had occurred. This study may have yielded different results if done with clients who were brand new to any type of therapy, or whose trauma was very recent.

An additional reflection takes into account the issues that may arise from being both a research and clinically-focused intervention. This intervention, as with any type of therapy, is not a panacea, and may not be suitable for some clients, or at all times in a client's journey. Clients' own mental stability should be considered in regards to their ability to engage in the project. During the second session with one participant who started the study, it was mutually agreed that it would not be in her best interest to continue due to a change in mental health needs that overshadowed the importance of completing the project. Therefore, ethical issues may arise with participants' needs, and their mental and emotional well-being must trump any desire the researcher or clinician may have to continue the study with all participants who started the intervention.

Implications for future research

As a feasibility study, this project laid a solid foundation for future more rigorous studies. Strategies to strengthen future studies could include engaging in member checking after the interviews are coded to ensure their responses were accurately reflected in the results. Utilizing a mixed-methods approach would be useful in gathering more data to analyze, such as adding a short questionnaire or existing standardized scale at various points in the intervention. One approach could specifically focus on monitoring the heart rate at various points throughout the intervention, such as measuring differences in heart rate before, during, and after sessions. Polyvagal theory discusses the importance of the vagal brake in regulating the nervous system, highlighting the significance of heart rate variability in returning to a sense of safety after threat is experienced (Porges, 1995). One study involving college women showed that participants who had experienced childhood abuse had more difficulty regulating their heart rate than those with no abuse histories (Dale et al., 2018). Therefore, it may be of interest to see if this intervention had any impact on participants' heart rate.

Additionally, this study focused on victims of interpersonal violence who were all college students at a single university. Expanding the study to other universities, or to other populations outside of college, could help generalize findings across settings. The positive results of this small study should not stop here, as many more victims of trauma could experience the power of rhythm with further research. Drumming as a therapeutic intervention for survivors of trauma can serve to be an important addition to other polyvagal-informed modalities.

Conclusion

This paper described the importance of integrating body-focused interventions into therapy for victims of interpersonal violence. This therapeutic drumming feasibility study provides some foundational evidence for its usefulness among interpersonal trauma survivors, particularly as it relates to their ability to feel more connected to their bodies and to other humans. The drumming sessions provided a safe, creative environment for participants to express deep wounds in the context of relationship, even without using words. Given that trauma memories are often "held in the body" rather than encoded in language, drumming provides a "way in" not available through the use of talk therapy. Integrating such visceral experiences into therapy may not currently be commonplace, but research is pointing to increased justification of its importance in the therapy room. Conducting further robust studies will serve to strengthen the argument that involving the body in trauma therapy should be the standard, rather than the exception.

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Debra Nelson-Gardell, *Ph.D., LICSW, served as Associate Professor in the School of Social Work at The University of Alabama in Tuscaloosa, Alabama, USA until her retirement in 2024. Her areas of scholarship include childhood emotional trauma with a focus on sexual victimization. Trained in clinical social work for her MSW and PhD degrees, she has presented at local, regional, state, national, and international conferences and worked as a treatment provider, supervisor, mentor, program evaluator, consultant, presenter, educator, researcher, and administrator.*

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Nancy Rubin *received her PsyD from the Graduate School of Professional Psychology, University of Denver, in 1990. Since then, she has been a member of the Department of Psychiatry and Behavioral Medicine at the College of Community Health Sciences, University of Alabama. Retiring from her full-time faculty position in 2024 at the rank of Professor, she continues to work with the college part-time. With interests in trauma, family systems, and EMDR, Dr. Rubin specializes in treating our most traumatized mental health clients who present with problems on a continuum from Post-Traumatic Stress Disorder to Dissociative Identity Disorder.*

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Appendix

Table A. List of session topics and objectives

Session	Topic	Objectives
Session 1	*Introduction / Safety*	Familiarize clients to the drums and to concepts of polyvagal theory and the different states
Session 2	*Boundaries*	Use rhythm to explore boundary violations related to trauma
Session 3	*Exploring fear and anger*	Use drums as a "container" for intense emotions and explore potential resolutions for fear and anger
Session 4	*Strengths / Resilience*	Identify rhythms for strengths that clients would like to highlight; Explore ways client has had to adapt to adversity after trauma
Session 5	*Drumming your trauma narrative*	Development of rhythm story reflecting the client's healing journey

Table B. Themes Generated from Participant Interviews

Theme	Sub-Theme
■ *Connecting with sound*	— Communication through sound
	— Emotional regulation
	— Processing difficult emotions
	— Processing trauma Memories
	— Symbolizing emotions through sound
■ *Insights gained*	— Insights related to self
	— Insights related to trauma
■ *Sense of agency*	— Agency after trauma
	— Agency over decisions made
	— Ownership of feelings
■ *Sense of safety*	— Comfort in sharing
	— Freedom to experiment
	— Memories of safety
	— Safety in processing trauma memories
■ *Social connection*	— Connection to others
	— Connection with therapist

IN MEMORIAM

Keeping the Flame Alive

Clover Southwell
1935 – 2023

Clover Southwell was one of Gerda Boyesen's first students in the UK. She became a Biodynamic Psychotherapist, supervisor, mentor, and one of the major trainers in England and abroad who touched, inspired, and changed the lives of many people. She wrote extensively, expanding the understanding and depth of Biodynamic Psychology and Biodynamic Psychotherapy, and influenced our field with her clarity and profound love for the work and for life.

In 2000 Clover became a founding director of the London School of Biodynamic Psychotherapy, and for many years she put an enormous amount of work into sustaining it. She continued to work as a supervisor and trainer until retiring in 2019. She was greatly loved, and her service to our community will be remembered with deep respect and gratitude.

Hilary Price
Director
London School of Biodynamic Psychotherapy

Providing the spark!

I am personally very sad to lose Clover. Even though we didn't meet very often, she has been an important figure in my life as a body psychotherapist.

When I trained at the Chiron Centre, and later, when I worked at the Cambridge Body Psychotherapy Centre, Clover was an almost legendary guest trainer and supervisor who would come every so often and deliver a very special day. Few people were able to make me feel seen as Clover did, and she always managed to say something personal to me – invariably short, but enormously compassionate and often extremely helpful. So in my mind, Clover became a bit of an oracle – a wise person who might just show me a way when I was stuck or lost.

It was also Clover who got me started in teaching and writing. In 2000, I was a barely accredited novice therapist, and she asked me to take on teaching the anatomy module to her students at the London School of Biodynamic Psychotherapy. On the strength of my previous training in biochemistry, she calmly took it for granted that I would be able to teach human anatomy and physiology. Naturally, I couldn't resist such a very flattering challenge, and accepted at once. She then followed this up with a lot of interest and praise for my teaching. I owe her a large debt of gratitude for her belief in me and her support – all the more so because the course formed the basis of my later book *Anatomy & Physiology for Psychotherapists*.

In my professional life, Clover opened several doors, planted important seeds, and provided the necessary spark to help me on my way. I am certain she was a similar blessing to many others who, like me, will remember her with deep gratitude and a sense of being immeasurably enriched by her presence. I cannot think of a better way to be remembered than as someone who inspired so much creativity and so much professional flowering.

Kathrin Stauffer
President
European Association for Body Psychotherapy

"The work is all about joy!"

I first met Clover when she interviewed me for training in Biodynamic Psychology in the late 1970s. I had come prepared to speak of my childhood, and expected something more formal. Instead, we sat in the garden of Acacia House, and talked mostly about how I would manage the regular journeys from Cambridge where I lived, on top of full-time work at the British National Health Service. What I found intriguing and slightly unsettling was that she seemed to be gazing at my moving hands as I spoke. She became my trainer, colleague, mentor, and friend, and we collaborated on many projects.

After studying at Cambridge University, Clover worked with refugees in Austria before transitioning to advertising. She did not find her life's work until the 1970s. She writes, "I knew NOTHING of therapy until late 1970 in San Francisco I went to an Encounter Marathon weekend" (personal email, 2012). She went on to attend groups at Quaesitor, a humanistic growth center set up in London by Paul and Patricia Lowe (aka Clare Soloway), who became Teertha and Poonam after their time at Poona in India. A world had opened up for Clover, and she embraced it wholeheartedly. At Quaesitor, Clover attended groups with trainers, mostly from the U.S., and she did a nine month super-intensive to become a group leader. It was Nadine Scott, a charismatic Bioenergetics trainer, who suggested she might become a psychotherapist. A seed had been planted.

At Quaesitor, Clover met someone who knew the Boyesen family. She went on to meet Mona-Lisa Boyesen in 1973, and Gerda Boyesen in 1974 (personal email, 2012). Clover found her therapeutic home in Biodynamic Psychology and the work of Gerda Boyesen and family. London was a rich and stimulating place to be in the 1970s. Clover was aware of other growth centers, and conversations around people like Ronnie Laing and Jo Berke, who were involved in the "People Not Psychiatry" movement. She recalled that everything began to "burst open" in 1980 at the Gerda Boyesen Centre, which blossomed into a substantial international hub attracting people from around the world wanting to train in Biodynamic Psychology.

I was fortunate to be living in Cambridge; when Clover's mother grew older, she returned to Cambridge to be with her. We often met. She volunteered at Fulbourn Hospital, a psychiatric facility, and offered movement groups on an acute admissions ward, a group for staff to explore Biodynamic Psychology, and co-led supervision groups with a friend who was an analyst and psychiatrist. When the Cambridge Body Psychotherapy Centre was set up, she came every month to lead us in discussion, which usually began by her asking "What is exciting you?" She had a way of listening and gradually helping us weave our conversation into something coherent.

In her teaching, Clover listened deeply, took time to speak, and paused before responding; her style was slow, but when she spoke, something precious always emerged. In working with any student, she trusted the emergent energy "impinging from within." She sat with them in complete focus and created safety with her kind presence. She resonated with subtle energy movements, and stayed alongside and inviting of the primary impulse(s) gathering momentum. She stayed elegantly with the process, and with ease changed her presence and tone of voice as the energetic movements became bigger and were accompanied by sounds. As the process unfolded, she moved from a wide perceptual field, deeply receptive to what was emerging "in endless time" into something firmer. She might demand, "Who do you want to say that to?" And as the movements subsided, she genuinely celebrated the new energy that the student had claimed. But the session was not over. She would go on to ask, "How are you going to take that into your life?" –

with no room for wiggling away from setting the intention to live in a different way. For Clover, it was all about developing the inherent latent potential and movement of energy, finding independent wellbeing, and living from there at home in one's body.

Her special contribution to the field was her passion for using language therapeutically, and especially when speaking to the energy. She used language exactly, and would often pause and search for the right word. She would speak, pause, sense into herself, say another word, and try another, until we all knew she had captured something when the "right" word emerged. She didn't like the terms "somatic counter-transference" or "somatic transference." She observed, "That is something quite different, with a whole different thinking and history behind it." She preferred "resonating," as it was closer to what we do. It hurt her deeply to hear colleagues talking about "doing bodywork" and "doing an intervention." She would say, "But we are interacting with persons." And she preferred "flesh" to "body." "Flesh and soul" were central to her. I always assumed that she was aware of how thinking shapes our words, and words shape our thinking, but never explicitly discussed this with her.

Clover was at her best when writing articles in response to questions arising from students or colleagues from current situations, or on an emerging theme in psychotherapy. She was a precise thinker, and had no time for intellectual debate. Discussion with her was always grounded in personal or clinical examples to tease out our perspectives. She liked hearing about differences, and this sharpened our thoughts. She generously shared her articles, and wrote many drafts until something was ready.

Clover was curious, and always mulling over something or other. In her 80s, she was shocked to recognize her colonial attitudes when participating in a workshop on the subject, and readily seized the opportunity to explore her internalized views.

Clover trusted deeply in life, and radiated that trust. When her eyesight was failing, I asked her how she managed to get around busy central London where she lived. She did not use a stick at that stage to indicate her blindness. She was slightly baffled by my question, but as usual she responded graciously: "There is always someone to help me. And, if no one offers, I ask."

As recently as 2018 at the EABP Congress in Berlin, she was part of a panel discussion. Her contribution stood out and she carried the room with her as she ventured her view. She observed "No one so far has mentioned joy! The work is all about joy!"

Clover was the senior elder in the UK body psychotherapy community, and has left a huge gap. We are all indebted to her. And I miss her.

Gill Westland
Director
Cambridge Body Psychotherapy Centre

She kept the flame alive

I met Clover in 1984 at the Gerda Boyesen Centre in Acton, West London, where she was one of the trainers in Biodynamic Psychotherapy. Clover was my teacher, supervisor, mentor, colleague, and a dear and loyal friend, up until she passed away.

Clover discovered Biodynamic Psychology and Psychotherapy (founded by Gerda Boyesen) in London in 1978, and was immediately fascinated by the work. She always remained faithful to its essence, and became one of the most prominent teachers of Biodynamic Psychotherapy, which she taught in London and across Europe and the United States.

Clover wrote extensively about Biodynamic Psychology and Psychotherapy, and about Biodynamic Massage. She had a talent for clarifying and expanding on Gerda Boyesen's concepts and theories, and wrote in a poetic yet precise and unique style that really conveyed the beauty of the Biodynamic work. Her articles have become a central part of the teaching material in the London School of Biodynamic Psychotherapy (LSBP), and a wise and educational resource for each new generation of students.

Gerda Boyesen had asked Clover and four colleagues to take over the training and running of the organization, and make sure that it met with the United Kingdom Council for Psychotherapy (UKCP) standards. Clover worked tirelessly to set up the LSBP as a member-run organization and postgraduate (UKCP-accredited) psychotherapy training school, which she served as one of its Directors. Although many of us contributed to creating and running LSBP, Clover was always at its heart, until she was no longer able. I have so many precious memories of a group of us discussing aspects of the work, or preparing documents together in her flat, and memories of shared weekends in her treasured cottage in the countryside. We are deeply grateful to Clover, for without her, LSBP would not be the training school it is today.

Clover loved and lived the Biodynamic work. It touched her soul and heart, her whole being. She kept the flame alive! She had great faith in and conviction about the Biodynamic method, undeterred by critics who sometimes doubted the validity of the work.

Clover Southwell was a generous, passionate, kind, caring and faithful friend and colleague. She is a shining example of how to live, love, and share a full life. She will be deeply missed.

Carlien van Heel
Biodynamic Psychotherapist
Supervisor (UKCP reg) and senior trainer at LSBP

The unifying force

My partner Jochen Lude and I first met Clover in 1978, when we moved to London to train at the Gerda Boyesen Centre for Biodynamic Psychology and Psychotherapy. We were peers in an advanced training group with Gerda. Occasionally Clover was also our teacher, as she was more experienced, but this did not prevent us from becoming good friends.

Clover was one of the purest practitioners of Gerda's legacy. Biodynamic work had changed her profoundly, and given her, as it did most of us, a new purpose and meaning in life. She loved presenting the biodynamic approach in different training institutes, and travelled two months each year to California for more than a decade, teaching leading Bioenergetic psychotherapists about Biodynamic principles and methods.

It was very close to Clover's heart that the Biodynamic approach should remain as close to Gerda's original teachings as possible. There was never any doubt in her mind that Biodynamic massage should remain an integral part of Biodynamic Psychotherapy, whereas other Biodynamically-trained therapists decided to keep massage work separate from psychotherapy work.

Clover had a special and unique way of working with energy as the unifying force connecting body, emotion, mind, and spirit. She used either massage or vegetotherapy to unblock the trapped life force (libido), and free the *primary personality*. She focused her teaching on the importance of using the right words, as well as touch, to reach deeper levels beyond defenses, and facilitate the *impinging from within*. She was connected to her own essence, and while teaching had her special slow way of speaking, which helped others leave their busy minds behind.

Clover had a joyful, deeply spiritual, and life-affirming personality, and it has been a pleasure to have her as a friend. She walked her talk, as they say, and was always authentic and connected to her deeper Self. In her fifties, she joined the Church of England as a way of being part of a spiritual community. This became an integral part of her life.

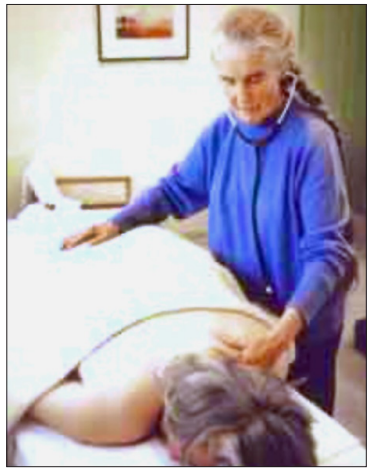
We had a lot of fun together. She loved the outdoors and her cottage near Cambridge, where she lived an earthy, robust life growing vegetables, cultivating her roses, and enjoying walks in muddy boots. Together, we took plenty of relaxing weekend walks on wild beaches near our home on the English South coast (West Sussex), or near our holiday home in the Algarve.

I will always remember her buying her last car – a sporty red convertible – which she enjoyed tremendously, and which was an expression of her open and adventurous nature. Clover also adored playing Racing Demon, a quintessentially English card game she had enjoyed since childhood. When playing, she revealed her competitive and fierce personality – she was truly unbeatable. She also played the harmonium, and delighted in sessions with her singing teacher.

Clover had been progressively suffering from memory difficulties, and was finally diagnosed with Alzheimer's. Soon after, she went into a care home, where we visited her frequently. She was well cared for and free from pain.

It has been a gift to have had Clover as a friend and colleague, and we are sure she will be greatly missed by many.

Bernd Eiden
Retired Director
Chiron Centre for Body Psychotherapy



The following excerpts from Clover's writings* convey her distinctive energy and the depth of her legacy

... in a sense it does not matter which aspect of the organism you choose to work with first: re-awakening repressed memories, encouraging emotionally expressive movement, massaging the muscular consistency ... Any fundamentally effective work on one aspect of the organism will, in time, inevitably affect every other aspect.

On life energy

Biodynamic Therapy works with a Person's Life Energy. Life energy is the force which moves us, which enlivens our physical substance. Everything that happens in us – physiologically, mentally, emotionally – is a manifestation of the energy moving in us: our thought processes, memories, fantasies, creations; our cell-building, blood flow, shivers and swellings; our actions, impulses, ecstasy, pain. These are all manifestations of life energy moving through the intermingling planes of human existence. We are not just flesh, we are not just feelings, we are not just spirit, we are not just consciousness. Our humanity lies in the continual interfusing of the planes. Our energy movements do not keep tidily confined within separate planes. A stream of memories may flow into a muscular change, the rhythm of rage may transmute to super-vitality or to ecstasy. Biodynamic Therapy works through these inter-fusings of energy, allowing the movements in one plane of living to precipitate or to strengthen activity in another plane, hitherto less 'open' to the client.

■ ■ ■

* Clover Southwell's articles are published in Courtenay Young's *The 'New' Collected Papers of Biodynamic Psychology, Massage & Psychotherapy* (2022).

Knowing ourselves

Many of us have lost our connection with our primary selves. We don't really know ourselves at this level. We restrain our exuberance, suppress our feelings, hide our fantasies, deny our spiritual experience, and repress our most troubling memories.

Gradually we develop a secondary personality. Though this secondary personality may serve us quite well in some aspects of life, it tragically limits the breadth and depth of our inner life, as well as the richness and authenticity of our relationships.

The core objective of Biodynamic Psychotherapy is to help a person reconnect with their primary potential. The more a person is in touch with this level and able to follow its promptings, the more fulfilling their life can be.

Note

The London School of Biodynamic Psychotherapy uses Clover's writings extensively in their training literature.

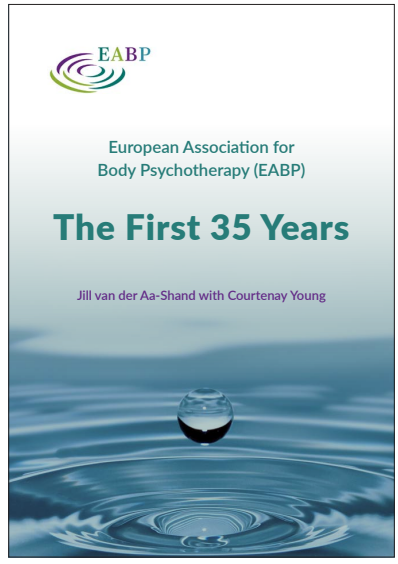
In 2016, Rubens Kignel interviewed Clover. Their dialogue, titled *Help Somebody to Feel at Home in Themselves*, can be found at https://www.youtube.com/watch?v=Py-y7CvksAk

BOOK REVIEW

EABP – The First 35 Years

by Jill van der Aa-Shand with Courtenay Young

Christina Bader Johansson



"Love, work and knowledge are the wellsprings of our life. They should also govern it."

Wilhelm Reich

This book, richly illustrated with photos, is an excellent description of the origin, history and structure of the European Association of Body Psychotherapy (EABP), and the place of Body Psychotherapy among other forms of psychotherapy, as well as its place in the social debate in different countries. Which therapies are based on science, and which can/should be paid for by health insurance systems? What difficulties have we faced during these 35 years? Are we still grounded in a holistic vision, although we have adopted a scientific perspective?

Body psychotherapy as such has been around for hundreds of years, but the first congress to bring together interested therapists was held in Davos, Switzerland in 1986. This event brought together different practitioners who all saw the body as essential to their work as psychotherapists. They saw a unity in body and mind, and were able to exchange

thoughts, knowledge, and experience, which sparked the formation of a community of like-minded people. Wilhelm Reich, together with Ola Raknes, had already developed vegetotherapy in Norway before Reich had to flee for his life to the United States at the start of World War II. They both emphasized the reaction of the vegetative nervous system to fear and terror, or love, calm and tranquility, which manifest themselves in the body. These bodily responses were seen as important information for the design of treatment, along with the client's own account of their problem. They recognized that an individual's health is influenced by the interaction between the whole person and society's support and demands, a concept now known as the biopsychosocial model of health and disease.

The book presents an overview of body psychotherapy pioneers with a concluding table-like overview, including Alexander Lowen, founder of Bioenergetics, who trained as a physician and studied with Wilhelm Reich; the Norwegian vegetotherapist Björn Blumenthal; the Norwegian physiotherapists Aadel Bülow-Hansen, Gerda Boyesen, Lillemor Johnsen, and Berit Heir Bunkan; and David Boadella, founder of Biosynthesis, who studied with Ola Raknes, among others. Ola Raknes was followed by Chuck Kelly with Radix, Jay Statton with Unitive Body Psychotherapy, Katherine and Malcolm Brown with Organismic Psychotherapy, and Ron Kurtz with Hakomi, to name a few.

Structure – congresses, presidents, committees and finances

At the second congress in Seefeld, Austria, held two years later in 1988, the EABP was founded based on a set of statutes, its Articles of Association. The purpose was "to bring together body psychotherapists from different disciplines working with the body in psychotherapy to support each other and find common ground." David Boadella became the Association's first president, and it was then based in Switzerland. In 2016, it relocated to the Netherlands, which is part of the EU, with the Euro as its common currency. From 1988 to 2023, nine people have served as EABP presidents. Congresses have been held every two years in different countries in Europe. At the same time, the General Assembly (GA) has also been held, where reports from the board's work are discussed and voted on in the so-called grey book. It is worth noting that from the beginning, EABP was a top-down organization with the board at the top, while gradually more authority has been given to its various committees.

Early committees that formed were the Training Standards Committee, and the Congress and Ethics Committees. The FORUM was established in 1997 from training institute representatives who meet a couple of times a year, and have the mandate to accredit new training institutes. As an organizational member of the European Association of Psychotherapy (EAP), the EABP was required to answer the "15 questions" to demonstrate the scientific validity of its trainings, which also provided EABP with quality assurance. A COUNCIL was formed in 2006, which presidents of the national associations attended annually. FORUM and COUNCIL have conducted joint meetings since 2014 to discuss and propose to the GA issues shared by different countries related to training, accreditation, and other relevant topics. In 2010, the congress held a thematic half-day in Vienna on research in body psychotherapy, and the SRC (Science and Research Committee) was formed two years later, in Cambridge in 2012. Since then, the committee has presented different research methods, case studies, and results at the biennial congresses. A proposal drafted by Christina Bader Johansson and Courtenay Young for a science and research module in the training program remains a work in progress. A Think Tank convened by Lidy Evertsen has met regularly since the early 2010s to develop a more detailed description of body psychotherapy (BPT), based on modern theories and science. All this has led to more grassroots work where more voices can be heard in a bottom-up system.

Maintaining control of the financial framework, with different membership fees for different member countries and membership status, became increasingly demanding over time. Rob van Schaik, a former banker, took responsibility for the finances in 2014, and with the help of modern digital technology, relevant software, regular business plans, and solid knowledge, he, together with Thomas Riepenhausen and Vladimir Pozharashki, among others, got the organization's finances in order.

Making BPT better known

In parallel with persistent efforts to make BPT more credible in the eyes of authorities, there are also efforts to make BPT better known to colleagues with a different psychotherapy focus, and to the general public. In 1998, Courtenay Young had already created the EABP Bibliography of Body Psychotherapy, with an expanded version in 2007 containing over 3,000 publications. Young has also been instrumental in developing greater collaboration with our North American sister organization, the USABP.

After considerable criticism that English was the only EABP common language, many congresses now present with simultaneous translations into at least two other languages, and the *International Body Psychotherapy Journal* (*IBPJ*), now has abstracts in several languages.

David Boadella understood early on the importance of joint publications to spread the knowledge of body and mind interaction. *Energy and Character* began in 1970, and was published in English and German versions, followed by a series of journals – *Bioenergetic Analysis*, *Body, Movement and Dance in Psychotherapy*, *körper-tanz-bewegung*, and *Somatic Psychotherapy Today*, edited by Nancy Eichhorn in the US. And our own journal, the *International Body Psychotherapy Journal* (*IBPJ*), is published in cooperation with the USABP. In this way, the EABP has evolved to include so many more countries outside Europe, which is also reflected in the participants at the congresses.

Since the early 2000s, numerous books, journals, and articles have been written, and many videos have been produced. Among these are (in German) *Handbuch der Körperpsychotherapie*, (in English) *Handbook of Body Psychotherapy and Somatic Psychotherapy*, with a variety of authors, edited by Gustl Marlock and Halko Weiss, *Body Psychotherapy: History, Concepts and Methods* by Michel Heller, *Körperpsychotherapie* by Ulfried Geuter – published in English as *Body Psychotherapy*, Kathrin Stauffer's *Anatomy & Physiology for Psychotherapists: Connecting Body & Soul*, and *Contemporary Body Psychotherapy by Linda Hartley*. Sheila Butler has produced a video introduction to body psychotherapy, which is featured on the website.

Good memories

The main purpose of the congresses is to present new theories, practical application of research findings, innovative ideas, and method development through numerous workshops. And the social function of the congresses has proven to be at least as important, with dancing, humor, singing, meeting friends to have fun, and being able to meet on a deeper level within the same frame of reference, giving meaning to the profession, and building strength for everyday life at home.

In short, as Jill van der Aa-Shand puts it, "So much positive and meaningful exchange between human beings has taken place, forming a different family, a collegial body." The gala dinner held in the magnificent King's College Hall in Cambridge is difficult to forget. The southern Europeans and their spontaneous gatherings were filled with warmth and humor, as in Lisbon, when we all got coffee before we could check in for the congress. For

many years, The Howling Shrinks were also a highlight – a little rock band playing and singing "Are you ready Eddie?"

In the book, three members describe why they value their EABP membership so highly. All three emphasize friendship across borders, respect for diversity, and a sense of purpose in the work they do.

Challenges over the years

Over the 35 years of its lifespan, EABP has developed a strong organizational structure. The financial administration is stable, communication between different parts of the association is maintained, and the association has a code of ethics with an ethics committee as quality assurance for clients. BPT has been seen as a mainstream in the EAP; we have sufficient research that proves its reliability as a treatment method. We can lean on modern theories that support the body's important role in treatment, and we affirm versatility. Despite all this, in most countries we have not yet been able to obtain coverage through health insurance, and have not yet made ourselves known and seen as a therapeutic approach for a number of different conditions. Perhaps this also says something about the health care system, and the perception of what can contribute to human recovery from disease.

This book reflects the first 35 years, where at least the initial 25-30 years were very much about different people who shaped the organization. Only in the last five years have theories and research results come more to the fore of the organization's profile. Increased cooperation with Stephen Porges, professor and developer of the Polyvagal theory, has contributed to this shift.

Could we succeed in combining spirituality, body, and mind with the influence of social conditions in a theory of our profession? I suggest that we should rather lean towards not Newtonian physics, with its part + part that always remains the same whole, but instead towards quantum physics, which says we are part of the same wave function in constant change influenced by its observer. The future will show how this can succeed.

As Carmen Joanne Ablack, President until 2023, points out, by understanding our history, we can discern our direction into the future. This is a book that should be found in every training institute, and read by every board and committee member, and by all members interested in the history of the EABP. I am feeling a smile on my face as the book describes people and events that have warmed my heart with priceless memories, and made me feel a love for my profession.

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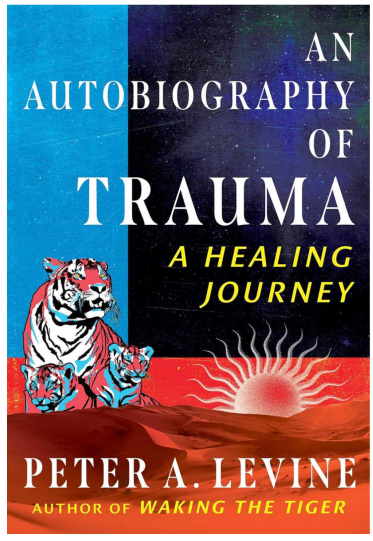
BOOK REVIEW

An Autobiography of Trauma

A Healing Journey

by Peter Levine

Helena Vissing



In his latest book, *An Autobiography of Trauma: A Healing Journey*, Peter A. Levine, the pioneering developer of Somatic Experiencing® (SE), offers an intimate and profound exploration of his personal journey to heal his severe childhood trauma. Levine, who has significantly influenced the understanding and treatment of trauma through his innovative Somatic Experiencing method, provides readers with a compelling narrative that intertwines his life story with the evolution of his therapeutic approach. This review aims to critically assess the autobiography, highlighting its strengths and offering nuanced reflections on its content, all within an acknowledgement of Levine's stature as a leading figure in the field of somatic trauma healing.

An intertwined personal and professional journey

Levine's autobiography is not merely a recounting of his life events. The lived experiences, including those related to trauma, are used in the narrative as an experiential guide that invites readers to engage deeply with their own somatic experiences. From the outset, Levine addresses his severe trauma with a directness that is both disarming and instructive. His approach to writing is sensorily sensitive, aligning with the principles of

SE. I found this particularly appropriate for the narration of highly traumatic events, which Levine already includes in the introduction. He provides readers with experiential instructions on how to navigate potentially triggering material using sensory awareness, thus modeling the very techniques of SE. Readers who are not familiar with SE or somatic psychology might be stirred by this approach, but it feels like a conducive and necessary experiential pedagogy. After all, an autobiography about a central pioneer in the field that addresses trauma in a surface-level way would have been disappointing. Levine casts himself as a modern-day Chiron, the wounded healer of Greek mythology, a motif that permeates the narrative. He juxtaposes the descriptions of childhood trauma and loss with moments of vivid joy and exuberance, illustrating the complexity of his emotional landscape. This duality serves as a foundation for his later work, highlighting the resilience and adaptability of the human spirit. Throughout the book, Levine's personal anecdotes are interspersed with insights into the development of SE, creating a tapestry that is both informative and deeply moving.

Development of Somatic Experiencing

One of the most compelling aspects of the autobiography is Levine's detailed account of how he discovered and developed SE. Drawing from his studies of wild animals, neurobiology, and over fifty years of clinical observations, Levine elucidates the principles underlying SE as an integrative, dynamic, and expansive approach. Through the developmental story of SE, it becomes clear how and why his method of helping individuals release traumatic energy stored in the body has revolutionized trauma therapy. Levine's historical contextualization of his life work emphasizes the radical shifts in our understanding of trauma that has occurred both within and beyond the professional fields during his lifetime. This explanation of SE is accessible yet profound, making complex concepts understandable to a broad audience.

Initially, Levine recognized the necessity of conforming to the scientific positivistic paradigm to ensure that his innovative approach gained the recognition and respect it deserved. By framing SE within this rigorous scientific context, he safeguarded its legitimacy, and facilitated its acceptance within the broader therapeutic community. Over time, however, Levine skillfully integrated more spiritual and transdisciplinary elements into his work, enriching his method and demonstrating the profound interconnectedness of body, mind, and spirit. His reflections on this evolution are particularly touching to read. They underscore Levine's commitment to a holistic understanding of trauma and healing, blending empirical rigor with a deep appreciation for the complexities of human experience. His acknowledgment of the need to protect his discoveries by aligning them with scientific paradigms also speaks to continued challenges in the field.

Levine also portrays the rich tapestry of relationships and influences that shaped the development of SE. He shares intimate stories of mentors, colleagues, and friends who played pivotal roles in his journey, each contributing unique insights and perspectives. These relational experiences highlight Levine's connection to a distinctive cohort of transformational pioneers, individuals who collectively pushed the boundaries of traditional therapeutic practices. Through these interactions, readers gain a profound sense of Levine not as a solitary innovator, but as an integral part of a dynamic and collaborative movement driven by a shared vision of holistic healing and the transformation of trauma treatment. This network of influences underscores the collaborative spirit and collective wisdom that have been instrumental in the evolution of SE. Levine includes both esteemed professionals and colleagues alongside personal and intimate friends and partners in these relational reflections, offering the reader an experience of vulnerability and honesty.

Jungian vibes: Inner journey and mystical experiences

The book is characterized by the focus on Levine's inner experiences, particularly his dreams and visions. He describes how dream visitations from Albert Einstein, whom he considers his personal spirit guide, played a significant role in guiding his work. Levine's discovery of a profound real-life connection to Einstein through his mother adds a layer of depth to his narrative. These mystical experiences are presented with a sense of wonder and respect, underscoring the importance of intuition and spiritual guidance in Levine's journey, and lending a distinct Jungian vibe. While these accounts are fascinating, especially to Jungian-informed readers as me, they may also pose a challenge for readers who prefer a more empirically grounded narrative. Levine's willingness to share these deeply personal and sometimes mystical experiences is a testament to his vulnerability and authenticity.

His contributions to the field of trauma healing are undeniable. Through SE, he has helped thousands of individuals recover from trauma, offering them a path to reclaim their lives. Levine's emphasis on the importance of telling one's story as a means of healing is a powerful reminder of the therapeutic potential inherent in narrative and self-expression. It made me wonder about the potentials for expanding storytelling components in the many uses of SE. As someone who has trained in and studied SE for several years, I found myself experiencing a more integrated and embodied internalized sense of what SE encompasses after having read the personal narrative of its development. I was reminded of a similar and interesting experience that occurred when I completed the Intermediate III module. I had followed the same cohort of students and assistants for my Beginning and Intermediate year, and we ended the last module with an exercise of everyone sharing a personal experience. The assistants deeply shared details about their personal processes in having assisted the cohort, which revealed a more nuanced and vulnerable picture of them as full and real people. They were clearly less so perfectly healed and attuned super-humans who were masters of SE, which had admittedly been a common projection from me as an SE student, as I was deeply humbled by the training. Now I could see that an assistant who had seemed to me to have been the pinnacle of calmness and anchoring had also been struggling with shutdown and freeze tendencies. Realizing that our mentors and guides are full and fully humans can be challenging but can also offer a new level of collective integration, or in the Jungian sense, a transcendent function.

The book also addresses the integration of SE with a diverse array of therapeutic modalities and traditions, reflecting Levine's commitment to a comprehensive approach to trauma healing. He delves into the role of sexuality in trauma recovery, highlighting its importance in reclaiming one's body and sense of self. Levine is candid about the challenges associated with healing trauma through sexuality, acknowledging the deep-seated difficulties, while maintaining a focus on hope and the possibility of recovery. His exploration of psychedelics as a therapeutic tool is marked by a cautious and balanced perspective, countering the current hype in the field. Levine provides compelling evidence and anecdotes that underscore their capacity for deep healing, yet he continuously emphasizes the need for responsible and careful use. Additionally, he explores the integration of shamanic traditions with modern therapeutic practices, demonstrating how ancient wisdom can enhance contemporary approaches to trauma treatment. These discussions are not only thought-provoking, but also indicative of Levine's innovative mindset and dedication to exploring all avenues that may contribute to holistic healing. A recurrent focus on attachment and early relationships as central to trauma healing is woven throughout his reflections, linking his personal attachment history with broader therapeutic insights. Through these integrative discussions, Levine not only broadens

the scope of SE, but also invites practitioners and individuals alike to consider a more expansive and inclusive view of healing.

Conclusions

While *An Autobiography of Trauma* is a significant contribution to the literature on trauma and healing, it is important to approach it as Levine's deeply personal narrative, rather than a textbook on trauma or an introduction to SE. For those seeking a foundational understanding of SE or trauma, Levine's *In an Unspoken Voice* (2010) will be more appropriate. This autobiography focuses on Levine's personal journey and the experiences that shaped his groundbreaking work, rather than the empirical evidence that supports SE. Readers looking for detailed scientific studies and empirical validation will find that these are covered extensively in his other works and scholarly articles.

Levine's narrative is rich with personal and mystical experiences, which can offer a unique and engaging perspective but may be challenging for those seeking a straightforward, clinical exposition of SE. The intertwining of personal narrative with professional development reflects Levine's holistic philosophy, emphasizing the interconnectedness of his life and work. This approach, while profoundly insightful, may not resonate with all readers, particularly those looking for clear-cut, objective analysis. It's essential to appreciate this book for what it is – a deeply personal account of Levine's life and the development of SE, rather than a conventional clinical textbook.

In summary, *An Autobiography of Trauma* is highly recommended for its depth, authenticity, vulnerability, and the invaluable insights it provides into the life and work of one of the foremost figures in somatic trauma therapy. Levine's journey underscores the importance of perseverance, innovation, and compassion in the pursuit of healing, offering a beacon of hope for those navigating the challenging terrain of trauma recovery.

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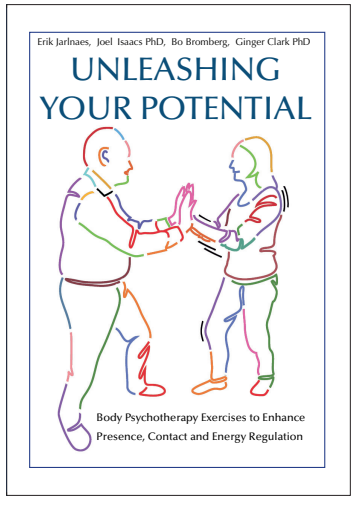
BOOK REVIEW

Unleashing Your Potential

Body Psychotherapy Exercises to Enhance Presence, Contact, and Energy Regulation

by Erik Jarlnaes, Joel Isaacs, Bo Bromberg, and Ginger Clark

Christina Bogdanova



The British neuroscientist and engineer Daniel Wolpert, whose primary scientific and research interests gravitate around the brain's sensorimotor control of the body, emphasizes in his 2011 TED talk that we have a brain for one and only reason: to produce adaptable and complex movements. He states, "I believe that to understand movement is to understand the whole brain. And therefore, it's important to remember, when you are studying memory, cognition, sensory processing, they're there for a reason, and that reason is action." And though it might sound like a cliché, life is movement – for example, the heartbeat and blood circulation, the breath, balancing and standing up, self-expression and protection, and giving and taking are some examples. We exist and meet our needs, interact with others, and affect the world around us through movement, whether by moving to get food, connect with others, establish a home, or do anything else. Interconnectedness through movement is what makes us human. All communication, including speech, sign language, gestures, and writing, is mediated via the motor system.

"So, it's all about moving," in the words of the Dutch psychiatrist, author, post-traumatic stress researcher, and educator Bessel van der Kolk. But what does happen with movement when we live with high levels of chronic stress, adverse experiences, or trauma – either developmental, relational, or shock? We often lose control over ourselves

and our lives; we feel powerless and helpless. We stop being capable of energy regulation, staying present, or connecting with others. Then, quickly, we might become stuck, frozen, and immobilized. And although movement is compromised in these situations, it is also the tool for overcoming psychological, behavioral, and sometimes even physical restraints and diminished quality of life, as the work of van der Kolk and many others has shown. To regain a sense of control, power, and vital presence, we must relearn how to move and take action to meet our needs, connect with ourself and with others, experience purpose and meaning, and feel joy from being alive and whole. This underscores the crucial role of movement in enhancing our quality of life.

Unleashing Your Potential: Body Psychotherapy Exercises to Enhance Presence, Contact, and Energy Regulation by Erik Jarlnaes et al. is a valuable guide to restoring the ability to move. The book includes a collection of physical exercises to improve psychological functioning, cultivate resiliency, and enhance well-being and joy. The exercises are grouped to address issues that frequently cause people to look for psychotherapeutic help, such as difficulties in dealing with hardships and overcoming their consequences, successfully managing external stressors and internal distress, and maintaining healthy relationships. They are organized and presented in an order that aims to develop or strengthen presence, energy regulation, and connection. Mastering the exercises provides people with embodied resources to face and grow from frustrating or traumatic experiences, and to bounce back from setbacks or conflicts in ways that strengthen their relationship to themselves and others, and enrich their lives with joy and meaning.

Although referred to as exercises, they might better be perceived as experiments, as the author suggests. The reason behind this is that the benefit from doing them comes when they are learned and experienced in a state of complete awareness and being present at each moment. It is not enough to do some movements mechanically and repeat them mindlessly. The substantive part is to notice our state of being before, during, and after completing the exercise, to be curious each time about its effect on our body and psyche, and to sense the change in our breathing as well as in our attitude towards ourselves and others. Thus, people's awareness of the underlying psychological function of the movements is enhanced. "Regardless of what we call the practice of these movements, experiments or exercises, our goal is to increase awareness and aliveness, and even a mindful curiosity that leads to discovery and, sometimes, even joy. We are strengthening the sense of our mind-body connection and developing our psychological resources for life quality," Jarlnaes emphasizes. (p. 13)

The book, written and prepared in close collaboration with Jarlnaes's colleagues Joel Isaacs, Bo Bromberg, and Ginger Clark is a helpful source for body psychotherapists to use in their individual or group work with clients and students, and for self-stabilization and growth. The authors provide detailed instructions and photos, explaining the intention of each exercise, when and why its use is appropriate, specifics in its implementation, how to begin or finish, and more. Several case examples illustrate the use of the exercises in connection with concrete psychological issues. Erik points out that a psychological problem or behavioral difficulty sometimes indicates which exercise to use. That's why it is so essential for the therapist to be proficient in doing the exercises themselves, and to have mastered "kinesthetic listening" to the somatic details presented by their clients. But it is also possible for exercises to activate psychological issues, or release psychological material from the body and mind during a session. Either approach might be a working entrance to help clients be present to what is happening to them in every moment. They might experience their typical unhealthy behaviors and their impact through their bodies, thus realizing what they no longer want, and become ready to change, and eventually begin to change. "When clients can sense their body, there is a

much better chance that the new action will become integrated and thereby be remembered and used," writes Jarlnaes (p. 15).

Unleashing Your Potential: Body Psychotherapy Exercises to Enhance Presence, Contact, and Energy Regulation consists of ten foundational exercises with variations for a total of over fifty. Jarlnaes proposes these concrete exercises because they target psychological issues that need to be overcome to develop or strengthen presence, energy regulation, and connection. The problems include but don't exhaust the options: freezing, giving up, staying silent, feeling bad, isolating, overloading, or acting out. The exercises aim to achieve or enhance the skills necessary to sense our center, express likes or dislikes, ground and stand up for ourselves, be flexible, dispose of burdens, stay present, contain emotions, express and constructively use anger when challenged or threatened, regulate tension levels, set, sense and keep boundaries, say "Stop!", "Yes!", and "No!" in relationships, and more.

Only true advocates of exercise and movement might create this book. It promotes how practicing or even playing with using the body freely and with enjoyment expands our limits and grows our abilities, thus attaining even unexpected results. The book doesn't have much text – only a few pages of synthesized theory, as well as detailed instructions and more than 220 photos to illustrate the instructions, making them easy to follow. In Jarlnaes' opinion, an important point is the focus on the actual body sensations – a crucial concept for body psychotherapists. He argues that the value of using body sensation questions such as "What do you sense right now?" or "Where do you sense it?" cannot be overemphasized, because body sensations are facts that don't include thoughts, interpretations, emotions, or feelings, thus providing more precise information about the person's experience.

I find it helpful that Jarlnaes suggests what to observe or hear that indicates the availability or absence of the skills needed for each exercise, thus using them as a diagnostic tool. There are instructions on how to do the exercises standing or sitting, alone, or in pairs or triads. When working with one or more people, it is essential to give and receive some resistance to "support the movement." The right amount of resistance – "not too fast or hard" and "not too slow or weak" – helps people to experience their power, thus supporting their core energy and rights, such as the right to be and have needs, to say "No!", or to use one's voice. A substantial part of the process is sharing the experience with an attentive other. "Doing these exercises expands people's movement options, their 'body vocabulary' so to speak, and increases their resilience and possibilities for growth. It becomes more likely that they will function well in difficult situations and beautifully in day-to-day situations," recapitulates Jarlnaes, who continues: "As we help them move past their historical limitations and expand their resources, somatically and psychologically, they have more choices and a brighter future ahead. This choice-fulness and improved functioning will also impact their partners, friends, colleagues, work culture, and beyond" (p. 17).

The book beautifully digests Jarlnaes' fifty-plus years of experience as a psychotherapist with specializations in Bioenergetics, Bodynamics, Human Element, Energy work, and Gestalt/TA, as well as being an athlete and coach in running hurdles, European handball, table tennis, and rowing, and a martial artist. He states, "Exercise and movement have been the cornerstones of my life, both personally and professionally, giving my life meaning, purpose, and joy, and deepening my connection with myself and others – in short, enhancing my 'life quality.' (p. 11) The good news is that the authors plan to release another volume with more exercises that enhancing vitality and life quality.

■ ■ ■

Christina Bogdanova, *MA, is a Neo-Reichian analytical body psychotherapist with an academic background, a BA in Journalism and Mass Communications, and an MA in Psychology and Psychopathology of Development. With an individual and group private practice in Sofia, Bulgaria, she is a trainer, teacher, and supervisor at the Bulgarian Institute of Neo-Reichian Analytical Body Psychotherapy. She is also a certified Somatic Experiencing Practitioner. Currently, Christina specializes in NeuroAffective Touch and Somatic Trauma Therapy.*

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