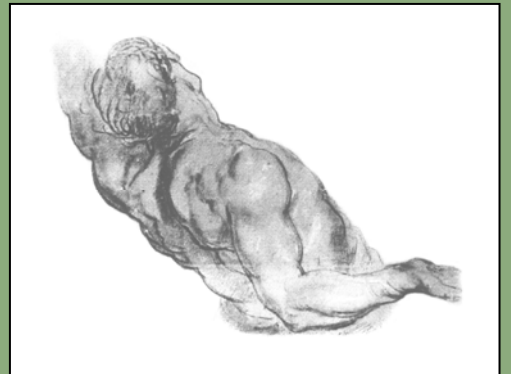


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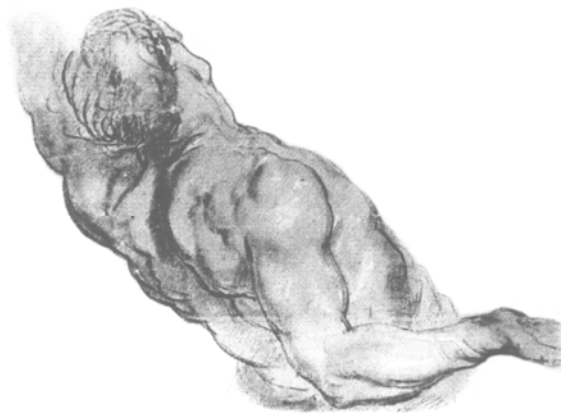


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USABP Mission Statement

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

The USA Body Psychotherapy Journal Editorial, Volume 7, Number 2, 2008

It is with enormous pleasure that I dedicate this research-focused issue of the *USABP Journal* to Alice Kahn Ladas, EdD, a leading light in the field of body psychotherapy.

Over the years we have served together on the Board of Directors of the USABP, I have frequently attempted to persuade Alice to write extensive memoirs, but she has been reluctant to do so at length. Below is a brief outline of her life in body psychotherapy in response to a recent query.

While I have never developed my own version of Body Psychotherapy, my contribution has been as a synthesizer and promoter of the field and especially of research.

My initial training was with such luminaries as Eric Fromm, Frieda Fromm Reichman, Harry Stack Sullivan and Nathan Ackerman when he was starting family therapy. I worked in his private office at that time. Dissatisfied with the results of therapy on me and on my clients, I became interested in the work of Wilhelm Reich, attended one Conference in Orgonon and had some personal orgone therapy. I worked for a time on the staff of Reich's Infant Research Center in 1950 which led me to write my doctoral thesis on "Breastfeeding The Less Available Option" published by the *Journal of Tropical Pediatrics* in 1970. Done with the help of 1100 members of La Leche League, this study together with a lot of other people's efforts helped to turn the tide back to breast feeding in the USA. As a result of my contact with Reich, I also taught the first Lamaze class in educated childbirth in the USA.

When Lowen began his Tuesday evening seminars and lectures in 1955, it was my idea to form a not-for-profit organization. In 1956 I hired the lawyer to create the organization, found Al his first publisher, became a member of the first Board and introduced Al at his lectures. I designed and wrote the first brochure (pictured in the last issue of this Journal) which included a commitment (never honored because thought was being downgraded in favor of feelings) to doing research. It took from 1956 until 2000 to finally realize that dream. USABP was the first organization to accept my suggestion to give a prize for the best research in the field.

There was a time when I was simultaneously on the National Boards of SSSS (The Society for the Scientific Study of Sexuality) and IBA (the Institute for Bioenergetic Analysis-later IIBA). One believed that only the vagina was important...the other that only the clitoris matters. I believed both were correct. This led to the study done with my late husband, Harold, "Women and Bioenergetic Analysis". Through a mail questionnaire, we gave all the women members of IIBA who had both received and given Bioenergetic therapy, a chance to say what they believed anonymously. Among the things they said were that the clitoris is important and so is the vagina and that this type of body psychotherapy had helped them sexually as well as in many other ways. However they did not agree with all the theories of its founder.

Under the title, "From Freud through Hite All Partly Right and Partly Wrong", I presented the results of the study in 1979 at a meeting of SSSS. It was there that I learned about the work of Whipple and Perry which led to another synthesis: the NY Times best seller, "The G Spot and Other Discoveries about Human Sexuality." A synopsis of that study has been translated into 19 languages and published in 29 countries. It is still selling world wide after more than 20 years. So that is rather widespread publicity for body psychotherapy.

But no matter how many times I urged the IIBA to develop research through offering a research award, it wasn't until I connected with the USABP through Erica Goodstone, that the first reward for research became a reality in 1999. When I joined the USABP Board in 2001, we expanded that effort and included a student research prize. Finally in 2005 research was given a place in the conference program where all attendees were able to acknowledge its importance. So support for the recognition of Body Psychotherapy goes way back to 1950 and my efforts on behalf of USABP are a continuation of what has been a very long term commitment to Body Psychotherapy

Three people have contributed memoirs of Alice: her sister-in-law, Carol Gaskin, her dear friend, Erica J. Kelley, and her colleague, Erica Goodstone, her predecessor as research chairperson of the USABP. Each sheds an additional light on this unique being.

My most vivid and amusing memory of Alice occurred one of the first times I met her. We were at a Board of Directors meeting in Egypt, Texas. In the heat of the day, on our lunch break, she was out on the tennis court taking on anyone who would play with her until they tired, and then she would summon the next one. None of them came within even 20 years of her age at that time. That is Alice!

Our lead article won the Student Research Award for 2008. Jeanne M. Denney conducted a study of the effects of states of compassionate presence on people in comatose states near death. She simultaneously measured heart rate variability (HRV) in both patient and in the person sitting beside the patient in self-identified states of compassion. Utilizing collateral

data from caregivers and family members as well as reports and interviews of the “sitter”, she explores important explanations and implications of the effects on both participants. Her protocol and presentation of data should serve as not only a pilot but a model for future studies.

Christa Ventling, Herbert Bertschi and Urs Gerhard studied the efficacy of bioenergetic psychotherapy on patients in three ICD-10 diagnostic groups: affective disorders, somatoform disorders and personality and behavior disturbances (F3, F4, and F6). Their retrospective analysis of questionnaires sent to 103 former patients of eight psychotherapists in private practice in Switzerland. Their inconclusive outcomes provide inviting avenues for further research. As has been found in most other types of psychotherapy, the authors conclude that the empathic qualities of the therapist as well as the way in which body interventions are integrated into the therapy may be the most important variables. And, as we know they are not only difficult to measure but challenging to articulate as well. The study also reminds us that we should be familiar with not only DSM diagnostic categories, but the more widely used ICD-10 as well.

Morgan Lazzaro-Smith is the recipient of the 2008 USABP Research Award for her study of body psychotherapy for the treatment of eating disorders. Interviewing nine therapists who use bodily interventions and seven eating disordered clients, she has identified important themes in the narratives of the clients’ descriptions of their attempts to manage the relationships between their bodies and emotions. And, she has mapped the significance of specific interventions and their outcomes for the interviewees.

Anastasia D. McRae’s thoughtful and sophisticated analysis of both qualitative and quantitative data collected from a sample of 164 licensed, practicing mental health professionals explores the attitudes toward touch of both those trained to touch and those who have had no such training. In this suggestive pilot study, she compares their attitudes and beliefs as well as their reports of what they actually do in various relevant circumstances.

In “What’s Under the Hood? Using What We Know From Brain Research to Design Creative, Clinical Mind-Body Interventions” Laurie Leitch, Co-Founder and Director of the Trauma Research Institute and Director of Research at the Foundation for Human Enrichment steps back from her concerns with large-scale evidence-based research to ponder how to use some findings of neuroscience research in our clinical practice. She gives us several ingenious examples of the use of what we know about the brain to design clinical interventions.

Several people have been inordinately helpful in the creation of this volume. My summer interns, especially Laura Shapiro and Aviva Bannerman worked tirelessly to make it as finished as we could. Laura worked with one of our authors to sharpen and focus her paper while Aviva did massive editing on many of the articles in this issue and some you will see in the next. Laurel Thompson, a fellow Board member proofread all the articles with particular attention to APA style.

Jacqueline A. Carleton, Ph.D.
New York City
November, 2008



Alice Kahn Ladas receiving notification that the USABP Research Award has been renamed the Alice Kahn Ladas Research Award. Award presented by Jacqueline Carleton. August 2008.



Carol Gaskin Ladas

Abstract

Carol Gaskin Ladas recounts her memories of her sister-in-law Alice Kahn Ladas.

Keywords

Alice Kahn Ladas – Memoirs – Body Psychotherapy History

I have known Alice Kahn Ladas since the early 1960s, when she and my brother, Harold Ladas, met and married. At the time, I was a new mom in my early twenties, and I was rather unworldly. Alice expanded my horizons enormously and continues to inspire me in many ways, from her dedication to breastfeeding and natural childbirth, to her knowledge of modern art and her passion for the disciplines of body centered psychotherapy.

When I moved to New York and lived with my brother, Alice, and my nieces for a year or so in the sixties, I had an opportunity to experience the excitement of Manhattan and the day-to-day artistic, musical and intellectual stimulation of the family. Through Alice, I discovered Wilhelm Reich's work on bioenergetics, along with the work of John Pierrakos and later the entire field of body centered therapy. I remember reading Reich's work on breathing and thinking how profound it was for me in regard to my own breath-work and body-experience. As a therapist, I was inspired by these experiences to explore, practice and teach mindfulness centered therapies such as Hakomi, Internal Family Systems and Focusing.

Alice's approach to the body, healthy food, vitamins, and exercise influenced me to make core decisions that have served me well in my life. Her dedication to health, strength and endurance continues through her regular yoga practice, insistence to commute everywhere by bicycle (even in New York City), and ski trips to Santa Fe. She shares her commitment by doing things such as several years ago when she took our whole family to Greece for a vacation to visit our Greek family there, she even went water skiing, to my amazement and delight.

From an early age, Alice was determined to live a full, well-rounded life in a way that stayed true to her vision. It is no wonder she and her family spent summers away from the busy city life of Manhattan; in the country, life was simpler. It was there that I met Alice's friends, Alexander and Eleanor Hamilton, who, through their care for children, created an alternative school in the Berkshires similar to Summerhill. Together, we discussed the fundamental aspects of a meaningful education, conversations that influenced my career as a teacher as well as encouraged me to explore educational alternatives for my daughter and to support the choices she has made for my granddaughter.

In reviewing the forty years I've known Alice, certain of her qualities surface again and again, qualities, such as courage, dedication and perseverance; she is full of energy, generosity and the determination to make a difference in the world. She has always been a synthesizer of information and a catalyst for change. During the late forties and early fifties, Alice worked in the private practice office of Dr. Nathan Ackerman, who went on to open the Family Mental Health Clinic of Jewish Family Services in New York in 1957 and publish the groundbreaking book, The Psychodynamics of Family Life: Diagnosis and Treatment of Family Relationships. She also directed the Department of Child Guidance in the Caldwell, New Jersey, Public School District and was assistant to the Director of the Maternal Care Adoption Service in Lakeville, Connecticut, where she later provided sex education classes to unmarried mothers.

In 1956, Alice was instrumental in founding the Institute for Bioenergetic Analysis, a pioneer organization in the field of body psychotherapy. She also helped to organize Dr. Alexander Lowen's lectures and put him in touch with his first publisher. In the 1960s, Alice taught the first Lamaze class in the United States. Her early articles on breastfeeding were published in Go Ahead and Live, a book that contributed to the Green Revolution, bringing environmental awareness to the question of providing babies with the best nutrition. For Alice, natural birth and breastfeeding were an integral part of the subject of sexuality and sex education. They continue to be an example of her lifelong commitment to bringing sex education out of the closet and into the classroom.

Alice's dissertation, Breastfeeding: The Less Available Option, was completed in 1970 with the help of 1100 members of La Leche League. It was published by The Journal of Tropical Pediatrics and was supported by Margaret Mead, who was the first person to join her dissertation committee. Thirty-four years later, Alice became the first person to lecture on sexuality at the Sunday Service of the New York Society for Ethical Culture on "The Sexual Revolution: Phase Two."

Alice sat on numerous boards throughout the years. During the 1970s, she served on the boards of both the Society for the Scientific Study of Sexuality (SSSS) and the International Institute of Bioenergetic Analysis. A study she conducted with my brother, Harold, on women and Bioenergetic Analysis, demonstrated the beneficial effects of body psychotherapy on women's sexuality. This study, presented at SSSS in 1979 as "From Freud Through Hite All Partly Right and Partly Wrong," led to the meeting with Beverly Whipple and John Perry that resulted in their collaboration on The G Spot, a synthesis of the work of Freud and sex researchers. Because of recent findings in neuroscience, which support the mind/body

connection, working with the body is finally being acknowledged as a significant aspect of effective therapy. As a member of the Board of Directors of USABP since the year 2000, Alice is finally able to promote research in body psychotherapy as she has always envisioned it.

Soon after the publication of The G Spot, Harold suffered a lengthy battle with cancer that required much of the family's time and energy. While Alice continued with her professional practice, she remained devoted to her husband and focused primarily on finding a cure. There was no cure, however, and Harold's death in 1989 was a huge loss for us all. Within the next few years, Alice moved into a co-housing community in the Southwest. It was a major change; leaving New York after all those years was not easy, but this new lifestyle in cooperative involvement is more in keeping with her real self.

Presently, Alice works on the staff of the Pastoral Counseling Center in Santa Fe, adding to the group the viewpoint of both a sex educator and a humanist; she is able to work with many Hispanic and Native American clients who are in need of these perspectives.

Alice has always been filled with boundless energy. She continues to maintain her clinical practice and remain devoted to her research in body centered therapies while traveling back and forth to New York to spend time with her children and grandchildren. In addition, she competes (and wins!) tennis competitions and competes in the senior Olympics. A few years ago, she fulfilled one of her greatest dreams when she played a Haydn piano concerto with an orchestra in Santa Fe.

Alice has made a significant impact on the world, especially in the lives of women, through her involvement with La Leche League, her influence on the Bioenergetic community, and in her clinical practice. Her publication of The G Spot, a bold move for that era, required great courage and perseverance, and it had a profound effect on the sexual awareness of women and men of our time. Alice has championed the cause of "coming back to our senses" for the life of the infant, for women's sensuality and sexuality, and for the emotional, physical and spiritual health of all humans. I applaud her unswerving devotion to family, somatic health and a better world, and I feel proud to be her sister-in-law.

Biography

Carol Ladas-Gaskin, M.A., is a certified Hakomi therapist, teacher and trainer and co-author with David Cole of Mindfulness Centered Therapies: An Integrated Approach. She is also a licensed massage therapist, award winning poet, author of Instant Stress Relief, and seminar leader for PESI (Professional Educational Seminars Incorporated) teaching Mindfulness and the Practice of Compassionate Presence for Health care professionals nationwide. Her email address is clgaskin@verizon.net ; www.seattlehakomi.net.

Alice Kahn Ladas

Erica J. Kelley

Abstract

Erica J. Kelley recounts her memories of Alice Kahn Ladas.

Keywords

Alice Kahn Ladas – Memoirs – Body Psychotherapy History

Alice would descend on us with the intensity of a comet. With every visit, my habitual complacency would be challenged by her penetrating eyes, her streams of questions, and her dazzling accomplishments.

Alice and my late husband Charles had been buddies since they studied Wilhelm Reich's work together in New York in the 1950s. I caught up with her in the '70s, when she came to California, first to present a workshop on Bioenergetic Analysis to our Radix trainees, and later to team up with Chuck for sex research, which included training with Hartman and Fithian in Long Beach.

Underlying every specialty is her passion, and compassion, for this planet and its people; I have always been impressed with her consistent determination and ability to put thought into action. Her investment in cooperative, sustainable living in Santa Fe, long before "green" became fashionable, is just one example.

Perhaps a ditty I wrote for her 80th birthday in 2001 best sums her up, and also reminds me of the mischievous twinkle in her penetrating eyes.

*An intelligent woman called Alice
Spent much of her life thinking "phallus."
Breastfeeding and G-spots she widely acclaimed,
And helped found Bioenergetics, which soon became famed.
From Wilhelm to Deepok, her interests wander;
From elephant-riding to UFO's yonder.
She writes theses and books, and musicals, too;
There's simply no end to what Alice can do.
Now it's magnets and tennis – what else have I missed?
-- The mention of lucky men Alice has kissed!*

With love and respect,
Erica Kelley

Biography

Erica J. Kelley co-founded Radix Education with her late husband Charles (Chuck) at the turn of the 1970s. She trained Radix teachers until she retired from the Radix Institute and direction of Radix Europe in the late '80s. She currently focuses on the legacy and development of Chuck's work through www.kelley-radix.org, among small efforts to make the world a better place, while enjoying family and the beauties of the Pacific Northwest. ericakelley@comcast.net

Tribute to Dr. Alice Kahn Ladas

Erica Goodstone, Ph.D., LMHC, LMFT, LMT, CRS

Abstract

Dr. Alice Ladas is one of the unsung heroes of women's liberation. She was a pioneer in sexology as well as body psychotherapy and an advocate for scientific research throughout her career; she currently serves as Research Committee Chair on the USABP Board of Directors, one of the few USABP members who worked directly with Wilhelm Reich and owned her own Orgone Accumulator. Dr. Ladas was one of a small privileged group to view the first presentation by Alfred C. Kinsey, renowned author of *Sexual Behavior in the Human Male* and *Sexual Behavior in the Human Female*, and she helped to found the original Institute for Bioenergetic Analysis.

Keywords

Alice Kahn Ladas – Memoirs – Body Psychotherapy History

I met Dr. Alice Kahn Ladas sometime in the early 1990s, years before the USABP came into existence. Sexuality played an important role in Alice's work from the very beginning. When we first met, I was chairperson of the New York Metropolitan Area Section for AASECT (The American Association of Sex Educators, Counselors and Therapists). In that capacity, I contacted local AASECT members in an attempt to build a supportive, collegial network with local New York City sexologists.

Most of the AASECT members I contacted agreed that creating an ongoing networking group was a great idea and said they would be happy to attend such a meeting when they knew "enough people" would be there. Dr. Ladas was one of the few people who was not only interested in such a meeting, but also helped and encouraged me to get it organized and running.

She invited me to her lovely Upper West Side Manhattan apartment where she treated me to a delightfully healthy lunch. As a result of this initial meeting, we exchanged a few body psychotherapy sessions: I offered her my Rubinfeld Synergy sessions and she gave me some Bioenergetic Analysis sessions. In doing so, we helped each other gain more insight and relief from our current life dilemmas.

Our first meeting led to the creation of a group of local sexologists that continued to meet for several years. As a group, we accomplished what none of us could have done alone. At one meeting, we discovered that four of us had submitted papers to be presented at the next AASECT meeting – and **all four papers had been rejected**. Our small group of four people created our own mini-conference presentation at the next AASECT conference. We had forty people in attendance, and all four of us were put on the official program at the AASECT conference the following year. That small group also created an AASECT sponsored conference (offering CEU's) at F.I.T./State University of New York, where I was working at the time.

Years later, when I became a USABP Board Member, Science and Research Committee Chairperson, I again reached out to Dr. Ladas for assistance. When we met for lunch, our discussions led to a framework of questions and goals that started the ball rolling. She became a committee member, and when I left the board, Alice eagerly became a board member and took over as Science and Research Committee Chairperson.

Dr. Alice Ladas is one of the unsung heroes of women's liberation. She has always been dedicated to spreading the word about what she believes to be true, a pioneer in both sexology and body psychotherapy. She met, studied, and trained with some of the leading professionals in both fields. She struggled to fight biases against her work in Sexology, prejudice against people's ideas that women should not be independent or successful, and resistance to her involvement with Body Psychotherapy and Bioenergetic Analysis.

Her initial training was Neo-Freudian at the Washington Square School of Psychiatry.. She got her MSW from The Smith School of Social Work, which she claims was quite orthodox Freudian.

After receiving her MSW, she worked at The Jewish Board of Guardians and The Payne Whitney Clinic, as well as in the private office of Nathan Ackerman, M.D., at the time that he was developing Family Therapy. She also was one of a select few to be invited to the first presentation by Alfred C. Kinsey (the renowned researcher and co-author of *Sexual Behavior in the Human Male* and *Sexual Behavior in the Human Female*) at the New York Academy of Medicine in New York City.

Dissatisfied with the results of traditional talk therapy, both for herself and for her clients, Dr. Ladas was attracted to the work of Wilhelm Reich because of its attention to the body and positive regard for human sexuality. At an early SSSS conference, she was among the first group of people to watch, behind locked doors, the earliest movies about the work of William Masters and Virginia Johnson.

In the 1980s, Charles Kelley, founder of the Radix Institute, and Alice studied together with Hartman and Fithian, co-sex therapists, who probably had trained with Masters and Johnson. Somewhere along the way, she also took Betty Dodson's workshop designed to assist women to better understand their own bodies through self-pleasuring.

Dr. Alice Ladas is currently a Diplomate for the American Board of Sexology, a Diplomate in Clinical Social Work, and a clinical member of the USABP. In the past few years, she has presented her work, information about body psychotherapy, sexuality, and the importance of scientific research at conferences such as The International Bioenergetic Analysis Society, The American Association of Sex Educators, Counselors and Therapists, The New York Society for Ethical Culture, and The USABP. Since her ground-breaking, best selling book, *The G Spot*, in the 1980s, she has continued to write numerous articles, including some recent ones for Cliniscope, The American Academy of Clinical Sexologists, and The Archives of Medical Research. She is currently a USABP Board Member, Science and Research Committee Chairperson, and she maintains a private practice in Santa Fe, New Mexico, and New York City.

Biography

Dr. Erica Goodstone has served the USABP as an original steering committee member, as Science and Research Chair on the Board of Directors, and as Newsletter Editor. She continues to assist as a member of the Research Committee. She is a Certified Rubenfeld Synergist®, Licensed Mental Health Counselor, Licensed Professional Counselor, Licensed Marriage and Family Therapist, Licensed Massage and Bodywork Therapist, Diplomate & Fellow, American Association of Integrative Medicine, Diplomate, American Academy of Pain Management, Diplomate, American Board of Sexology, and a Certified Sex Therapist, American Association of Sex Educators, Counselors and Therapists. She maintains a private counseling practice specializing in relationships, sexuality and body psychotherapy. She can be reached through her web site at www.DrEricaWellness.com.

The Effects of Compassionate Presence on People in Comatose States Near Death

Jeanne M. Denney

Abstract

This study investigates the effects of compassionate presence on hospice patients in non-communicative states near death, and on the hospice workers offering this compassionate presence (called sitters). Simultaneous measurements of heart rate variability (HRV) were collected from patients and from sitters in self-identified states of compassion with them. Other measures, such as interviews with caregivers and family members, and reports from and interviews with sitters were used to assess effect of these interactions. This study offers possible explanations of responses that comatose patients and their sitters had to the experience of compassionate exchange, explores implications about the dynamics of compassion and suggests directions for future research.

Findings of this investigation were that the patients studied appeared to have significant responses to caring people in their environment, as well as interventions such as prayer, meditation and touch, while the act of sitting also exerted a significant effect on sitters.

Keywords

Dying – Hospice – Burnout – Coma - Compassion

Introduction

In the United States alone, each year over 2.4 million people die. The vast majority of these deaths are neither accidental nor sudden, but are related to disease processes (Hoyert, Kung, & Smith, 2005). Since most disease processes resulting in death culminate in a comatose or non-communicative state for some period of time before death occurs, most Americans – indeed, most people living - will experience this state before their last breath is taken. Yet because there is generally no return to coherence from this state of consciousness, there is still much to be learned about the inner experience of this state or the emotional or spiritual care most likely to help in this transition.

While much has been reported in recent years about how the dying die, and the beauty that this change can hold, most information on the dying is presented as anecdote or story that offers inspiration for hospice workers and bereaved family members, and opens spiritual ideas to others working through life processes. It is not common for researchers to study the non-communicative dying and their responses directly. Indeed, a cursory search of journal articles and periodicals resulted in no direct physiological or psychological studies of this stage of dying. Most studies screened focused on the responses of family or caretakers to death, or on the experiences of dying people while they are still in communicative states. This may indicate either reluctance by researchers to question or investigate the consciousness state of dying person with objective scientific instruments, a feeling that this state is impenetrable, or the conclusion that findings are ultimately irrelevant to life and the living.

Clues to the mystery of the transition out of life are offered by research on the Near-Death Experience (NDE), stories from people who have survived coma and unconscious states, the experiences of people who care for the unconscious, comatose and dying, as well as esoteric and spiritual practitioners. Numerous reports from practitioners and coma patients suggest that the presence of others who are loving or caring is helpful and meaningful for those who venture into unconscious states near death (Boerstler, 1986; Lawrence, 1995; Parker, 1984; Sogyal Rinpoche, 1992; Tosch, 1988; Villaire, 1995). Further, if caretakers are aware and sensitive to their own experience, providing this presence can be transformative for them as well, often leaving them with a changed perspective on their lives (Morris, & Knafel, 2003; Smith 1998; Sutherland, 1990; Whitfield 1998).

This pilot investigation explored the possible effects of compassionate presence on the mental, emotional, or physical states of a dying person and those of people who hold this state of compassionate presence with them. Ultimately, it is an investigation into non-verbal communication with people in the altered state of consciousness. It explores whether it is possible to use direct, instrumental means to study these subtle human interactions and the people in these states of consciousness.

Methods

The primary method used in this pilot investigation was the exposure of people in near death, non-communicative states or coma to a particular experience: that of a loving, respectful and non-invasive presence called compassion, and the

measurement of possible effects of this experience on both patient and sitter by several means. This investigation used both quantitative and qualitative methods. Quantitative measurements were made with The HeartMath Freeze-Framer heart monitoring program on laptop computers with finger sensors for both patient and sitters. Qualitative methods were interviews with families and sitters and descriptive sitter reports. Comparisons were made both within measurement vehicles and between them.

Participants

This project worked with four patients and a total of five sitters including myself. Patients were drawn from a non-residential Hospice population, while sitters were drawn from a population of Hospice volunteers. Patients were residing in two care facilities, one a 203 bed private nursing home, the second a 341 bed public County Sanatorium.

Selection of Patients

Patients selected for this study were to be non-communicative or in a state of metabolic coma in the final stages of life. Patients were in situations in which there was a limited amount of human contact similar to what is being provided by this study. They were also required to have a person qualified by them to give consent for the study on their behalf. Patients were to be female. Finally the patients were to have been in Hospice care for at least one week.

Selection of Sitters

Sitters who provided compassionate presence to patients were UHR trained volunteers selected for experience with relaxation, meditation, or training in healing modalities, body awareness and/or self-regulation of consciousness. Prior to participation, sitters were tested for their ability to hold a conscious, positive state of presence in isolation as measured by the biofeedback instrument, The HeartMath Freeze-Framer.

I attempted to use sitters other than myself in sessions with patients. However, in numerous time-limited situation in which there were no sitters other than myself available for a session or a sitter did not show up for the session, I filled in. As a result, I participated in a total of 10 out of 27 sittings. In this case I operated the software and was responsible for patient finger sensor adjustment as well as providing compassionate presence.

Sitter Training

Before the project began sitters received 2 hours of training to provide education about the project and reduce sitter anxiety through practice. At conclusion, sitters were pre-qualified for their ability to sustain HRV coherence on the Freeze-Framer program in a normal setting. Specifically, sitters were required to sustain a Heart Rate Variability within the medium to high coherence ratio range for at least five minutes of a 10 minute reading. The program setting for this qualifying test was challenge level two, or "normal".

A total of five sitters were trained and pre-qualified for participation.

General Parameters for Sittings

1. States of compassionate presence were held for each patient for no fewer than six contact sessions.
2. During sittings, biofeedback data on Heart Rate Variability for both sitter and patient were simultaneously collected by means of a HeartMath Freeze-Framer heart monitoring system.
3. Pre-project baseline readings were collected from patients before the first sitting to allow for comparison. Adjustments were made to protocols after the twelfth sitting when I began to collect pre-sitting baseline readings as well.
4. Interactions lasted at least 20 minutes per session measured from beginning of instrumental measurement to end.
5. Patients were exposed to different sitters within the study period.
6. Each sitter completed a survey report after each interaction with patients. Reports were completed prior to knowledge of external measurement outcomes (except when I was functioning as both sitter and operator of the equipment).

Protocols for Interacting with Patients

Though patients were not communicative by ordinary means, it was not assumed that they were insensitive to what was going on around them, nor that they could not communicate through body movement of some kind. Patients were greeted by myself and by the sitters at the beginning and thanked at the end of each session. This greeting consisted of taking the patient's hand and speaking to them, telling them who we were, what we intended to do and asking them for a sign of some kind if this activity is not alright with them. Specific suggestions for a "no" response were often made based on patient capacity, such as blinking eyes, squeezing hands or moving head.

Sitters were instructed to sit within two to four feet of the patient and to maximize their sense of connection with the patient. Freeze-framer sessions were initiated when introductions were concluded, HRV sensors were in place and sitter was

comfortably situated. Sitters were encouraged to experiment with breath synchronization or position during the session if they felt that it enhanced the sense of connection.

Aside from greetings and closure the project was originally intended to be an investigation of silent, non-physical contact and interaction. However, later in the project, touch, prayer and meditation were experimented with and will be described below.

Data Collection

The Freeze-Framer program used in this project was designed and is marketed by the Institute of HeartMath as an interactive learning program for prevention, management and reversal of stress in general populations. It includes a patented heart monitor system (software and sensor) that processes heart rate data and develops graphical images of HRV, as well as other parameters. Using this technology, the Institute of HeartMath (IHM) has done research on correlations between emotional state and HRV to help people in the general population learn and maintain more optimal states of well-being as understood by IHM. Because Freeze-framer was available, portable and because there was a body of research connecting HRV with states of unease and well-being, it was the biofeedback device selected for this use in this study.

One important heart behavior that IHM identified and studied was the tendency of the heart rate to vary in a consistent, sinusoidal oscillation during periods of emotional well-being. This pattern is called Heart Rate Variability (HRV) *Coherence*. IHM research also showed that the HRV of one person can have an effect on, or can “entrain”, the HRV of another person. (McCraty, 2003) Further, IHM research has suggested that an individual’s coherence can be influenced by a phenomenon of group coherence, or the effect of a group of others. (Childre and Martin) Analysis of HRV, then, offered the possibility of evaluating the emotional states of non-verbal patients and the effects of relationship with another.

In addition to biofeedback and coherence measurements, possible effects of states of presence were evaluated through interviews with family and/or caretakers and sitters as well as written sitter reports.

Results

At the completion of this study, a number of factors were identified for analysis. Findings of this review are summarized below.

Patient Responses to Sittings

After review of HRV data it appeared that, though there were differences in receptivity and responsiveness, most patients were responsive to most sitters. Responsiveness in this context was defined as discernable patterns or changes in patient HRV that coincided with the sitting, or with the sitter patterns, changes or actions. As discussed above, responses to sitters were often very subtle. These responses are discussed more fully below.

Patient Coherence and HRV

Patient Coherence was analyzed and compared with baseline measurements and post-sitting measurements. One of the first clear findings of the study was that coherence parameters developed by studying healthy people were not a parameter useful for directly evaluating patient well-being near death. Three of four patients were not able to sustain much heart coherence as monitored and analyzed by the Freeze-Framer heart monitoring system. Patient coherence was variable, but generally low. In some cases (such as a patient who was on a ventilator) it was nearly non-existent. Indeed, each patient seemed to have characteristic patterns of HRV, but these patterns were often unstable, influenced by medical conditions, medications and medical implements, and subject to sudden change. As a result, pre-project baselines did not provide a useful measure of the normative state for the patient. As noted above, pre-sitting baselines were introduced in the twelfth sitting and thereafter, providing more accurate measures of the influence of the sitter.

Comparisons with available baselines showed that patients had an increase in coherence in 14 out of 28 sittings, and a decrease in patient coherence in 6 out of 28 sittings. In 7 of 28 sittings there was no significant change in coherence (changes of 1% were not considered significant). In one sitting, coherence values were undecipherable.

The most neurologically damaged patients were understandably the least responsive to sittings in terms of coherence. A patient I will call Pamela who was both on a ventilator and the most heavily medicated patient, was the least responsive to anyone in her presence other than her husband. However, even Pamela showed evidence of subtle responses to sitters.

Two patients had post-sitting baselines measured for one sitting each. These measurements occurred immediately after a sitting in which the patient either lost coherence or had a very minor change during the sitting. Interestingly, in both post-sitting baselines there was an overall increase in final coherence over pre-sitting baseline and sitting measurements.

Table 3.
Coherence Scores in Sitting #15 and #27

	Pre-sitting Baseline		Sitting		Post-Sitting Baseline	
	Medium	High	Medium	High	Medium	High
Pamela	0%	0%	1%	0%	0%	6%
Maureen	15%	4%	8%	4%	21%	15%

Sitter Coherence

The most clear and unanticipated result of this investigation was that with few exceptions sitters were *unable to maintain the level of heart coherence at the bedside of a patient that they had achieved in their qualification test*. Sitters did not achieve periods of continuous coherence for most sittings. An analysis of sitter coherence was tabulated and is provided in Appendix K. The average loss of sitter coherence with respect to the qualifying sitting was 56%. Values are tabulated in the table below.

Table 4.
Percent Reduction in Average Coherence with respect to Qualification

Sitter A – Beth	-63%
Sitter B – Cynthia	-68%
Sitter C – Sally	-72%
Sitter D – Ellen	-22%
Sitter Z – Jeanne	-57%

At first this striking loss of coherence was attributed to self-consciousness and the effect of participation in a study. However, the consistency of this result throughout the study suggested that the setting, the sensitivity of the sitter and possibly the activity itself, may have played a part in this outcome. It suggests the possibility that being in groups of persons in states of need or distress may have the effect of lowering the HRV coherence of people who come into that group, an outcome that IHM research would likely have predicted based on the theory of entrainment.

The settings in which this work was done were medium to large convalescent facilities. The pain, suffering and loneliness of many individuals, combined with the fact that these facilities are manned by overburdened staff, likely had the effect of lowering the coherence level of sitters whose expressed purpose was to be a compassionate present witness. Clearly, because the coherence of others in the environment was not directly measured, this theory is only based on a subjective experience of stress in these environments. However, the idea that coherence in groups of this nature may be low is supported by research on the HRV of people who are ill and elderly, as well as research that suggests that there is a high level of stress on caregivers in health facilities. (McCraty and Atkinson, 1996; Aiken, Clarke, et al., 2002).

Another possible explanation for the lowering of sitter coherence is that training and preparation of the sitters was inadequate. However, while poor training and lack of experience might explain low coherence values, it does not explain why all sitters did significantly better in their qualification sessions at a time when they had no experience with patients. Other explanations will be explored below.

Aside from the issue of reduction of sitter coherence with respect to qualifications scores, there was a significant difference between sitters in the field. Mean coherence scores for each sitter are summarized below.

Table 5.
Mean Sitting Coherence Scores for Sitters

	Medium	High
Beth	12%	21%
Cynthia	18%	11%
Sally	16%	6%
Ellen	21%	56%
Jeanne	19%	35%

Sitter's Response to Sittings

Review of coherence scores, above, indicates that there was some degree of struggle or discomfort with the experience for sitters on an unconscious level, at minimum, during sittings. This was echoed in several sitters' conscious reflections on their experience. However, though interviews with sitters indicated that the overall post-sitting effect on them was varied, the experience seemed to have generally supported their personal growth. Four of five sitters (including myself) noted feeling good about what they had done for a variety of reasons. Cynthia reported the feeling that her heart was more open, that she had more presence and fewer judgments. She also noted feeling the "embarrassment of riches" of her present life and health. This experience deepened her gratitude for mobility and awareness. She noted "a deepening appreciation for this stage of life"(referring to the end of life). Beth felt more neutral about the experience itself, but felt good about herself as having been a participant in a study. Sally felt good about having been part of the study and having been a witness to the comatose state of Pamela. Two sitters (Sally and Ellen, both sitters of Pamela) seemed to feel more sober or as if they had been wakened to a very different reality. Sally stated, "I felt like I did coming home after visiting a foreign country. There was no way to communicate the experience and it was hard not to be able to be able to share it." Ellen said: "When you leave people who are talking, you feel kind of uplifted. I left these patient's in a quieter state...I left there feeling a little more melancholy... I was able to feel the compassion. That was the same. But I was wondering if it was meaningful for these people."

Four of five sitters said that they would be willing to do this again. Sally qualified her affirmative response to the question of whether she would do it again with "...but I would be more conscious of the fact that it would take me on my own journey." Ellen (interestingly the most coherent sitter) stated that she would not seek this experience out again. "I like to converse and see at least an apparent exchange. I wouldn't seek it out." It is interesting and possibly significant to note that Ellen was technically the most coherent sitter and the sitter least available for participation. The irony of Ellen's coherence and response is discussed further in the Discussion below.

Sally expressed a similar anxiety, however she seemed to understand this experience as a positive challenge. Sally stated that this experience had "allowed me to hold more questions." She noted that being able to hold more questions was her definition of being more alive. "It was life-affirming in the farthest possible way, though the surface was disturbing."

In sum, having listened to the experiences of the sitters I would characterize most all responses, even Ellen's, as providing evidence of growth and personal evolution through the experience of sitting with a form of existence that was new to them and that raised new questions. No sitter was resoundingly overwhelmed, disturbed, depleted or depressed by the experience. Sitters seemed to internalize the experience with different levels of intensity, and interpreted the experience based mainly on how it related to personal issues and questions.

Evidence of Relationship

Evidence of Relationship was evaluated through the careful examination of HRV graphs and coherence scores and comparison of these with sitting notes. Relationship in this context was evaluated by apparent influence of one person on the other. The following is a list of the types of responsiveness that was noted when HRV graphs were analyzed.

Simultaneous Response. The most obvious and pervasive evidence of relationship in sittings was what I chose to call simultaneous responses. These were places in the HRV graphs where changes occurred simultaneously in sitter and patient HRV. In 24 decipherable sittings, simultaneous responses were noted in 23 sittings. In three of the remaining four of the 28 sittings, the reading was undecipherable because one or the other of the participant's readings was not clear. In only one clear reading was no evidence noted.

Cross-Influence. Cross-influence is a specific type of simultaneous response. It was not observed often, but its presence certainly seemed to indicate a particular type of relational dynamic: that in which one participant takes on or trades an HRV pattern with another. This was identified in 6 out of 28 sitting but may have occurred more. Five of these occurred with myself as sitter.

Coherence. Though coherence scores themselves did not prove a simple, direct way to evaluate patient well-being, they did prove to be important in providing evidence of relationship. A few additional observations are made here with respect to particular relationships.

The most profound evidence of relationship was seen in review of the coherence analysis for Patient Pamela. Pamela had the lowest coherence of any of the patients and seemed impervious to influence by others in her presence. She had severe neurological damage, was on a ventilator and was heavily sedated. The total coherence for Pamela ranged from one to six percent, with little significant difference between sitters. Further, the coherence score of the sitter did not seem to have a significant impact on her coherence. However quite by chance at the beginning of the project, Pamela's coherence was measured in the presence of her husband at his request. Her coherence score with her husband, Larry was over nine times greater than the average score with sitters (28%), even though Larry's coherence itself was relatively low (8%). This result seems to suggest that there is a factor of loving relationship that has a positive effect on heart coherence, but is not causally related to another's coherence through entrainment.

The second evidence of a relationship and its effect on coherence could be seen in the exploration of Patient Anna and Sitter Beth. In sitter interviews, Beth stated her strong attraction to and fascination with Anna. Examination of Anna's coherence scores showed that Anna had approximately twice the coherence with Beth as any other sitter. Beth's coherence

with Anna was more consistent and was higher than her overall average for sittings. Unfortunately there were no pre-sitting baselines done for these sittings that might have shown Beth's influence on Anna more clearly.

The third evidence of relationship seen in coherence analysis was subtle but could be seen after an examination of Karen's coherence data with myself. I had been working with Karen for about 10 months as a hospice volunteer and had paid her 20 visits prior to the project beginning. I had never known her in a non-comatose state, however there were many times where I perceived that we had a good connection, a perception I gained through my own meditative state. Though my averages with her were in fact higher than other sitters, it did not appear to be a large difference. However, two things were noted after reviewing these numerical averages.

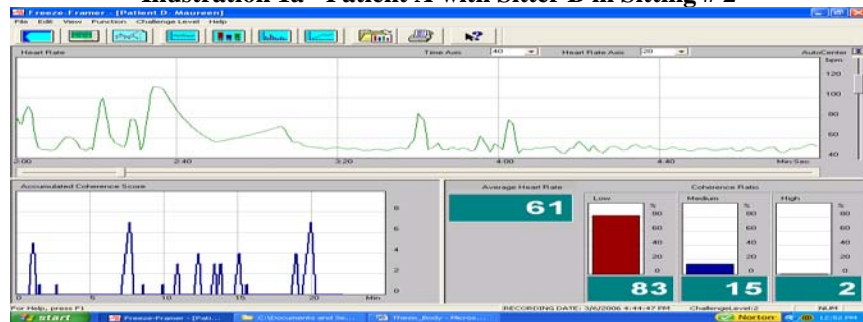
First, Karen died approximately six weeks after my last sitting with her (Sitting #13) after many years in a brain damaged and comatose state. This last sitting, in which there was very little coherence (combined coherence of 3%), took place over two months after the main body of all other sittings with Karen. There is a considerable contrast between this last sitting and Sitting #9 with me (combined patient coherence of 19%) which was markedly different than her scores with other sitters or her baseline figures. It seems very possible that her near-death state may have lowered her capacity to demonstrate heart coherence at a level that is recognized by the Freeze-Framer. If this were true, it would have negatively influenced her average coherence figure with me.

A second curious occurrence between Karen and myself also underlined the possible effect of relationship and may have distorted calculated figures. In Sitting #7 with Sitter Beth, Karen demonstrated her maximum coherence peak when I walked near her bed to make an adjustment 17 minutes into the session. This accounted for at least half of the coherence that Karen demonstrated in that session with Beth. The other half was demonstrated in the first few minutes of the session when I was also nearby. It seems unlikely to me that this was a coincidence. Since this was recorded as coherence with Beth, this probably inadvertently distorted these comparisons. If these factors were to be removed (ignoring her last session with me and reducing Beth's coherence in Sitting #7 by 50%), Karen's total coherence with me would be approximately four times that of other sitters.

Changes in Patient Amplitudes During Sitter Coherence. An interesting phenomenon observed in this study was that typical amplitudes of patients would often change, either decrease or increase during periods of sitter coherence. For example, the "jagged hill" pattern of Karen would often flatten. Or, at times the nearly flat pattern of Pamela would begin to have a long slow hill pattern.



Illustration 1a - Patient A with Sitter B in Sitting # 2



**Illustration 1b - Patient D with Sitter D in Sitting #28
Examples of Flattening during Sitter Coherence Period**

Though many examples were not as clear as these, this type of shift was noted in 17 out of 24 decipherable sessions. It was not noted in 7 out of 24 sessions. Four sessions were indecipherable.

Changes in PNS Mediated Responses. A PNS mediated response is a response due to the fact that the PNS is suddenly activated or interrupted, and which results in a sudden change in heart rate. The presence of this type of pattern in a

normal population is usually considered a sign of incoherence, or an indicator of stress or anxiety (McCraty & Atkinson, 1996). The graphs were reviewed for signs of whether PNS mediation increased or decreased during the sitting. In 24 decipherable sittings, PNS mediation was decreased in nine sittings. There was no change in PNS mediated patterns in eight sittings. There was an increase in PNS mediation in six sittings. In three sittings, there was a mix of responses, including both decrease and increase.

Discussions with IHM researcher, Rollin McCraty, pointed out the fact that in the state of overall instability that this population exhibits in HRV, even the smallest stimulation could provoke PNS-mediated responses, even if they were a result of excitement. His opinion was that this was not necessarily a negative response, but rather a sign of the nervous system attempting to activate the body (R. McCraty, personal communication, April 24, 2006).

One interesting thing to note concerning Patient Maureen is that she exhibited more overall capacity for reactivity to sitters in her presence than other patients. She was also the patient who demonstrated the highest coherence in baseline measurements, and who had the greatest amount of loving contact and family relationship in her life. All of these facts seem to confirm the assertion of IHM that people who are in loving relationship are “better able to receive cardiac signals from others” (McCraty and Atkins, 2003, p.12).

Other Evidence of Relationship. Further evidences of relationship could be seen in the exploration of touch, prayer and meditation that was introduced in later sittings. These findings will be discussed further below.

Phenomenon of Cross-influence

In numerous examples in this study there were situations in which it appeared that the sitter took on patterns or characteristics of the patient’s HRV, such as shifting to more PNS mediation, taking on similar amplitude and quality oscillations, shifting to similar peak spectrum ranges or heart rates. In some cases the patient simultaneously seemed to benefit from this shift, either by becoming more coherent or by experiencing a more normalized HRV pattern, for example with less PNS mediation. I am choosing to call this phenomenon “cross-influence”.

The first and most dramatic observation of this occurred when I was present as a sitter, therefore watching laptops during the sitting. Because I am somewhat proficient at coming into coherence using the Freeze-Framer, when I noticed that I was not in a coherent pattern I tried to come into one by deepening my breath and focusing on my heart. I was able to do this, but I noticed that in order to do this I had to interrupt compassionate focus on the patient, remove my focus from her and put it onto myself. When I became aware of her again, my coherence level instantaneously dropped. Later in the same session when I was again in a coherent pattern, the patient began to show signs of intense discomfort of some kind, which did not seem to me to be physical. I chose to make physical contact with her and placed my hand on her leg. At the same minute that contact was made, my HRV became incoherent, and the patient technically (by Freeze-Framer) came into coherence and exhibited reduced HRV amplitudes, though the patterns did not appear to be sinusoidal. That pattern was repeated in a later episode within the same sitting. See Illustration No. 2 below.



Illustration No. 2a – Sitter Z with Patient A – Sitting #6

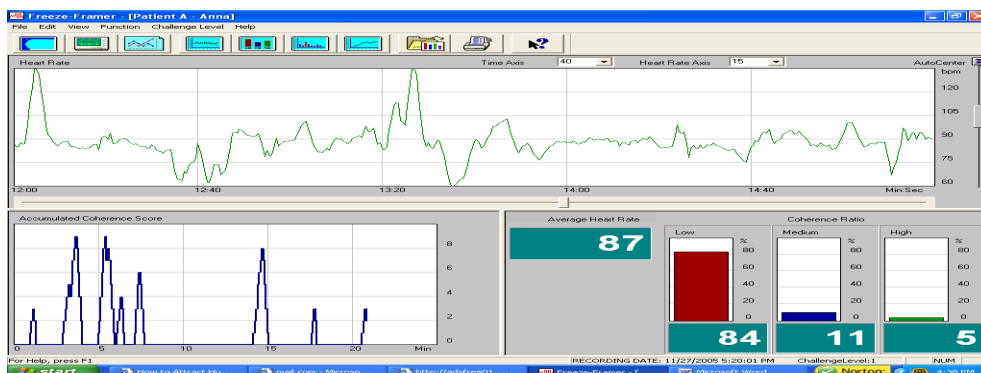


Illustration No. 2b – Patient A with Sitter Z – Sitting #6

Note that my pattern became similar to Anna's as if I were "taking it on", while Anna's amplitudes shift to a range similar to mine previous to contact. It is unfortunate that these effects occurred with myself, as researcher, in the role of the sitter. However, if I had not been the sitter and therefore monitoring the laptop while also doing the sitting, I probably would not have been able to experience the simultaneity of these events as observer of both inner experience and external readings.

It seemed that this effect was more likely to happen with certain sitters than with others. Cynthia and I were the sitters with whom this phenomenon was identified.

Effect of Touch

As noted above, there were times during this study when touch was used, either to respond to a perceived patient need, or was deliberately added at the end of a session as a part of the investigation. There were usually clear responses to touch, in patient and/or sitter. Generally, touch created a destabilization of the patient's HRV pattern and an increase in amplitudes. Often a destabilization of the sitter's HRV pattern would also occur. Most commonly, the HRV amplitudes would increase at the moment of touch and for some period afterwards. See Illustration No. 2 below. This pattern might be considered a negative response, indicating possible startle, but it is not clear that disruption of HRV is a long-term effect of touch in either sitter or patient. Note that touch was introduced at the end of the session at or near 20 minutes.



**Illustration No. 3 – Example of Patient Response to Touch
Sitting #2**

Touch was noted with time correlates in a total of 15 sessions. Patient response was noted in 9 out of these 15 sessions. In five of these sessions I was unable to determine a response or it was unclear for some reason, such as finger sensor placement. In one session there appeared to be no response. Sitter HRV response to touch was also noted in 9 out of 15 sessions. Sitter and patient demonstrated a simultaneous response to touch in six sittings.

Unfortunately, many of the examples of touch were used at the end of the sittings, added experimentally to non-contact sittings. As a result, there are not good examples of the effects of touch over time. The example given below in the case of touch used with meditation (see Illustration 5a and 5b below) does seem to indicate a possibility that the startle response might at some point give way, or that touch might be a source of comfort in the context of a trusting relationship. This may have been a part of the relatively high coherence of Pamela with her husband, who was continuously stroking her nose during his sitting with her.

Effect of Prayer and Meditation

Though there was not originally an intention to explore the effect of this parameter in this study, as the study ran its course different questions emerged. The effect of prayer and meditation came into the study because I had regularly used meditation at the bedside of non-communicative patients in order to establish a mode of communication with them. This was a normal form of my bedside presence. As the study progressed with myself as a sitter, I began to become curious about the effect of this activity on patient HRV. This technique was not one that I could easily describe for other sitters to explore. However, the use of prayer at the bedside of patients is widely used as a method for helping the dying in many spiritual traditions. Many people have a working understanding and active practice of prayer. Cynthia in particular, an interfaith minister, had a strong connection to the use of prayer as spiritual practice. For these reasons I asked three sitters to experiment with the introduction of prayer at a given point in their sittings.

The introduction of silent prayer was explored in seven sittings in the later part of the study, one with Patient Karen and six with Patient Maureen. The instructions for this prayer were for the sitter to simply to ask silently for spiritual help for themselves and the patient using any spiritual images, identities or words that felt sacred to them.

Sitter responses to prayer were noted in five out of seven readable sittings. Patient responses were noted in six out of six readable sittings. All but one of these responses appeared to be in the direction of increased regularity and evenness of

HRV oscillation, though there was often an initial disturbance or increase in amplitudes around the time of the prayer. See Illustrations 4 and 5 below. In most cases, prayer had the effect of lowering and evening amplitudes for sitters. However, in one sitting when meditation was used with touch it had the effect of increasing amplitudes (See Illustration 6a). It is noted that this increased amplitude was within a coherent pattern. This is generally a positive shift.

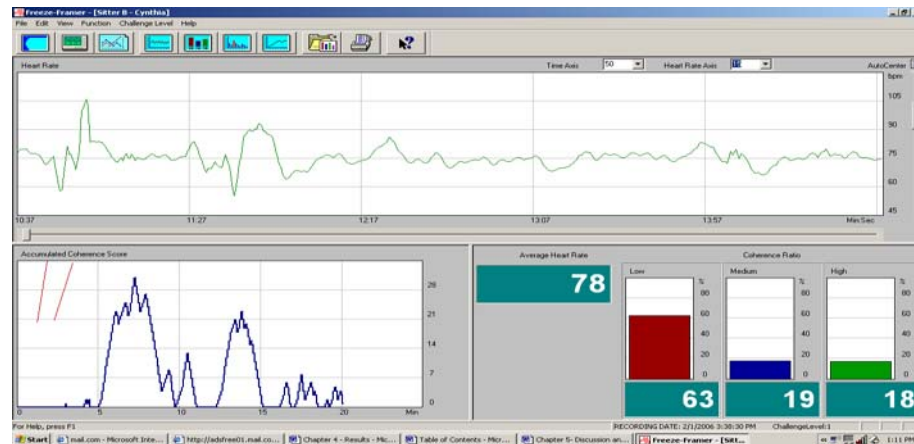


Illustration 4a – Effect of Prayer on Sitter B-Sitting 23

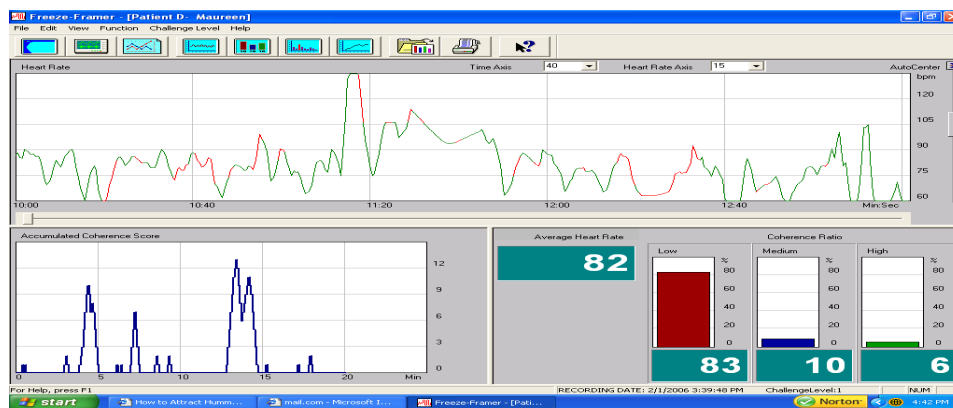


Illustration 4b - Effect of Prayer on Patient D – Sitting 23

Prayer was noted to have been introduced near 12 minutes. Note that these illustrations are one frame apart, so that the peak in the Patient HRV occurs just before the peak in the sitter’s HRV.

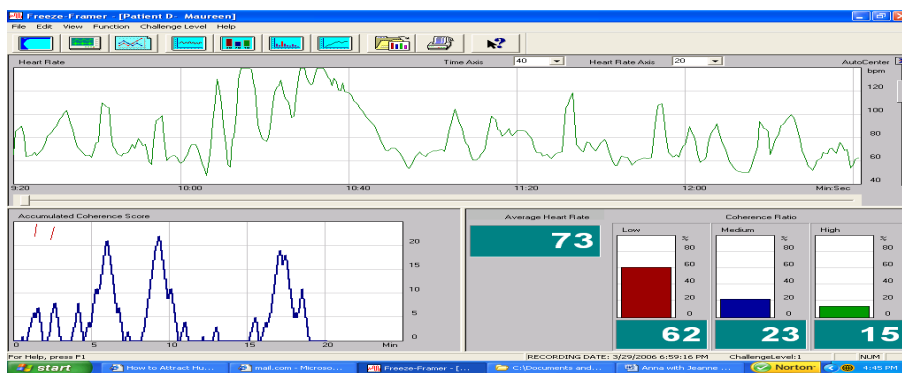


Illustration 5a - Effect of Prayer on Patient D- Sitting 28

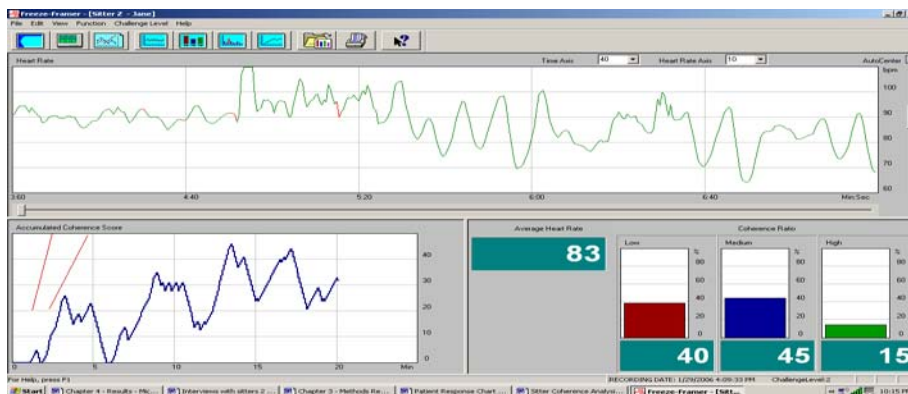


Illustration 5b - Effect of Prayer on Sitter D- Sitting 28

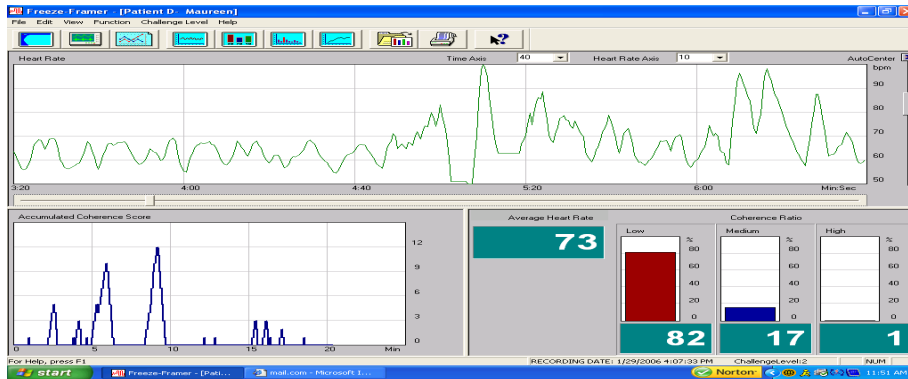
Prayer was initiated between 11 and 11:30 minutes in Sitting 28. Note that sitter response appears as a low, even pattern. In both examples given above, Patient D seemed to have anticipated the prayer offering and exhibited higher amplitude oscillations or peaking before the sitter actually to offered the prayer. During this interval I would have been near both sitter and patient prompting the sitter that this might be a good time to consider offering a prayer. My proximity could also have been a factor in this response.

One of the most interesting anecdotes concerning the use of prayer was observed in Sitting 25, the sitting in which there was not technically a positive response. In this sitting between Cynthia and Maureen, Sitter Cynthia offered a prayer that was later reported to include affirmations of infinite love, God, and invocations of Jesus and Mary. At just this point, Patient Maureen made a loud and articulate exclamation: “Be quiet!” While this may have been coincidental, it was very unusual for Maureen to use clear, discernable speech and her response seemed poignantly related to the subject matter. Cynthia had no idea that Maureen was reported by her husband to have become resistant to Catholic religious figures and rituals. In a later, different prayer in the same sitting, Maureen shifted into coherence. Cynthia reported her perception that Maureen seemed to “relax into it and fell asleep.” This experience obviously raised the possibility that patients not only might be positively affected by the introduction of prayer, but that they may be sensitive to the actual content and imagery used in prayer and may also have extremely personal responses to the content. While the sitter showed a sharp increase in amplitude at the point of this prayer, it is possible that this response was a response to Maureen’s unexpected words rather than to the prayer itself.

The meditation technique that I have used with hospice patients as a volunteer was noted in a total of eight sessions. This technique involved finding a mental image of the patient and observing the patient within this meditative state, as well as my interaction with her. Unfortunately, because this type of tracking was not an original focus of this investigation, a timeline correlation with this technique was made in only two later sittings (Sittings 13 and 21). There was an observable change in the my HRV with Karen in Sitting 13, and a probable shift in Karen’s at about the time of this introduction of both prayer and meditation. In Sitting 21 with Maureen (See Illustration 5a and 5b below), there was a shift in both patient and sitter HRV. Note the disruption of sitter pattern at five minutes when touch was reported and prayer was begun, and that within approximately 30 seconds the pattern changed to a deeper, more coherent sinusoidal pattern.



**Touch and Meditation Used Together
Illustration No. 6a - Sitter Z with Patient D – Sitting 21**



**Touch and Meditation Used Together
Illustration No. 6b - Patient D with Sitter Z – Sitting 21**

In sum, though it was necessary to screen these sittings with an expanded timeline, there seemed to be significant evidence that touch, prayer and meditation all have the capacity to influence the dying in ways that were generally positive for the patients and sitters investigated in this study.

Conclusions

Review of HRV data, reports and interviews, seems to provide evidence of interaction between sitter and patient in these sittings as well as probable influence of techniques such as prayer, touch and focused meditation on HRV. These results were sometimes calculable, such as information that was generated by the Freeze-Framer coherence analysis, but more often were observed by a close, simultaneous investigation of the HRV patterns of patient and sitter.

In sum these results seemed to suggest the following ideas:

- 1) Patients near death have highly unstable HRV patterns. Changes in these patterns seem to indicate significant sensitivity to people in their environment.
- 2) Even profoundly brain-injured patients seem to differentiate between caregivers that they are familiar with and those that they are not familiar with.
- 3) Patients may be affected by very subtle aspects of the people in their environment, such as their thoughts and intentions.
- 4) Loving relationship appears to be a significant factor in a patient's response to a sitter regardless of the sitter's level of coherence.
- 5) Relationship may be developed with caregivers even if the caregiver has only known the patient while they were in a non-communicative state.
- 6) The heart coherence of sitters is significantly reduced when engaging in compassionate presence with people near death in large institutions. This reduction may be related to nature of the care environment, the level of concentrated distress patients have in a care environment, or it may be an aspect of the activity of compassionate presence itself.
- 7) The interventions of touch, prayer and meditation in sittings appears to have a significant effect on the HRV patterns of patients and sitters in many cases .

A discussion of these findings and conclusions follows below.

Discussion and Conclusions

Clearly the subtlety of response of these patients might have been easier to study and monitor with a tool designed specifically for them, one that could more objectively analyze parameters specific to their highly sensitive condition. The parameter of HRV coherence is probably not such a parameter, in that it measures an offset from a relatively ideal form generated by a healthy population in ideal circumstances. Trauma, illness and dying are not such circumstances. It appears possible that different forms govern these physical conditions. Nevertheless, though there were limitations to the application of Freeze-framer in this study, biofeedback measurement of non-verbal somatic communication (or presence) with a highly sensitive population offers insights into not only hospice and critical care work, but may give insights on work with verbal populations as well. The wide-ranging evidence of response and reactivity observed in these patients shows that there is somatic sensitivity to persons in their environment and the capacity for relationship even when that relationship is established in a non-communicative state. These results support the possibility that somatic or energetic communication may be operative in care relationships in normal populations, and that these relationships might similarly be influenced by interventions such as prayer, touch and meditation.

Finally, the obvious issue of effect of compassionate presence on the caregiver was raised by the responses of sitters in this study and will be discussed further below.

Reduction in sitter coherence was the most clear and consistent results of this pilot investigation. It suggested the possibility of group coherence or incoherence, and that this phenomenon may exert influence on individuals that enter groups. However other explanations for this result must also be considered. Reduction of sitter coherence scores in care facilities could have been a result of the activity itself (compassionate presence and witness), or emotional responses to the environment or the state of the patients in them.

Sitter interviews made it clear that each sitter had some degree of struggle with either the environment or contact with the reality of the patients they sat with. This was particularly true of sitters who were with relatively young patients in long-term comatose states. Sitters were often absorbed in speculating about the patients' lives and whether this was or was not a fair situation for them. Sitters Sally, Cynthia and Ellen all noted that they became involved with questions of their own mortality and the projection of themselves into this situation during sittings and after. This may have provoked an unconscious anxiety that was not conducive to coherence. If this is the only explanation, however, it does not explain why there is such a wide variation in sitter coherence loss, from 22% to 72%.

It was particularly unfortunate that Ellen, the most consistently coherent sitter, was only available for three sittings in this study, two of which were with Patient C. With such a small sample of sittings, it is not easy to draw conclusions about why Ellen lost significantly less coherence than other sitters involved with the project. IHM commentary has suggested that people who are more coherent are indeed less vulnerable to the incoherence of their environments. (McCarty and Atkinson, 2003, p.12)

Certainly Ellen demonstrated similar anxiety about the patient situation as other sitters, if not more than other sitters. She was the only sitter who said that she would not wish to seek this kind of contact as a volunteer again, for example. This may have been one factor in the fact that I was only able to engage her in three sittings. This raises a possibility that the lower percentage reduction in her coherence scores may have also occurred in part as a self-protective response. However, my speculation is that Ellen may have had a deeper effect on patient coherence when she was more vulnerable herself. This may have had the effect of lowering her coherence. This interpretation was influenced by my own experience as a sitter in which I noticed difficulty actually focusing on the patient while holding a coherent state. The possibility that contact may sometimes be *inversely* related to coherence in situations like this is discussed further below.

In analyzing my own coherence loss (-57%), I note that my experience was significantly different than other sitters and was probably influenced by different factors. It was clear from observing session recordings that my own coherence loss was affected by acting as both sitter and project administrator, the activities of adjusting patient finger sensors, monitoring the power supply of two laptops or answering the questions of staff members during sittings. Further research projects would ideally eliminate this dual role.

Cross-influence and the relationship between compassion and coherence

A preliminary assumption of this study was that heart coherence, or the achievement of states of well-being, gratitude, or appreciation, is in some way related to states of compassionate presence and loving relationship. However, this study opened the possibility that there may be fundamental differences between the dynamic of compassion and personal HRV coherence that were not fully anticipated. Compassion by its very nature may require a measure of resonance with, experience of, or perhaps even an energetic "taking on" of another's pain and suffering similar to the Buddhist practice of Tonglen (Sogyal Rinpoche, 1992). It does not seem difficult to imagine that this would have a short-term effect of destabilizing a sitter's personal sense of well-being as he or she contacts the experience of suffering, particularly in environments where there is overall lack of coherence. In this situation the dynamic of coherence did not seem to be simply modeled as one person directly drawing another into their coherence by simple entrainment.

If one person's willingness to be affected by the suffering of another is a true dynamic of compassion, it raises important questions for therapists and caregivers. First, it raises the question of whether this experience has an enduring negative effect on a helper's HRV, such as the phenomenon of vicarious trauma, or whether ultimately this contact can engender positive growth leading to an expanded heart and a more coherent HRV. When a patient appeared to have a negative response to a sitter or reduced coherence in a sitting, it was unclear whether this was simply short-term destabilization (such as a startle reflex, the sign of excitement or the adjustment to an unknown person in their presence) which ultimately had a positive influence on the patient as the relationship developed, or whether it was a simple negative response that contributed to a longer-term degradation of the sense of well-being. These questions are raised, but not fully explored in this study except in sitter and family interviews and two post-sitting baselines that were done. Though the sample is inadequate, these seem to indicate that effects of these sittings endured beyond the theoretical limits of the project, and that these effects may have been positive for some sitters and patients regardless of the short-term response.

If this is the case, the question of what it is that allows the disruption of coherence to be processed into positive growth for some caregivers and patients becomes particularly interesting, especially at a time when the causes of emotional

burnout, compassion fatigue, vicarious trauma and caregiver depletion are being actively researched and debated (Brotheridge & Grandey, 2002; Alderidge, 1994; Bolton, 2000). More study on the somatic effects of this issue would be a very worthy endeavor with implications far outside of care of the dying. My speculation on this issue is that without relationship and the ability to feel into and recognize another's pain, as well as the capacity to feel the truth of our own pain in their presence, there is probably little that we can do for others even with perfect coherence. On the other hand, without a way to work through emotional responses to the other's pain, or some way to be held in or process the pain that is encountered in this experience into personal growth, these experiences may become difficult for a caregiver to sustain and contribute to caregiver burnout. It is noted that volunteers in this study had much less exposure and much more support than typical caregivers for the dying do.

The increasingly intense and rigid requirements of institutional care facilities on caregivers do not commonly allow for this type of self-care. A caregiver's emotional or spiritual system that might normally be sustaining and enervating, may shut down in response to the daily experiences as a result. Feeling deeply in response to others in a context of positive self-care may be part of what allows caregivers to maintain and expand their capacity for helping. Another possible theory is that the requirements for rigid perfectionism of any kind, including the requirement to be in an optimum coherence state, may create a bind or a split when confronted with the reality of a person suffering or in the process of dying. To enter into the experience and resonate with pain may perhaps be a natural, indeed healthy, function of the human heart. To deny this capacity in the face of another may create a split that in the long run depletes enthusiasm for the activity of caring, or resistance to the experience of connection.

The Capacity for Relationship Near Death

Though the sample was too small to draw firm conclusions, the apparent effect of relationship in this investigation did not seem coincidental. This fact should be investigated more deeply with this population in further studies for several reasons. First, clearly, there is an advantage to understanding more about patient needs and care in this state. There is a strong indication that relationships exist up to the point of death and that there may be need for compassionate relationship and support at this juncture. Second, if the responses of the two spouses I worked with were any indication, this information could provide tremendous relief and hope to family members of people in non-communicative states near death. The question "Does she know that I am here?" weighs very heavily on the hearts of the family members that I worked with in this project and elsewhere. Understanding more about how people in these states perceive and respond could greatly enrich the sense of meaning, depth of exchange and closure at this point of life.

Families commonly feel that their loved ones know them and comment on their loved one's preferences and emotions. It is also unfortunately common for family members to be told that their loved ones cannot possibly perceive their presence due to neurological damage or intellectual impairment. Both husbands that I worked with had had very difficult experiences of this nature with medical authorities that had caused them to doubt their felt sense of connection to their spouse. Both men independently reported depression and anger that lasted a significant period of time after such incidents. Even if this study had no net influence on patients, the confirmation of enduring family ties and of the validity of felt senses in relationship is itself an important reason to pursue further work in this area.

The Use of Prayer and Meditation

Because prayer is one of the most widely used interventions at the bedside of the sick or dying, it seemed useful to explore its effects. The short-term effects on HRV appeared to be clear, particularly on patients. The degree to which this was true was surprising. A better controlled experiment of the somatic effects of prayer would be exceptionally interesting and useful, particularly given the number of prayer studies now being debated (Benson et. al., 2006; Byrd, 1988; Targ et. al., 1998). Most likely, study with this instrument will not demonstrate the long-term effects of prayer, but only the short-term energetic shifting of HRV that might occur before, during and after a prayer, similar to the physiological response to prayer and meditation that has been investigated by Herbert Benson and others, termed the "relaxation response" (Benson & Klipper, 1976). However in this case, prayer is being offered on behalf of others without their conscious volition. It would seem useful to have a working understanding of the patient's spiritual history and disposition before undertaking such an exploration. Meditation similarly might be usefully explored for somatic effect.

The Use of Touch

The effect of physical touch was more difficult to interpret in this study. Because touch is a means of communication that is commonly used with the ill and dying, the importance of looking at its effects seems clear. I did not feel that many conclusions could be drawn from the responses to touch in this investigation, other than that there was often what appeared to be a startle response in both patients and sitters. More investigation of this nature that focuses on the longer-term ramifications of touch would be useful.

Interestingly, off-body or therapeutic touch when introduced often seemed to evoke similar responses as physical touch. This fact seemed to confirm the sensitivity of patients at this point in their life process. However, more deliberate work would need to be done to draw any conclusions about the effect of off-body touch.

The largest unanswered questions left by this study are questions about appropriate and inappropriate caregiving, the nature of caregiving environments and the long-term care of caregivers. Even within a small sample such as this one, there were different models of care and concepts of caregiving brought by every sitter as well as different states of presence. The idiosyncrasies of each caregiver in such a small sample make evaluations of appropriate or inappropriate care, or presence, nearly impossible. Each person had a very unique offering. Still, I offer my own observations and interpretations.

The model of care held by researchers at the HeartMath institute are that holding a state of coherence itself is possibly an optimum model of caregiving, in that he or she will automatically create conditions for others to come into such states. Fear, frustration and anxiety are negative emotions to be overcome with positive attitudes, reflections on love and gratitude (Childre & Martin, 1999). Indeed these are powerful techniques for people to use in their own process of growth and it is hard to argue that these actions do not have a profound effect on others who are fully engaged with life. However, this project was reflecting on a different state of being and a different process than the one of self-improvement, or the project of coming expansively into life and productivity. It is difficult to expand a model of self-improvement into an over-reaching model of healing or helping near death.

In my own experience as a healing practitioner and hospice worker, healing does not have to do only with the accomplishment of expansion and order, but includes a traditionally shamanic penetration into a world of distortion, chaos, darkness and pain, including the facts of death and dying. The facilitation of other people's healing has to do with providing compassionate presence through these processes. Compassion and presence in this view may require helpers to have a demonstrated capacity to go into these states themselves, and the capacity to come out of them again in a renewed state. In short, healing processes and optimization processes are both useful and in their essence may be different. It seems likely to me that we will find that patterns of HRV coherence, while a very useful parameter, must be meaningfully qualified or redefined in order to be applied as an evaluative tool within a relational healing or helping construct.

The capacity for sitters to be emotionally and somatically affected by their environment or the patients they encounter does not appear to me to be necessarily negative, nor necessarily an indication of over-care as IHM defines it, a definition which includes ideas like worry, anxiety and over-attachment (Childre & Martin, 1999). In fact, in my view, somatic-emotional presence and response is probably a natural and healthy response to people at end of life if appropriate boundaries are maintained and helpers have opportunities to support and integrate their experiences, thereby stimulating their own growth.

Optimally, caregiving environments would be supportive of the longer-term needs of caregivers, families and patients. In terms of patient needs, this investigation suggests the possibility that patients may be best served by smaller, less concentrated environments (such as low density rooms, private homes or smaller hospice facilities) that are particularly designed for their needs and the needs of their caregivers.

Patients appear to need supportive relationship with regular, loving caregivers. It seems obvious that this contact would be enhanced if the caregivers understood and felt that patients were aware of them. Another need is for care to be taken of the extreme sensitivity that patients have near death. This would include the reduction of unnecessary startling or disharmonious noises, such as shouting, loud televisions, cleaning equipment, as well as gentleness and courtesy when touching or moving these patients. An environment of peace, courtesy and respect is optimum. Because patients appear to be so sensitive to the states of others in their presence and their sudden introduction, it might also be best for people entering rooms of the dying to have a method for preparing themselves and becoming attuned to the patient before entering. Support of families and caregivers might include things like rooms for their rest and rejuvenation and counseling support for the expression and exploration of their experiences.

Conclusion

This pilot investigation attempted to expand understanding of the passage of end-of-life and the influence that compassionate presence can have on those near death. This project used research developed by the Institute of HeartMath and the heart monitoring system, Freeze-Framer, which was developed to track the heart's variability patterns. Results were interpreted using HeartMath research, which links emotional states with heart rate variability behavior. The work of this study has also been guided and the results interpreted by the experience of the hospice and death and dying movements and the writings, teachings and practices of Tibetan Buddhism.

This pilot investigation indicates that patients are sensitive to relationships and people in proximity at end-of-life. It also indicated the possibility that patients are capable of forming new relationships, even in non-communicative states, and are reactive to interventions such as touch, prayer and meditation. That the environment in which caregiving occurs has an effect on caregivers also seemed to be strongly suggested by this investigation. This investigation raised questions about the nature of caregiving environments on patients and discussed different thoughts about caregiving for this population.

The governing role of the human energetic heart through the process of dying is one that has been noted by esoteric traditions. It has also been witnessed by many people's work with the dying, as well as those of many caregivers and

families. The human heart, in its physical and emotional forms, appears to be a crucible that holds the potential of transforming our mental, emotional and physical bodies during our lives, and of facilitating their great change in form from one state to the other during death.

The processes of death are certainly not insignificant to life processes or the living, as we are always undergoing these processes if we are fully engaged with life. If this is true, the study of the human heart through the end-of-life passage may be significant in developing an understanding of the transformation of the human spirit at all ages, and advancing the mythologies of death and the promotion of meaning. Indeed, though this idea is not widely held in western culture, the idea that the dying are in fact doing something of great importance in the larger world, and that it is exceptionally important to support them in doing this work well is a tenet of Tibetan Buddhism.

At the very least, deepening our understanding of this process is important to the comfort and care of the dying and their caregivers. Since a comatose state is a passage experienced by the vast majority human beings before they die, this may be reason enough to advance understanding of relationship with people in non-verbal states near death.

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Biography

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Efficacy of Bioenergetic Psychotherapy with Patients of known ICD-10 Diagnosis: A Retrospective Evaluation

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Abstract

In this study, the efficacy of Bioenergetic Analysis and Therapy (BAT) was evaluated retrospectively by means of two questionnaires sent from private practices to former patients with known ICD-10 F group diagnoses. The first questionnaire, the SCL-90-R, was modified to allow assessment of the symptoms at the beginning as well as at the end of therapy. The second questionnaire was self-constructed and contained questions about the quality of the therapeutic work, the body work in general, the relationship with the therapist, and the therapist's techniques. Both questionnaires were answered anonymously. Eight psychotherapists (medical doctors and psychologists) participated, contacting 103 former patients. Forty-eight patients (46.6%) returned the questionnaires. Of these, 10 patients belonged to the F3 group, 26 to the F4 group, and 12 to the F6 group. All data could therefore be interpreted for each of the F groups as well as for all the patients together.

According to the SCL-90-R, BAT reduced symptoms considerably in all three F groups. Analysis of the SCL-90-R individual symptom scales showed high to very high symptom reduction. These were not related to the F group diagnoses. Insight gained as a result of body work produced an even greater symptom reduction independent of the ICD-10 F group diagnosis. Patients receiving BAT rated their therapy favorably and judged their relationship with the therapist as very good. The efficacy of and the satisfaction with the therapy were rated high. The formulation of a therapeutic goal at the beginning of the therapy was most likely not a prerequisite for a positive outcome of the therapy. The present study confirms and complements previous efficacy studies of BAT.

Key words

Bioenergetic Analysis - Psychotherapy Research - Efficacy Study - Private Practice Setting - Retrospective Evaluation.

In Bioenergetic Analysis and Therapy (BAT), we use body work primarily to solve chronic psychological and/or muscular somatic defensive patterns. We aim to modify these patterns in such a way that emotionally effective insights can be verbalized. We also aim to make use of new knowledge arising from infant research or from neurobiology and, whenever possible, incorporate this into our treatment. BAT is used mostly in private practices with ambulant patients.

A number of published case studies of patients suffering from various serious disturbances and receiving BAT treatment show that BAT is an effective method for these particular disturbances, which include severe war traumas, social or emotional stress adjustment problems, chronic severe depressions, somatic disturbances, preverbal or very early childhood traumas, incurable somatic diseases, and eating disorders (Eckberg, 1999; Mahr, 2001; Ventling, 2002; Ventling, 2004, etc.) The studies show that BAT is a suitable treatment modality for a great variety of disturbances. However, they do not enable us to make a general statement about the quality of the therapy, the effectiveness of the treatment, or the stability of the achieved result. Quantitative data are needed to answer these questions.

The very first large-scale investigation into the efficacy of BAT was done by Gudat (1997), who had 309 patients, diagnosed by their respective bioenergetic therapists according to the Diagnostic and Statistical Manual of Mental Disorders (1987) 3rd edition, revised fill out the "Questionnaire on Changes in Experience and Behaviour" (VEV; Zielke & Kopf-Mehnert, 1978) following termination of their therapies. He found altogether high rates of positive changes as a result of the therapies; the results were above average with patients who had neurotic or psychosomatic problems, and somewhat less pronounced with patients who had personality, obsessive-compulsive or borderline disorders. There were no negative effects. Neither the influence nor the mode of working with the body was examined by the questionnaire, due to the fact that the VEV is applicable to psychotherapy in general and not to body psychotherapy. Ventling & Gerhard (2000) filled in the missing link by constructing a special questionnaire that assessed the influence of body work on changes in experience, behavior and insights. They confirmed the data on the positive effects of BAT published by Gudat (1997) with a statistical analysis of the answers from patients who had terminated their therapies as far back as six years prior to the study. While this information allowed for conclusions to be made about the stability of the therapeutic result, because of the anonymity of the returned questionnaires, the data could not be related to the ICD-10 diagnosis previously established by the therapists. While the stability of the result was found to be excellent and body work could be shown to be significantly effective, the question of whether the efficacy of the BAT is ICD-10 diagnosis-dependent could not be answered. In the present study, these questions are revisited.

Two aspects of BAT are reinvestigated using new and different questionnaires:

1. The effectiveness of BAT on patients with a known ICD-10 diagnosis will be investigated retrospectively. More specifically, emphasis is placed on the question of whether BAT is equally suitable for all ICD-10 F diagnosis groups. For this purpose, the standardized "Symptom-Checklist" (SCL-90-R) is used.
2. The question of the effectiveness of body work will be asked again. For this purpose, a special questionnaire is constructed.

Two Hypotheses:

1. BAT is an effective method for patients belonging to the three most common ICD-10 diagnosis groups: F3, F4 and F6.
2. Body work is a prerequisite for successful therapy.

Methodology

Data Collection

All licensed psychotherapists of the Swiss Society for Bioenergetic Analysis and Therapy (SGBAT) who worked in private practices with adults were contacted and asked to provide information on their last 10 to 15 clients who had terminated their therapies after a minimum of 20 sessions. The following data was requested: gender, age, number of therapy sessions, and ICD-10-F diagnosis. Eight therapists (4 medical doctors and 4 psychologists) sent in the data of a total of 106 former patients. With the exception of three F5 patients – too few for a statistical study and therefore excluded – all clients' data were used. The remaining 103 subjects consisted of 28 F3 patients, 55 F4 patients, and 20 F6 patients. In order to preserve the anonymity of the patients while making use of the data, we printed the questionnaires in three colors, one color per F group, and asked the therapists to mail questionnaires of the appropriate color to the corresponding patient. Questionnaires were returned anonymously. Thus, we were able to evaluate them in relation to the F categories of the patients.

Questionnaires

The SCL-90-R, developed by Derogatis (as cited in Franke, 2002), is a simple questionnaire designed to reflect the psychological symptom pattern of the respondents and is often used in efficacy studies. This self-report checklist covers nine dimensions and measures the subjectively felt impairment by means of 90 items related to these dimensions. Each of the items is rated on a five-point scale of distress ranging from “not at all” to “extremely.” The nine primary symptom dimensions are labeled as: somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism.

The SCL-90-R is suitable for investigating the psychological changes of the past few days, but not for those of a longer time period. Since we needed to examine changes that occurred between the beginning and the end of the therapy, the time window had to be modified accordingly.

The second questionnaire is a reworked and extended version of one used in a previous study (Ventling & Gerhard, 2000). The updated version contains more specific questions pertaining to the effect of body work on mental insights, the relationship between therapist and patient, and the general satisfaction with the therapy. It is called the “Questionnaire about General Therapeutic Satisfaction“ (FATZ) and consists of 13 questions, 4 of which concern the experience of body work, 3 that relate to general satisfaction with the therapy, 3 that enlighten the relationship between therapist and client, 2 that refer to a possible therapeutic goal, and 1 that asks the gender of the client. For 9 of the 13 questions, there exist 4 possible answers according to the Likert scale: “Definitely not,” “Somewhat yes,” “Partially yes,” and “Definitely yes.” The question that asks about a therapeutic goal can be answered with, “Yes,” “Partially yes,” or “No,” and the remaining 2 questions can be answered with a simple “Yes” or “No.”

Statistical Analysis

Statistical analyses were done with the SPSS 10 program for Windows. The T-test for paired and unpaired variables and the One-way ANOVA were used. Results were significant at $p < 0.05$, highly significant at $p < 0.01$, and most significant at $p < 0.001$.

Results

Sociodemographic Data

Table 1: Number of questionnaires sent to and returned from each F-diagnosis group.

F Diagnosis	Sent (%)	Returned (%)
F3	28 (27.2%)	10 (20.8%)
F4	55 (53.4%)	26 (54.2%)
F6	20 (19.4%)	12 (25.0%)
Total	103 (100%)	48 (100%)

Of the 103 contacted patients (76 women, 27 men), 48 persons (36 women, 12 men) returned the questionnaires (return rate 46.6%, proportion women to men unchanged 3:1). The average age of the women was 39 years (varying from 19 – 61 years), and the average age of the men was 41 years (varying from 26 – 64 years). The average number of therapeutic sessions was 106 hours (varying from 20 – 334 hours) for women and 148 hours (varying from 22 – 748 hours) for men.

Short Description of the ICD-10 Diagnosis Groups F3, F4 and F6

F3: This category consists of affective disorders. Typical symptoms are mood or affect changes, usually in the direction of depressiveness, but also towards elevated mania.

F4: This group is characterized by various somatoform disorders, incapability of tolerating pressure, phobic disturbances (F40), general anxiety and forms of anxiety disorders not initiated by defined stimuli (F41), panic disorders (F41.0), obsessive-compulsive disorders (F42), maladaptive disorders (F43), and disorders due to coping problems and long-lasting depressiveness.

F6: This group of personality and behavior disturbances contains those with long-lasting, steady and characteristic behavior patterns that express an individual lifestyle, with a specific reflection about and comprehension of oneself and others.

The diagnosis F4 fit more than half of all the patients in the study. This group also contained three times as many women as men.

Improvement of Symptoms

Table 2: Comparison (T-test) of distress symptoms of all patients before and after psychotherapy. Data gathered using the SCL-90-R.

	M pre	M post	M diff	T	df	p<
All patients	1.1601	0.5273	0.6328	8.191	47	0.0001
Women	1.2209	0.5462	0.6747	7.213	35	0.0001
Men	0.9780	0.4707	0.5073	3.937	11	0.002

M pre = mean before psychotherapy; M post = mean after psychotherapy; M diff = mean of the differences before and after psychotherapy; T = distribution of values (T-tests); df = degrees of freedom; p = probability; SCL = symptom check list.

Table 3: Ratings of SCL-90-R symptom items before and after psychotherapy (T-test).

Symptom Dimensions	M pre	M post	M diff	T	df	p<
Somatization	0.5069	0.4837	0.0231	3.193	47	0.003
Obsessive-compulsive	1.1648	0.5822	0.5826	6.852	47	0.0001
Interpersonal Sensitivity	1.5668	0.6921	0.8747	8.187	47	0.0001
Depression	1.6286	0.7718	0.8568	8.825	47	0.0001
Anxiety	1.0287	0.4495	0.5792	6.176	47	0.0001
Hostility	1.1882	0.5035	0.6847	6.527	47	0.0001
Phobic Anxiety	0.6895	0.3304	0.3591	5.089	47	0.0001
Paranoid Ideation	1.2194	0.5493	0.6701	6.085	47	0.0001
Psychoticism	0.8549	0.3563	0.4986	5.936	47	0.0001

M pre = mean before psychotherapy; M post = mean after psychotherapy; M diff = mean of the differences before and after psychotherapy; T = distribution of values (T-tests); df = degrees of freedom; p = probability; SCL = symptom check list.

Table 4: Ratings of SCL-90-R symptoms by the F-diagnosis groups F3, F4 and F6 (T-test).

F-Diagnosis Group	M pre	M post	M diff	T	df	p<
F3	1.0663	0.2967	0.7696	3.339	9	0.009
F4	1.0809	0.5431	0.5378	6.731	25	0.0001
F6	1.4101	0.6853	0.7247	4.157	11	0.002

M pre = mean before psychotherapy; M post = mean after psychotherapy; M diff = mean of the differences before and after psychotherapy; T = distribution of values (*t*-tests); df = degrees of freedom; p = probability; SCL = symptom check list.

Table 5: Ratings of SCL-90-R symptom items for the F3 diagnosis group (T-test).

Symptom Dimensions	M pre	M post	M diff	T	df	p<
Somatization	0.3308	0.3167	0.0141	1.157	9	0.277
Obsessive-compulsive	0.9600	0.3700	0.5900	2.579	9	0.030
Interpersonal Sensitivity	1.4208	0.3944	1.0264	3.700	9	0.005
Depression	1.4885	0.4622	1.0263	3.860	9	0.004
Anxiety	0.9200	0.2200	0.7000	2.743	9	0.023
Hostility	1.1133	0.3633	0.7500	3.528	9	0.006
Phobic Anxiety	0.6429	0.1000	0.5429	2.478	9	0.035
Paranoid Ideation	1.1500	0.3000	0.8500	2.918	9	0.017
Psychoticism	0.8400	0.1600	0.6800	2.531	9	0.032

M pre = mean before therapy; M post = mean after therapy; M diff = mean of the differences before and after therapy; T = distribution of values (T-tests); df = degrees of freedom; p = probability; SCL = symptom check list.

Table 6: Ratings of SCL-90-R symptom items for the F4 diagnosis group (T-test).

Symptom Dimensions	M pre	M post	M diff	T	df	p<
Somatization	0.5321	0.5157	0.0163	1.545	25	0.135
Obsessive-compulsive	1.1427	0.6363	0.5064	5.080	25	0.0001
Interpersonal Sensitivity	1.4583	0.7174	0.7409	5.917	25	0.0001
Depression	1.5713	0.8241	0.7472	6.562	25	0.0001
Anxiety	0.8252	0.4026	0.4226	4.944	25	0.0001
Hostility	1.0346	0.4949	0.5397	5.058	25	0.0001
Phobic Anxiety	0.5696	0.3297	0.2399	3.370	25	0.002
Paranoid Ideation	1.1359	0.5141	0.6218	4.635	25	0.0001
Psychoticism	0.7551	0.3564	0.3987	4.323	25	0.0001

M pre = mean before therapy; M post = mean after therapy; M diff = mean of the differences before and after therapy; T = distribution of values (*t*-tests); df = degrees of freedom; p = probability; SCL = symptom check list.

Table 7: Ratings of SCL-90-R symptom items for the **F6** diagnosis group (*t*-test).

Symptom Dimensions	M pre	M post	M diff	T	df	p<
Somatization	0.5991	0.5537	0.0454	3.331	11	0.007
Obsessive- compulsive	1.3833	0.6417	0.7417	3.935	11	0.002
Interpersonal Sensitivity	1.9236	0.8854	1.0382	4.321	11	0.001
Depression	1.8697	0.9167	0.9530	4.561	11	0.001
Anxiety	1.5602	0.7426	0.8176	3.371	11	0.006
Hostility	1.5833	0.6389	0.9444	3.137	11	0.009
Phobic Anxiety	0.9881	0.5238	0.4643	3.199	11	0.008
Paranoid Ideation	1.4583	0.8333	0.6250	2.602	11	0.025
Psychoticism	1.0833	0.5194	0.5639	3.592	11	0.004

M pre = mean before psychotherapy; M post = mean after psychotherapy; M diff = mean of the differences before and after psychotherapy; T = distribution of values (T-tests); df = degrees of freedom; p = probability; SCL = symptom check list.

From the beginning to the end of the therapy, all symptoms decreased remarkably (Tab. 2). Among the 36 women in the study, the result was most significant; among the 12 men, it was highly significant. We can see maximum reduction in all categories (Tab. 3), with somatization symptoms reduction slightly less pronounced than the others, except for somatization, which is still highly significant. BAT shows a high to maximum effectiveness, i.e., significance for the diagnosis groups F3, F4 and F6 (Tab. 4). There were no statistically significant differences between the F groups.

Comparing the degree of the various SCL-90-R symptoms within the three F groups allowed for no distinction at the beginning of the therapy ($F = 0.91$, $df = 2$, $p < 0.41$); at the end of therapy, these symptoms were significantly decreased in all three F groups. In the F6 group, there was a significant improvement with regard to somatization. (see Tab. 5, 6 & 7).

Satisfaction with The Therapy

The answers to the questions of the FATZ showed a high to very high satisfaction with the therapy obtained for all F groups. The quality of the therapy was judged as satisfactory throughout: 90% of all patients evaluated it as good or very good, and nearly all of those who did (97.5%) would recommend their therapist to others. More than 85% of the patients stated that they could speak openly about their problems with their therapist, and 92% stated that their therapist understood their problems.

Satisfaction with the experienced body work is also evident. While there was little agreement regarding the question that asked if body work was a prerequisite for the improvement of the quality of life, those who felt they gained new insights by means of body work profited from an increased reduction in burdening symptoms that was twice as high as in those patients who had not had this experience (Tab. 8, $T = -2.470$, $df = 42$, $p < 0.018$).

Of the 48 patients, 32 (66.6%) started therapy with a goal in mind. Of these, 14 (43.75%) claim to have reached it completely, 16 (50%) speak about having partially reached it, and only 2 patients (6.25%) claim to have not attained it at all. However, the 32 patients with a set goal did not profit more from BAT than the remaining 16 patients without a goal ($T = -0.644$, $df = 46$, $p < 0.523$).

Discussion

Retrospective investigations are economical because they use just one time point (the present) to judge events that took place months or even years before. While this is advantageous, there are two disadvantages that should be noted: First, the remembered facts might be distorted, and second, the selected cases might be one-sided. We simply do not know the accuracy of the memory of a health state or symptoms that existed before the therapy. What we do know from research about memory is that as time passes, certain events fade while others are distorted by other memories or blended with more recent memories of similar events. However, we know of no research that proves that a certain health state is systematically remembered as better or worse than as it would have been judged while experiencing it. We also know that certain negative events from the past can be forgotten or embellished – most likely for psycho hygienic reasons. The retrospective judgment of a past therapeutic experience by a patient could be an exaggeration as a means of justifying the enormous effort he put

into it (see theory of dissonance). While patients at the beginning of a therapy sometimes tend to dramatize their symptoms in order to get attention, they may play them down at the end of therapy, in order to terminate faster. This last argument is not an issue in this study because all questions were answered anonymously and patients did not have to answer to their therapists for the therapy.

A condition to participate in this study was a minimum of 20 hours of BAT therapy experience; participants who terminated before 20 hours were excluded. Even though we asked psychotherapists to provide the information of their last 10 to 15 cases, we do not know if our colleagues selected patients. Problematic cases were possibly purposely excluded; while this certainly is a problem, it is not a phenomenon restricted to retrospective studies. In prospective studies, there exist other ways to exclude patients who seem unfit for the study.

In reviewing our return yield of questionnaires, we refer to the large-scale inquiry of Seligman (1995), who stated conditions for best results was an expected 25% returned answers. In our previous study (Ventling & Gerhard, 2000), our return yield was 49%, and in our current study, it was 46.6%, both very satisfactory results. One could, however, argue that only patients who were satisfied with their therapy took the trouble to return our questionnaires, an effect that would have distorted the results. However, as we found out, not everybody was indeed satisfied: while 87.5% of all the patients would recommend their therapist, 12.5% would not. In our previous study (Ventling & Gerhard, 2000), 13% would not recommend their therapist. In addition, the question that asked if body work is a prerequisite for later mental insights was not judged unanimously: only 40% (previously 44%) of all patients answered in the affirmative.

This study confirmed results obtained in previous investigations on the efficacy of BAT (Gudat, 1997; Ventling & Gerhard, 2000). While three times more women than men were patients in a BAT and their average age was around 40 years, these data are not unique for BAT; similar data were found for patients from psychoanalytical (Frossard, Kaiser, Mullejans & Richterish, 1993) and behavioral psychotherapies (Hutzli & Schneeberger, 1995). The average duration of therapy in the present study was 116 hours, which compares favorably with the findings of Gudat (75 hours) or Ventling & Gerhard (91 hours). At the usual frequency of weekly sessions, these figures suggest a total therapy length of about 2 years. BAT is thus a long-term therapeutic modality.

By far, the largest number of patients (> 50%) was given the diagnosis F4, which, in general, is the most common diagnosis among adults in ambulant psychotherapies (Frossard et al., 1993; Gudat, 1997; Ventling & Gerhard, 2000; Schweizer et al., 2002), followed by F3, F6 and F9. Our hypothesis, that BAT is equally effective for all three ICD-10 categories F3, F4 und F6, is confirmed by the reduction of negative symptoms in each category. The effectiveness of BAT is confirmed by the reduction of distressing symptoms in each ICD-10 category as well as the overall reduction of symptoms in all patients. The group of personality disorders (F6) had the highest level of negative symptoms before therapy and the highest rate of symptom reduction after therapy. Since personality disorders have historically been considered therapeutically resistant because they were defined as incorrigible disorders, the results look promising for these types of disorders. In the subcategories “uncertainty” and “depressiveness” of the SCL-90-R, we found highest symptom reductions.

In the previous study, we showed that most of the patients acknowledge their problems and accordingly set goals to overcome them (Ventling & Gerhard, 2000). In the present study, the T-test does not give a significant result ($T=0.644$, $df = 46$, $p<0.5$), proving that a therapeutic goal has no influence on the effectiveness of the BAT. Thus, successful therapy does not necessarily require the complete fulfillment of a goal. (see Lairaiter, 1995).

Table 8: Difference in ratings of SCL-90-R symptoms of patients who gained new insights after body work.

Body Work led to	M diff	n
None or partial new insights	0.3875	12
Often or very often new insights	0.7936	32
No mention		4

M diff = mean of the difference before and after psychotherapy; n = number of patients; SCL = symptom check list.

Curiously enough, the body work aspect does not provide uniform results. About 80% of all patients are satisfied with the body work they did, with neither the desire to do more nor the wish they had done less. Only a small percentage of these patients (8%) feel that body work was the cause for their new and improved quality of life, while 44% agree that it contributed to it. Body work can lead to mental insights, and those who profited from these insights showed twice as strong a symptom reduction than patients without such insights (see Tab. 8). No relationship was found between a specific F diagnosis and corresponding answers to questions about body work.

Conclusions for Practice

We conclude from this investigation (and from data of previous studies) that the efficacy of BAT most likely depends on the empathic qualities of the therapist and the way he or she integrates body work into the therapeutic process. It is also based on how these techniques are interpreted by the client. Furthermore, it is of prime importance that patients can make new insights independent of the therapeutic goal and the ICD-10 F diagnosis the therapist ascribes to them. The duration of therapy will most likely be long and depend on the weightiness of the diagnosis. Lastly, the extent to which a symptom reduction occurs depends on the quality of the given psychotherapy and not on the F diagnosis of the patient.

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- The investigation described above was part of the requirements for the Masters Degree (lic.phil) of Herbert Bertschi at the University of Basel, Switzerland. The original, more elaborate article was published in German as follows:
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Biographies

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Urs Gerhard obtained his Ph.D. in psychology from the University of Frankfurt, Germany, in 1977. His doctoral thesis dealt with the development of a questionnaire for obsessive-compulsive disorders. From 1980 to 1995, he was engaged in psycho-physiological research at the Psychiatric University Clinic (PUK) of Basle with the aim to differentiate schizophrenia, depression and personality disorders using signals such as background EEG, EVP, and GSR under various mental tasks. He also did research on the driving fitness of these patients under medication. He was active in the development of diagnostic instruments for determining early phase dementia as distinguished from pseudo dementia in affective disorders. In 1995, he became Assistant Professor at the University of Basel, Switzerland, Department of Psychology. Since then, his main interest has focused on practical diagnosis of psychiatric patients, including their driving ability, research on psychotherapy outcome and reasons for discontinuation of psychotherapy. E-mail: urs.gerhard@unibas.ch

Body Psychotherapy for Treating Eating Disorders

Morgan Lazzaro-Smith, M.A., LPC

Abstract

Eating disorders are a growing concern among medical and mental health professionals. Because they are disorders of both body and psyche, the orientation and experiential techniques of Body Psychotherapy/Somatic Psychology can be particularly effective in their treatment. Previous studies have identified variables correlated with eating disorders, which include acute and developmental trauma, anxiety, self-esteem, media influences, and awareness and expression of emotion. Few studies have addressed body-centered treatment approaches, which can be especially well suited to address these factors therapeutically. This study uses interviews with nine therapists and seven eating disordered clients to investigate why and how treatments incorporating somatic elements can be useful for eating disorders. Findings suggest that the development and symptomology of such disorders very often involve a disrupted relationship between mind, body, and sense of self, and a closely associated inability to effectively feel or express emotion. Body-oriented treatment methods help clients reconnect to their bodies and emotions, and thus build a stronger, more embodied sense of the true self. As they learn to better manage and respond to affective arousal, the body becomes less estranged and emotions less frightening, and priorities and perspectives shift. Applicable body-centered techniques are those that focus on breathwork, mindfulness, sensory awareness, relaxation, self-regulation, centering, and movement.

Keywords

Eating disorders - Body psychotherapy - Body-centered therapies – Embodiment
Self - Dance/movement therapy

INTRODUCTION

The number of people struggling with eating disorders and disordered eating is growing at a significant rate among both men and women of diverse backgrounds (Kalodner & Delucia-Waack, 2003). Of the more than 70 million people worldwide with eating disorders, at least 24 million of those are in the United States, and as many as 1 in 5 American women engage in disordered eating to some degree (Renfrew Center, 2003). For this reason, and because eating disorders have the highest mortality rate of any mental illness, it has become crucial that mental health professionals, educators, and the general public be given the tools needed to recognize and combat an ever-growing epidemic.

The question guiding this study was this: How to best counteract the social and developmental forces, as well as the traumatic experiences that disrupt individuals' self-acceptance and their healthy, cooperative relationships to their bodies? In other words, what kinds of treatments can effectively repair the severed ties between body and self? And more specifically, how can treatments incorporate the body-oriented, experiential elements of Body Psychotherapy (BP) to serve this purpose?

Some identify eating disorders as psychosomatic illnesses, an “unconscious dynamic between the psyche and a bodily manifested symptom” in which individuals come to believe that “their bodies are the problem and their behaviors the attempted solution” (Krantz, 1999, p. 84). In reality, their bodies have become “the barrier against feeling and growth” (p. 84). Underlying the symptoms are painful psychic and emotional conflicts that such individuals have made an unconscious decision not to feel or express, usually because they believe it is unsafe or unacceptable to do so. Research is making it increasingly evident that many of these cases involve a history of acute or developmental traumas, which have resulted in “a relationship with the body in which it seems to them unintelligible, uncontrollable, undermining, and at the extreme under the control of alien or enemy forces” (Attias & Goodwin, 1999). Regardless of the origins of their pain, these clients often turn to the body as a concrete focus of attention and a means of relief from what they cannot bear to feel. It is widely acknowledged that the people most susceptible to eating disorders are those who do not have a strong sense of their selves. Without a stable internal sense of identity, they can be steered by external standards towards what they are shown is acceptable, admirable, and loveable. And like the profile for those who struggle with addictions, they will seek something to fill the emptiness or to calm the feelings and sensations that for them are too overwhelming to manage.

Eating disorder diagnoses include (APA, 2000):

- 1) Anorexia Nervosa (AN): Refusal to maintain normal body weight, intense fear of weight gain, significant disturbance in perception of body shape or size, and amenorrhea. Anorexics are classified as either Restricting Type or Binge-Eating/Purging Type.
- 2) Bulimia Nervosa (BN): Recurrent episodes of severe binge eating followed by inappropriate compensatory behaviors to prevent weight gain, such as vomiting, laxatives, diuretics, enemas, fasting, or excessive exercise. Bulimics are classified as either Purging Type or Nonpurging Type.
- 3) Eating Disorder Not Otherwise Specified (EDNOS): Includes all disorders of eating that do not meet full criteria for Anorexia or Bulimia. One of these, Binge-eating Disorder, is estimated to be twice as prevalent as AN or BN, and as symptom severity increases, a progression towards diagnosable BN may occur (Kalodner & Delucia-Waack, 2003).

Separate from the clinically diagnosed eating disorders, there are a high number of people who are dissatisfied with their body shape and engage in unhealthy and disordered eating and/or exercise practices as a result. From 19 to 23% of the

general population in 2003 were estimated to have had such eating disturbances (Kalodner & Delucia-Waack, 2003). That statistic has likely increased with the years, as has the number of people with diagnosable other eating disorders.

Central Principles of Body Psychotherapy

What sets Body Psychotherapy (BP) apart in the larger field is simply that it is an integration of body-oriented techniques into the traditional framework of psychotherapy. Its unique assumptions, theories, and practices occur in addition to, not instead of, the cognitive, verbal approaches that are more widely known. One of the most important assumptions of BP is that there is no real separation between body and mind, so it is ineffective in the long run to work from the old Cartesian dualism that is currently being questioned in all reaches of academia, in medicine, and in the personal healing efforts of people world-wide. Since 1998, the National Institutes of Health have included a Congress-mandated National Center for Complementary and Alternative Medicine, which clearly acknowledges the importance of the mind-body connection to understanding health, and actively supports related research and education (Dunn & Greene, 2002; National Center, n.d.). It is more accurate to speak of the body and mind as a unified “feedback loop or continuum rather than two separate though cooperative systems” (Caldwell, 1997, p. 7). The following principles are central to the orientation and clinical practice of BP:

Mind/Body Wholism

Consciousness is a bodily phenomenon that cannot be located in isolation somewhere in the brain. Our thoughts and mental images ripple out into the body via numerous pathways, which scientists are beginning to better comprehend (Pert, 1997). We know that what we experience is processed through complex cerebral systems of perception and memory. What might be often overlooked is that all of this information is first taken in by our bodily sense receptors – eyes, ears, skin, mouth, nose, and proprioceptors. BP acknowledges, therefore, that memory is also encoded in the cells of our bodies (Pert, 1997). Events in our lives affect us somatically as well as cognitively, shaping not only our belief systems about the world, but also the ways our bodies form themselves in relation to the world – muscular rigidity, tension and postural patterns, areas of numbness or of sensitivity, even proneness to certain illnesses (Aposhyan, 2004).

Embodiment

In BP, to be embodied in any given moment means to be deeply aware of what one is experiencing in response to the environment. It means knowing oneself in a sufficiently integrated and variegated way, able to sense and to trust one’s internal emotional responses and impulses rather than relying on external sources for validation. It is not a static trait, once accomplished forever a given, but rather something that anyone – therapist or client – must intend and practice. “Our embodiment is the alchemical process that transforms us in this world” (Conger, 1994, p. 198). It is a comprehensive self-awareness that includes all levels of one’s experience: body, mind, and emotions. Improving one’s level of embodiment is accomplished through building the fundamental skill of somatic awareness and increasing one’s ability to feel comfortable in their own body.

The body can serve as a resource when dealing with the extremes of either high arousal states or a dissociative flattening of affect and energy, especially in the context of trauma. Simple somatic practices can help the client learn to self-regulate when at risk of being overtaken by intrusive memories or images. Exercises that engage clients with their immediate sensory experience land them more solidly in the body, and they are empowered with the new option of remaining present and allowing resolution to occur within the safe container of therapy (Ogden, 2003). Additionally, the resourcing skills they learn in treatment can become part of their repertoire, and they are likely to use these skills when faced with anxiety-arousing situations in their lives, rather than “checking out” or resorting to dysfunctional coping behaviors.

Conger (1994) speaks of the development of an “enduring self” (p. 203) as the goal of BP with fragmented, disembodied clients. This lasting, durable sense of self can observe the environment and events that occur with neutrality; it knows itself as related to others, to nature, and to life itself; and it can trust its own ability to get through the pain and suffering of the present moment without seeking to dull it or escape it. With a solid embodiment of this enduring self, clients are better able to discern what it is they long for, what their hearts are hungry for, and what they need in order to feel safe enough and strong enough to take desired steps in their lives. This concept seems closely related to that of the “true self” versus “false self” (Miller, 1981; Winnicott, 1965), which is often crucial to the understanding of body image issues and eating disorders.

Organicity is a term used in Hakomi Therapy as developed by Ron Kurtz (1997). While not all body psychotherapists use this term, the essence of the concept is a widely accepted starting point for the work. It refers to the inherent drive of the psyche toward health and healing, given the right environment. Just as damaged cells will naturally rebuild themselves in a clean and dry environment, the human psyche will find its way to health if supported within a therapeutic container that is safe, compassionate, and attentive. "...By exploring one's experience in a safe and sensitive environment, a deepening will take place that will lead to an inherent wisdom and a reorganization of characterological structures, permitting more of the essential self to emerge" (Fisher, 2002, p. 6).

Developmental Psychology and Neural Plasticity

Our early environments shape the formation of the self, which occurs through the body's developing neurophysiological functions and is visible in the physical structures of the body, as well as in behavior and thought patterns. A certain amount of safety, affection, and responsiveness to our basic needs is crucial throughout childhood, and especially in early infancy, for us to progress through the stages of development and integration of the self. "The degree to which this Self finds its authentic expression through the person's emotional, cognitive, and relational life is profoundly influenced by early childhood experience when the Self is at its most fragile and vulnerable" (Rand, 1997, p. 75). Our increasing knowledge of the human nervous system is showing that old habits can be replaced by new behaviors and new beliefs, which become, through repetition of embodied experience, new neural networks in the brain and body. Through corrective therapeutic experiences, dysfunctional patterns can be replaced with more appropriate, adaptable modes of being that allow for a fuller expression of one's true self. Focusing on bodily, present-moment experience rather than abstract concepts leads to more grounded, concrete insight and understanding (Kurtz & Minton, 1997). Old character structures and holding patterns, because they are largely physical phenomena, can be dissolved more effectively through "direct experiences of our authentic energy and movement" (Caldwell, 1997, p. 12) than through verbal insight-seeking means alone.

Common Basic Techniques Across BP Modalities

These include mindfulness (or mindful awareness), breath work, and sensory awareness; centering, grounding, and assessment of paraverbal and non-verbal patterns; and incorporation of movement, play, and creative arts. The techniques of BP are becoming more widely used in the mainstream therapeutic culture, as models of health and healing are expanding. The over-arching paradigm of mind/body wholism is gradually moving out of the fringes and into the mainstream of health care. A large part of BP's value lies in its appreciation for the importance of an embodied lifestyle and a multi-faceted model of health. As clients' sense of self expands and takes root more firmly in the physical being, a larger repertoire of response to life becomes possible, and clients can greatly increase their personal effectiveness.

METHODS

Sample and Procedure

Participants in this study included nine psychotherapists and seven clients (n = 16). All participants were female. Eligibility for therapists was based on a self-reported degree of specialization in eating disorders and body image, and at least one year of working with this population. Years of experience range from one to ten years. While one of the therapists reported initially that she did not incorporate body-oriented techniques, it was determined upon further questioning that this was not in fact the case, and her interview was used for data along with the others. Of the nine participating therapists, four were currently working at established eating disorder treatment centers, and the others were found through the local advertising of their private practice specializing in eating disorders.

All clients reported being diagnosed with an eating disorder, and each had been in ongoing treatment targeted specifically at the eating disorder. In addition to outpatient treatments, five of the seven had also experienced inpatient residential programs. They were at varying stages in the recovery process, with ages ranging from twenty-one to fifty-two, and a mean age of thirty-five. Their treatments had included a great diversity of therapeutic modalities, some of which were not explicitly somatic. Interviews allowed, however, for the uncovering of any aspects of their treatments that had been body-oriented and experiential. Two of the seven clients were referred to the researcher by their therapist, who had been previously interviewed. She informed them of the purpose of the study and told them to send an email if interested in participating. Her assessment of their ability to participate was based on the knowledge that they were well along in the recovery process, and had already expressed in various ways their appreciation of the somatic treatments they had received. One client volunteered herself after seeing the flyer that was posted at her treatment center. The remaining three learned of the study through a notice that was posted in an online newsletter for eating disorders. For all clients, an initial discussion via email determined their understanding of the study and their willingness to participate. In several cases, the researcher emailed a copy of the thesis abstract for them to read. All clients were then mailed the consent forms to sign prior to the phone interview.

Data Collection and Analysis

Data were collected via in-depth, open-ended, semi-structured interviews that lasted between forty-five and ninety minutes. In most cases, the interview lasted about one hour. A prepared list of questions served as the starting point, but interviews were highly personalized according to the participant. In all cases, additional questions and requests for clarification were meant to take the interview in the most meaningful and elucidating directions possible. While participants were informed of the purpose of the study, the researcher tried not to steer their responses towards any particular viewpoint. Rather, bias and leading questions were avoided as much as possible. In just two cases, interviews were preceded by written questionnaires, which were merely shortened versions of the interview questions. This was because these participants were not sure initially if they would do an interview. These individuals chose to be interviewed later, so both their questionnaires and the interviews were included in the data.

Data collection and transcription happened simultaneously, with some interviews being transcribed by the researcher while still in the process of conducting interviews with other participants. This helped familiarize the researcher with the material, and better focus questions for subsequent interviews. To begin the analysis process, all interviews were read in their entirety. Passages of text that were in any way related to the research question were segregated for further use in the analysis. These portions were then searched for “meaning units,” relevant phrases that could be organized according to their relationship to the research question. With multiple searches of the complete data, repeating themes were extracted and then systematically organized using the methods of constant comparison and analytic induction. As patterns emerged within concepts, additional sub-themes were delineated and the data were regrouped. Interviews were read thoroughly multiple times throughout the analysis, in order to hermeneutically confirm the themes within the original context. Throughout the process of analysis, theoretical memos were created to document the emerging relationships between concepts, themes, and sub-themes. These relationships were thus inductively derived directly from the participants’ statements. Negative examples, which may not necessarily support the research question, were not excluded, but rather were given equal consideration.

RESULTS

In analyzing the complete set of data, three major themes emerged in relation to the thesis question of how Body Psychotherapy (BP) can be a useful element in the treatment of eating disorders. The first theme pertains to why BP can be useful. Both therapists and clients spoke to some degree about what they perceived to be the origins of the eating disorder, as well as some common characteristics among people with such disorders. Certain issues emerged here that indicate body-centered problems calling for body-centered interventions. The second theme pertains to the specific usefulness of BP, and seems to stem directly from the issues addressed in Theme 1. Within Theme 2, it becomes clear what the techniques look like and how they are experienced as helpful. The third theme that emerged highlights the larger outcomes of treatments involving BP on several levels – cognitive, somatic, and emotional. Theme 3’s section highlights the ways in which clients take what they learn in treatment out into their lives, and the positive changes that result. Besides naming some of the characteristics of this population, they highlighted why these characteristics seem to call in many cases for therapeutic modalities that address both mind and body, in order to work towards a more cooperative and functional mind/body unity.

Clients usually enter treatment in a state of relative disembodiment, unable to effectively identify or express what they are feeling. Estranged as they are from body, emotions, and self, therapy must therefore focus on building the skills needed as clients begin to uncover and reconnect with these suppressed parts of themselves. With the experiencing of emotion so unfamiliar and scary for them, therapists must facilitate the learning of self-regulation skills for managing the emotions, help clients find a more gentle and accepting manner of self-relating, and encourage them as they begin to express themselves with more clarity and confidence.

Since BP often emphasizes the nonverbal, clients can access unconscious material for which they may know no words. Inherently present-centered and “hands-on,” it also provides opportunities for new experiences and real practice that can contribute to changes in deeply-embedded behavioral patterns. This can lead not only to the cessation of symptoms, but also to a profound reconciliation with the body and self. Clients can come to know their bodies as a source of wisdom, strength, and pleasure. More aware of who they are and what they feel, they are empowered to make different choices in their lives and to seek what is truly fulfilling and satisfying.

The following tables offer a summary of the central themes and sub-themes that emerged in the interviews:

Table 1. Eating Disorder as a Mechanism of Managing the Relationships with Body and Emotions

I. Relationship to Body	A. Estranged from one's body	1. Mind/body disconnect 2. Tendency to intellectualize
	B. Fear of one's body	1. Body hatred 2. Shame and dissociation
II. Relationship to Emotions	A. Disconnected from one's emotions	1. Eating disorder to avoid or manage emotions 2. Self-judgment for feeling emotion
	B. Excessive Anxiety	1. Eating disorder to avoid or manage anxiety 2. Fear of being oneself 3. Fear of relationships with others 4. Pressure to perform/succeed

Table 2. Applications of BP in the Treatment of Eating Disorders

I. Self-Regulation Skills	A. Relaxation B. Breath C. Grounding/containment D. Identify and distinguish emotions and anxiety E. Recognize dissociation cues and strategize for avoiding dissociation F. Identify needs and take responsibility for getting those needs met
II. Other BP Techniques	A. Mindfulness B. Recognition of satiety cues C. Embodiment of the therapist
III. Additional Useful Elements of BP	A. Practice/experience vs. solely talking B. Movement or art can be revealing C. Express through movement or art what one cannot say or think clearly with words

Table 3. Outcomes of BP Techniques and Approaches

I. New Perspectives (Knowledge) Gained from BP	A. Understanding of one's body as a resource B. Understanding of moderate exercise as being healthy and helpful C. Understanding that answers/wisdom can come from oneself D. Understanding the body's need for fuel/nourishment
II. New Relationship with One's Body/Self	A. Trust and appreciation for one's body and self B. Self-acceptance and non-judgment C. New relationship to exercise D. Enjoyment of food E. More vitality F. Sense of self or identity beyond the eating disorder or the body/appearance
III. New Relationship with the Environment	A. Less avoidance of engagement with others and/or with one's life B. More sense of choice and empowerment C. Shifting priorities regarding one's life D. Permission to have feelings and desires
IV. New Relationship with Emotions	A. Decreased fear of emotions B. Relaxation is acceptable and enjoyable

DISCUSSION

The extensive responses of interview participants provide a great deal of information as to how experiential, somatic treatment modalities can be effective for clients with eating disorders. Recognizing the extensive range of eating disorder etiology and symptomology, the question arises: How much generalizing can be done accurately and responsibly? It seems that, above all, therapists must assess the *individual's* needs in developing the appropriate treatment and tailor techniques accordingly. This study sheds light on some important therapeutic issues, which must be considered within the context of the unique history and current circumstances for each client.

Rigor of Study

Credibility, Auditability, and Fittingness

Throughout the data analysis process a high degree of attention was given to assuring that the information was conveyed accurately and responsibly by the researcher. Triangulating across data sources, the researcher continuously compared and contrasted what was reported by the different participants. The congruence of findings was continuously assessed, with both typical and atypical elements of data being taken into consideration and thoroughly mapped out during analysis. Through ongoing readings of the interviews in their entirety, emerging themes and sub-themes were hermeneutically confirmed within the original contexts.

A high degree of auditability was achieved by taking extensive notes before, during, and after interviews, as well as throughout data analysis. These notes served to record the ongoing subjective impressions of the researcher. The documentation trail clearly lays out such importation factors as: researcher's perspectives, purpose of the study, questions arising during the literature review and data collection, means and duration of data collection, the stages of theme development, and the process of data coding according to themes.

The degree of fittingness of this study, though always limited by the chosen population studied, has the potential to be quite high. For qualitative research, sixteen participants (n=16) is a large number, so data becomes relevant to a greater range of individuals. Among participants there was considerable diversity in terms of their perspectives, eating disorder diagnoses and levels of recovery, histories, and treatment approaches. It is hoped that this study will lead therapists of any orientation to acknowledge, and even incorporate, the beneficial somatic elements into their practices when working with eating disordered clients.

Additional Strengths of this Study

Qualitative research provides us with in-depth personal accounts of phenomenological experience. In this case, subjectivity is valued as we listen to what people can tell us about the process of recovering from mental illness. While the objective, empirical nature of quantitative studies can measure outcomes, qualitative research attempts to achieve an understanding of how and why such outcomes may occur. This study provides new information in several relevant areas. It fills in a piece of the large gap in scientific literature pertaining to somatic treatments for eating disorders. It is also one of just a few studies that focus on describing the personal experience of clients with eating disorders, whether in recovery or already well-recovered. In addition, as far as can be discerned it is the only study that looks at therapists' experience treating this population. Most clinicians do not regularly take such time to reflect upon and define the way they work with such focus and precision, especially when their methods might start to feel instinctual and automatic after a long time in practice.

Previous research has attempted to measure outcomes for the most common mainstream modalities, especially Cognitive-Behavioral Therapy and Family Therapy, which have been shown relatively successful depending on factors such as eating disorder type, severity, duration, and the individual's age. Where the phenomenological relationship to one's body itself fits into this picture is a topic largely neglected. Considering the high relapse rate for this population, the psychosomatic nature of eating disorders, and the extreme level of disconnection to the body and its feeling states that is usually such a significant part of the problem, it makes little sense to attempt recovery without some sort of body-oriented work. Based on this study, BP offers a unique orientation and set of techniques, which can be particularly suited to treating eating disorders.

The comprehensive effects of experiencing some of these somatic methods, according to those interviewed, include an overall shift in perspective in which the body becomes re-integrated into one's sense of self.

The original question of this study was how using the body itself in therapy can make treatment for these issues more effective. During the process of the research, the question seems to have become more specific: Why must we and how can we incorporate the body to help bring back to light the true self of someone lost in an eating disorder? Although the etiological origins of these disorders cannot be universalized, characteristics that are commonly shared were clearly identified. It may be safe to say that in most cases, regardless of the reasons, the body comes to be perceived and treated as *other* rather than *self*. The reality of its biological needs and responses, and of its genetic predisposition towards a certain natural shape, becomes a hindrance and a force with which to battle. Sometimes the body becomes a bitter enemy.

Research is elucidating the effects of trauma, both acute/situational (as in the case of abuse, assault, and other significantly impactful events) and developmental or relational, on the body/mind/self. Whether it is the result of a single event, chronic abuse, or a whole childhood of insufficient nurturing, one's natural state of integrity and wholeness can be severely disrupted. Where there should ideally be a continuous dialog and interplay between perceptions, thoughts, feelings, and actions, there is instead a vast disconnectedness. The system cannot regulate itself effectively, and the individual instinctively seeks out ways to cope with the overwhelming chaos of his or her internal and external world, which he or she is without the skills to navigate.

Compounding one's personal distress, the messages communicated by the media contribute to the creation of a culture in which happiness, success, and love are clearly equated with physical attractiveness. And the single standard for attractiveness is limited to a body type that very few adults naturally possess. It seems clear why many individuals reach the conclusion that the reason they don't have the life they want and feel the way they want to feel is because they don't have the body that society tells them they should. Research confirms the deleterious effects of the thousands of media images most people are bombarded with yearly. Those who do not have the foundation of a solid sense of their identity and adequate self-esteem are at high risk of internalizing the media messages, especially when required to find something to help them cope with their pain or emptiness.

Limitations of this Study

A major limitation is that only one person conducted the research. Ideally for this type of study, having at least one additional researcher involved in the steps of data coding and analysis would lessen the chances of unconscious biases influencing the results. While it is recognized that bias is impossible to avoid, the author is aware of a personal assumption that somatic interventions can be highly useful and often necessary. Having additional researchers might also lend a diversity of perspectives that could contribute to additional themes and sub-themes being revealed.

There are a few areas where the sample was limited. First, all clients and therapists interviewed were female. It is possible that male clients would have expressed different opinions of how or if somatic treatments have been useful for them. Likewise, some male therapists may come from a different frame of reference and therefore offer more variety of clinical experience.

Dual diagnoses, while indirectly reported to be the reality for many clients, were not taken into account when analyzing the data. This is something that clearly has a significant impact on both the experience of pathology and the recovery process. In particular, the ways in which PTSD and mood disorders such as depression, anxiety, and bipolar disorder interact with clients' eating disorders could not be investigated within the scope of this study.

Because all clients interviewed have experienced different therapeutic modalities throughout the course of their treatments, it is difficult to isolate specific effects of each. Causality cannot be determined, therefore, and we are left only with their accounts of what they remember to have been helpful or currently perceive as such. It is possible that, knowing the nature of this study, clients could have favored the somatic elements in order to comply with the researcher's goals. The only attempt made to avoid such acquiescence was to avoid leading questions and to actively seek out information related to all types of treatment perceived as personally beneficial.

Implications for the Field of Psychotherapy

Embodiment: BP's Unique Contribution

The concept of embodiment was addressed in some way in almost every interview, whether the term was used or not. It is a meta-theme encompassing several other concepts that were addressed – self-regulation, somatic awareness, mindfulness, relationship with body and self, and vitality. Its counterpart, which can be termed *disembodiment*, is implicated

by therapists and clients as a disconnection between mind and body that manifests in estrangement from the body and self, varying degrees of dissociation, and a potentially harmful incapacity to recognize what they feel.

The discovery and practice of an embodied way of being might offer the key to recovery for many clients. It is not enough in and of itself; on the contrary, without an impeccably safe container and consistent guidance, support, and modeling by the therapist, increasing body awareness can be overwhelmingly scary and counterproductive. Some therapists said that clients simply may not be ready at first to approach the body this way, and insist on progressing with caution. Choosing words and activities wisely becomes important in these cases. Still, it seems that developing a new way of relating to body and self, which incorporates and necessitates the consistent practice of embodiment, remains body psychotherapists' over-arching goal.

Integrative approaches including embodiment. It must be noted that some clients report it extremely helpful to examine stressors, needs, goals, and core beliefs – all typical elements of Cognitive-Behavioral Therapy (CBT). Clients also report that incorporating journaling and verbal processing with their therapist have been beneficial additions to BP methods, especially when used in conjunction with the body-centered exercises such as movement or sensory awareness. It appears, therefore, that strengthening the body/mind/self connection can greatly enhance the effectiveness of other common therapeutic methods, such as CBT, as the practice increases present-moment awareness and receptivity to insight. The researcher means not to discredit any of the traditional treatment methods used for eating disorders, but rather to demonstrate the usefulness of expanding upon them with the addition of complementary somatic techniques.

Mindfulness. There are actually many varieties of mindfulness, coming from different traditions and holding different intentions. A fundamental element to the somatic treatments, mindfulness is becoming a popular concept throughout the field of psychotherapy, even beyond the clearly body-oriented models. Though the term has come to be used rather loosely to describe any intentional state of self-awareness, it may be necessary to specify with more precision which types of mindfulness are actually suited to these clients.

Other Treatment Considerations

Medication. Therapists note that many clients benefit from medications such as anxiolytics and anti-depressants, and sometimes cannot proceed with the work of facing their emotional experience without this basic level of stabilization and support. In other words, some cannot do the work of facing their difficulties without medical assistance in achieving some needed sense of balance and regulation. Several clients concur, saying that the successful medical treatment of some of their symptoms has been a large factor in their recovery. They, too, refer to medications targeting anxiety and/or depression, and in one case, dissociation.

Group therapy. Some therapists cite the benefits of group treatment for this population, particularly because it is an arena for working with the relational difficulties with which they commonly struggle. Several clients report that groups of various types were very helpful. Groups offer clients the chance to give and receive emotional support, sometimes for the first time. They can cheer each other on through the recovery process, challenge each other when necessary, receive regular reality checks, and emerge from the isolation and aloneness that are so often part of the eating disorder. Some clients also say that they were greatly inspired by witnessing the successes of other group members.

Family therapy. Whether family therapy is conducted from a somatic orientation or not, it seems from participants' reports that, when a viable option, it is often a crucial element to treatment. Some clients say they could not have recovered without their families' willingness to be part of the process with them, insisting that eating disorders are rarely the problem of the identified patient alone. Perhaps even more important with the younger clients who still live at home, it is often the case that the context within which the disorder developed must be addressed and tended to before real change can be possible.

Need for Eating Disorder specialization. The area of eating disorders appears to be one of those for which therapeutic expertise is particularly important. Therapists must have the sensitivity and the skills to support clients appropriately during weight gain when relevant, during the often-painful process of emotional awareness-raising, and during the letting go of familiar coping tools and the gradual learning of new ones to replace them. Therapists must also be aware of the counter-transference issues that can commonly arise in relation to this population. A degree of wariness can be helpful in regards to the sense of urgency and the need to perform successfully, which is cited as common with these clients, and can often lead the therapist to be overly concerned when progress is slower than hoped (Reindl, 2001). Some therapist participants also stressed the necessity of being well acquainted with their own relationships to food and body, so that transference and counter-transference issues can be effectively approached throughout the process of treatment.

Readiness for change. It seems that therapists must assess clients' readiness to change their perceptions and let go of familiar coping strategies. Acknowledging that some do not begin treatment in a state where experiencing embodiment could be useful, work must sometimes proceed very slowly. Without both a solid therapeutic container and a basic level of self-regulation skill, it can be entirely overwhelming and possibly counterproductive to the recovery process if clients are led to

heightened awareness of their internal world without the skills necessary to face the pain and fear likely to arise. Especially if there is unresolved trauma dysregulating their systems, the foundational skills must be built in before work can proceed.

Suggestions for Future Research

The relationship between eating disorders and addictions could not be well explored in this study. It was referred to throughout the literature and the interviews, but in most cases indirectly. Thus far, no thorough exploration has been made as to the similarities and differences between eating disorders and the well-known addictions – substances, sex, gambling, etc. Because there are quite a few apparent similarities in terms of origins and unconscious impulses or drives, it could be informative to look at the ways in which eating disorders may meet the criteria for addictions. Furthermore, with so much recent progress being made in the understanding of the neurophysiological aspects of addictions, drawing parallels here could contribute a great deal to eating disorder treatments.

It could be exceedingly useful for outcome studies such as those conducted for Cognitive-Behavioral Therapy to be done for the somatic therapies. In addition to the anecdotal literature and the occasional case studies, the field is lacking in empirical research to support claims of BP's efficacy. Not only would such studies add to our comprehension of how and why the somatic therapies are effective, but they would also lend much merit and allow BP to step more firmly into place beside the more well-known and recognized modalities.

Additionally, it would be well worth examining how best to incorporate BP into the short-term therapeutic programs now mandated for insurance coverage. Insurance companies are now requiring more formal and systematic documentation of treatment goals and successes. Especially, though not exclusively, for therapists working in inpatient eating disorder hospitals and clinics, it may be necessary to clarify how their modalities can fit into the type of protocol approved by these companies. Several participants lamented that people needing treatment are often denied because of such restrictions, especially in the cases of anorexia, which typically take longer to treat than bulimia.

Finally, how can somatic modalities serve the purpose of eating disorder prevention? There are increasing numbers of programs in communities and schools that target prevention in children and adolescents, certainly a crucial task. It could be extremely productive to explore how BP techniques can help build a strong sense of self and reinforce healthy relationships with the body, which will help carry the children through their difficult transitional periods into adulthood. With this in place, it is hoped that they would not develop such debilitating levels of body dissatisfaction, and would not turn to eating disorders to cope with or shield themselves from life's stressors.

A few words from the clients interviewed in this study:

You were created a certain way for a certain reason, and there's power and strength behind that. And just to embrace that and know that it'll be OK. And to know that if you just kind of sit comfortably in your body and not fight it, that it'll make life so much easier. Because if you always live in this internal war with your body and with your emotions and with an eating disorder, then you have no other energy to put towards anything else that'll make your life or other people's lives better...And when you're in war with your body you think the only thing that's within reach is working on your body, or working on your external appearances more than your internal peace...I'm just so thankful that there is something else behind just the physical body. And there's like a whole story behind that. And everybody's is different. And that's what makes it so beautiful.

You are who you are because God made you that way. And being unique is absolutely the greatest thing...Our bodies are extremely important because they're the vessel that we live in, but at the same time just because that's the visual part that people see does not mean that that is simply who you are, just your body. That's not who you are at all, it's the stuff inside that makes you who you are as a person. And we should value that. And not have to just be brainwashed that our bodies are the only thing that matters.

I feel like so many years were wasted. And I know that was my process, and like I said that's what I needed to get here. But I sometimes see women and I just want to shake them up and go 'It doesn't matter! It doesn't matter what your hair looks like or what clothes you're wearing or how sexy you or someone else thinks you are or whatever. There's just so much value in just being yourself.' I don't feel comfortable in my body because my body looks exactly the way I want it to... In the end you're either going to die or you're going to have to go down to the core of yourself anyhow. And so like, cut to the chase, right? The sooner you do it the better.

I wish I'd known I guess that my body was OK, that there wasn't always something wrong. I wish I'd been comfortable with my body from childhood on. And I guess partly what I want to say to someone is 'look what it's doing to your brain'. Um, and that there is help, and hope... To keep going and keep trying.

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Biography

Morgan Lazzaro-Smith graduated from Naropa University in 2006 with a M.A. in Somatic Counseling Psychology and a concentration in Body Psychotherapy. Previously, she received a B.A. in Cultural Anthropology from the University of North Carolina at Chapel Hill in 1999. She currently works in Fort Collins, Colorado as a family therapist and has a private practice, Sage Living Psychotherapy, specializing in the treatment of trauma, adolescent and family issues, eating disorders, and stress management. She is trained in Level 2 EMDR.

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Clinicians' Use of Touch and Body Awareness in Psychotherapy: Trained vs. Untrained

Anastasia D. McRae, MSW

Abstract

A national purposive expert convenience sample of 164 licensed, practicing mental health professionals responded to an anonymous online survey regarding their use of touch and body awareness in their treatment with clients. The findings show that while training in the use of touch or body awareness does influence positive attitudes toward both, clinicians without training incorporate body awareness at about the same rate as do those with training. In fact, the major difference between those with training and those without surfaced sharply only in the area of actual use of touch. Attitudes and beliefs about the importance of the body, both the therapist and the client's, and of their use as therapeutic tools were very similar.

Keywords

Touch – Psychotherapy – Body awareness

Just as a controversy existed many years ago regarding whether it would ever be clinically appropriate for the psychotherapist to use self-disclosure in therapy (Jourard & Friedman, 1970) a controversy continues among clinicians as to whether the use of touch is or ever can be appropriate in psychotherapy. Touch is perhaps the most powerful way animals communicate. It is only logical that humans have used it for centuries as a way to help each other heal.

Though it is still thought of by many as a taboo, use of touch is a branch of psychotherapy with roots going back to and beyond Freud. Unfortunately, the power of touch brings with it both positive and negative possibilities. As one writer notes, the body and the touching of it are difficult and confusing subjects culture-wide:

Many of the difficulties in integrating bodymind psychotherapy into psychotherapy as a whole are reflecting of general cultural problems around bodies and touch. Body-centered therapy rubs—literally—on some of society's sorest spots. It brings to light all the ways in which themes and experiences of embodiment become traumatizing aspects of individual history, through our culture's deep sickness in relation to sexuality.... Working through the body, and with and through the feeling and thoughts that this work mobilizes, necessarily uncovers our trauma of socialization: a trauma which cannot fully be repaired or undone. To fantasize such an undoing is to fantasize a state outside culture (Totton, 2003, p. 147).

Although Freud once wrote that “the ego is first and foremost a body-ego,” (as cited in Smith, 1998b, p. 5), the person existing with bodily deprivations and needs is something of a pink elephant in the treatment room since Freud ceased touching his own clients and insisted all other analysts in his early psychoanalytic circle do the same (Totton, 2003). Much, if not all, training of psychotherapists is curiously lacking in knowledge relative to seeing the person living within and as a body, other than, perhaps, courses on pharmacological issues and physical trauma.

The field of neurobiology has, however, expanded contemporary conversations concerning the nature of the body in relation to mental and emotional processes. This is especially the case in the area of trauma where it is argued that the brain and physical development of a person are greatly impacted by emotional distress and that the body in turn remembers that emotional distress as physical symptoms that may have no obviously physical antecedents (van der Kolk, 1994; Ogden, 2000; Solomon & Siegel, 2003).

In recent years studies also show the increased use of complementary and alternative therapies by populations engaged in psychotherapy, including touch therapies like massage, acupuncture, and Reiki, Bioenergetics, etc. (Elkins, G., Marcus, J., Rajab, M. H., & Durgam, S., 2005; Field, 1998a, 1998b; Mamtani, R. & Cimino, A., 2002). Many clinicians in the mental and physical health arenas, often users of alternative modalities themselves, have turned to what is today termed *holistic medicine* in an effort to span what had become the chasm between treatment of the *bodymind*. Some of these clinicians have sought out formal training in or dialogue on the use of touch or body awareness and use one or both in their psychotherapy practice. Even still, most psychotherapists continue to think of touch in the treatment room as contraindicated for their patients, and legally and ethically risky, if not outright dangerous for the patient and therapist.

The purpose of this study was to answer the following question: “Do clinicians with training regarding the use of touch and body awareness report using these modalities more often and report more positive attitudes towards them than do clinicians who report no training in the area?” This research question incorporates two hypotheses of difference: 1) that training in the use of touch and body awareness engenders more use of both among mental health professionals; and 2) that training is also a significant predictor of a clinician's attitudes and beliefs about the use of touch and body awareness. The sample includes clinicians with and without training in the use of touch and body awareness. The term *bodywork* refers to the intentional use of systematic touch to therapeutically assist clients in the integration of body awareness and the release of

stored habitual tension patterns. *Body awareness* is defined as a means of perception as experienced through movement, gesture, illness, or sensation. While these were the main hypotheses, the results of the study revealed a number of avenues for future related research.

METHODOLOGY

Formulation

This study was conducted using a mixed method, relational design, in an effort, as Anastas writes, "...to describe whether or not a phenomenon or a characteristic of it is systematically associated with another phenomenon and, if so, how" (Anastas, 1993, p. 150). The study used primarily quantitative survey questions with a limited number of qualitative questions. The participants were comprised of mental health professionals, including clinical social workers, psychoanalysts, and otherwise licensed professional counselors.

The mixed method design was appropriate for this study in two ways: it allowed for the quantification of responses as well as some possibility for deeper narrative response. One weakness of the quantitative portion of the study is that during data analysis it is difficult to ask all the necessary questions to account for the multitude of variables present thereby forcing the researcher to ask and answer only a small selection of questions that will undoubtedly leave many more questions unanswered. A weakness of the qualitative sections is again during data analysis, as the complete richness of the coded data may not come through due to the difficulty in finding similarities in every answer. "No study can presume to isolate, measure, and discuss every variable of possible interest" (Anastas, 1993, p. 157). With that in mind, the vision of this study is to serve as a preliminary effort that may lead to future research.

Sample

A purposive expert convenience sample of one hundred sixty-four mental health professionals took part in this study. Clinicians were able to participate if they were licensed mental health professionals—either as psychotherapist, psychoanalyst, professional counselor, or clinical social worker—with at least five years clinical experience. If the clinicians currently used a specific touch modality, they needed licensure or certification to practice that particular modality to participate in the study.

Data Collection

Participants were asked to complete a fifteen-minute thirty-six question anonymous online survey about their use of body awareness and touch in sessions with clients, about their training and familiarity with touch and body awareness as a component of their practice, as well as about their attitudes about touch and body awareness. There was also a series of demographic questions for participants to answer.

Quantitative data was collected because of its concreteness and the opportunity of doing correlational analyses, while qualitative data was collected for the richness of more individualized, in-depth and personal responses that numbered responses to survey items might not capture. The design of one question in the survey instrument (#17) replicates Smith's taxonomy of touch (Smith, 1998a). Smith's taxonomy allowed for the inclusion of a recognized, accepted, and clear categorization of touch (Durana, 1998; Stenzel & Rupert, 2004).

Licensed mental health professionals were recruited through the Smith College School for Social Work alumni association (graduates from 2005 or earlier to ensure at least five years in practice), the National Association of Social Workers, the American Psychological Association—Divisions 29 and 39, and the Illinois Association of Clinical Social Workers. Clinicians who might have more formal training in the use of touch and body awareness were recruited through national organizations, schools, and training facilities including the California Institute of Integral Studies, the Naropa School, the United States Body Psychotherapy Association, and the training institutes for Hakomi, the Rosen Method, and the Rubenfeld Synergy Method. Participants were also identified through association or a snowball sampling method by which participants were encouraged to pass along the survey to colleagues they identified as having interest in the study.

Recruitment began with phone calls and emails to the above listed organizations after receipt of approval from the Smith College School for Social Work's Human Subjects Review. Once initial contact was complete, a recruitment letter was sent electronically to the identified person who had agreed to send it along to the organization's list-serve. The recruitment email included information about the intent and description of my study, participation requirements, and the risks involved in participation.

Once possible participants received the letter and agreed to take part in the study, they received instruction, in the body of the letter, to click on a link that took them to the online survey. The first page available to participants was the informed consent to which they answered YES or NO prior to proceeding to the instrument. If they answered YES, they went to the first question of the survey. If they answered NO, they went to a "thank-you" page and directed out of the survey.

Participants were also asked to supply demographic information pertaining to age; sex; years in practice; state of licensure; type of mental health licensure; theoretical framework from which they work; type of arena in which they practice; and how they identify racially or ethnically.

Data Analysis

Once the data were collected, statistical tests were run to ascertain any relationships among variables using descriptive statistics, including frequencies and cross-tabulations. Descriptive statistics were further utilized to view the data based on which respondents reported some level of training and which did not and to ascertain whether chi-square tests for difference were possible. Chi-square tests were run for gender; use of touch and body awareness, and training variables on a series of questions highlighted as those most salient in regard to use of touch and body awareness and the therapist attitude toward both.

FINDINGS

The absence of training and dialogue about the use of touch and body awareness in psychotherapy has been cited as one plausible reason for ethical misconduct vis-à-vis physical contact in the treatment room. This research project focused on a small facet of this debate by asking whether training in the use of body awareness and the use of touch among licensed mental health professionals was a predictor of more and different, non-erotic, use of physical contact. The major finding of this research is that training does have an effect on both use of and attitudes about touch and body awareness in the psychotherapy practice of those surveyed. The results also revealed continued ambivalence about the use of touch, even among those reporting training in a body-oriented modality.

Characteristics of Respondents

164 respondents between November 2007 and February 2008 started online surveys. 103 surveys were complete and useable. Surveys were eliminated due to missing consent or demographic information; out of country mental health licensure; and listing a non-recognized mental health licensure or theoretical background. The following demographic information is for the remaining sample (N=103). Respondents to the survey were a diverse group across sex, age, practice setting, years in practice, and location (see Table 1).

Overall Sample Characteristics

The median age of the respondents in the sample was 51 with the maximum age at 86 and the minimum at 29. Ninety-one (88.3%) of the respondents were female and twelve (11.7%) were male. Respondents answered variously to an open-ended question about race or ethnicity with 79.6% answering "Caucasian or White;" 8.7% "Jewish;" 2.9% "Arab-American or Lebanese American;" 1.9% each for "African American or Black," "Latina or Hispanic," and "Native American;" and 2.9% answered "Other" (see Table 1).

The median number of years in practice among the respondents is 17. More than half of the respondents (54%) reported working in private practice settings (see Table 1). Twenty-six states are represented in the sample as counted by licensure, including Arizona, Connecticut, California, Illinois, Massachusetts, Washington, and West Virginia (see Table 1). The bulk of the sample (73.8%) reported having mental health licensure as clinical social workers though there were others represented (see Table 1).

The reported theoretical framework of responding clinicians varied a great deal. The largest grouping was of psychodynamic therapists (N=37), followed by those claiming an eclectic background (N=19). Other frameworks reported were psychoanalytic (N=6), Body Oriented or Centered Psychotherapy (N=7), Jungian (N=5), CBT (N=5), Somatic Psychotherapy and Integrative (N=4, each), Gestalt, Object Relations, and Narrative (N=2, each), and Other (N=10).

Characteristics of Those Reporting Some Level of Training in the Use of Touch or Body Awareness

TABLE 1

Demographic Characteristics of Respondents

	Frequency	Percent			
Sex					
Female	91	88.3			
Male	12	11.7			
Race or Ethnicity					
Caucasian or White	82	79.6			
African American or Black	2	1.9			
Jewish	9	8.7			
Latina or Hispanic	2	1.9			
Arab or Lebanese American	3	2.9			
Native American	2	1.9			
Other	3	2.9			
Mental Health Licensure					
Clinical Social Worker	76	73.8			
Marriage and Family Therapist	8	7.8			
Professional Counselor	10	9.7			
Psychiatrist	2	1.9			
Psychologist	6	5.8			
Other	1	1.0			
Practice Settings					
Private Practice	56	54.4			
Community Mental Health	21	20.4			
Adult or Child Inpatient	2	1.9			
Hospital Adult or Child Outpatient	3	2.9			
Other	21	20.4			
States Represented by Licensure and Distribution of Respondents					
Arkansas	1	Massachusetts	21	Oregon	2
California	12	Maine	4	Pennsylvania	3
Colorado	6	Maryland	4	Rhode Island	1
Connecticut	10	Minnesota	1	South Carolina	1
Delaware	1	North Carolina	2	Texas	1
Florida	1	New Hampshire	1	Virginia	1
Georgia	2	New Mexico	4	Washington	2
Hawaii	2	New York	10	West Virginia	1
Illinois	4	Ohio	1		

The sample was further broken down according to those who reported some level of training in the use of touch or body awareness. Of the total sample, 59.2% reported having some training in touch and body awareness and their use in the treatment room either through coursework, in supervision, or for a bodywork modality (see Table 2). Fifty-three women (58.2%) reported some training in the use of touch or body awareness and eight men (66.7%) had some training. By mental health licensure, the majority (83.3%) of the psychologists, half of the psychiatrists, 47.4% of the clinical social workers, and 100% of both the marriage and family therapists and the professional counselors reported some level of training in this area. The mean age for this group was 51.70 and the mean number of years in practice was 18.97 (see Table 2).

Clinicians involved in a particular body centered psychotherapy reported training that had lasted, for most (77.4%), more than one academic term, included personal treatment as part of the training (82.1%), involved information on professional ethics (86%), and included methods to help in the integration of the modality into their mental health practice (71.9%). Clinicians trained in a formal bodywork modality or particular branch of body centered psychotherapy reported practicing from many schools of thought including Reichian therapy, Somatic Experiencing, Radix, Rubenfeld Synergy Method, the WaveWork, Hakomi, Cranial Sacral therapy, Bodydynamics, Polarity therapy, Reiki, Sensorimotor Experiencing, and Rosen Method Bodywork.

General Findings

The findings are grouped below in two primary areas: attitudes and beliefs about and the actual use of touch and body awareness in mental health practice with a focus on the differences between those who reported some training in the use of touch or body awareness and those who did not.

Attitudes and Beliefs

Attitudes and beliefs were assessed through a subset of questions designed to get an impression of how clinicians in this study thought about the physical body as a clinical component of the psychotherapy process. Likert scaled questions and an open-ended question focused on the respondents' emotions, thoughts, or concerns about their participation in the study.

A majority (91.8%) of those reporting some level of training said they view tending to the physical as equally important as tending to the emotional while over half (65.9%) of those who reported no specific training in the use of touch or body awareness agreed that the physical is equally important. A similar trend is apparent in ideas about memories stored in the body and a clinician's use of both her and the client's physical reactions during treatment. Some part of the work of many clinicians (91.8% of those with training, 85.7% of those without) in this study is informed by a belief that memories are stored in the body and have an effect on the health and well being of the client.

Two respondents, both reporting some level of training, voiced their opinion about the importance of training in these areas:

My... training was NEVER to touch clients. I do a lot of supervision of interns and discuss touch with my students regularly. I do believe therapists should think before using touch and should understand why they do it. It should never be for the therapist's comfort or benefit. Body awareness and discussion of body experiences are a critical part of my work in a family trauma clinic. It is helpful for me that touch is openly discussed in my workplace and a topic of clinical team meetings as well as trainings. [Respondent reported training in the form of classroom discussions, seminars, and supervision.]

I've worked in the mental health field for many years and the profession has given me mixed messages when it comes to "touch," "feel" so I have had to rely on my own personal professional opinion. The majority of cases that I carry are either latino/a or african-american ethnic/culture. I try to accommodate & respect the individual's culture and rituals. [Respondent reported training in the form of seminars.]

Another respondent who reported no training in the use of touch or body awareness stated his or her concern a little differently: "[I] now have a fuller appreciation of what use of touch can mean, and I now see that I use it and think about it more often than I realized." [Respondent reported no training.]

A respondent who reported formal training in a bodywork modality wrote in: "For me in general touch belongs to human being. We all learned in an essential way through being touched, so using touch in psychotherapy is an important tool for learning about oneself and for communication."

Respondents saw the bodily reactions of the clinician along with those of the client as important indicators in the course of treatment. Ninety-five percent of those with training and 73.8% of those without training strongly agreed or agreed that their bodily reactions and those of the client are important information. It is salient in each of the three instances mentioned that even those without training, more than half from that group, think of the body, both theirs and the client's, as

important and are influenced by their awareness of physicality in the room. Some, however, voiced concerns about scope of practice:

I think that touch is not really the role of a psychotherapist, unless one wants to pursue a specialization, such as Reiki, and offer services concurrently. I see this as both a therapeutic and legal issue. We should be professionally qualified for the things we do. That said, I think that discussion of sensations in the body, body memory, and physical experience should occur more. This allows a clinician to reach more clinical topics with quiet individuals, cultures who may be more likely to experience feelings somatically, and of course, people experiencing illnesses. I think that clinicians are sometimes concerned that they are not qualified to discuss physical or medical experiences not having gone to medical school. I think that this is a shame. We are not providing medical interventions. We are opening new dialogues. Mind and body do not stand juxtaposed to each other. [Respondent reported no training on the use of touch or body awareness.]

There are basic ethical principles that must be followed whether one uses touch or not. Therapists must be educated in the modality and experience total comfort when employing touch in therapy. [Respondent reported formal training in a bodywork modality.]

TABLE 2

Characteristics of Those Reporting Training in Body Awareness or Use of Touch

	Frequency	Mean	Percent
Female	53	--	58.2
Male	8	--	66.7
Years in Practice	--	18.97	--
Age	--	51.70	--
Mental Health Licensure			
	Frequency	Percent	
Clinical Social Workers	36	47.4	
Marriage and Family Therapists	8	100	
Professional Counselors	10	100	
Psychiatrists	1	50	
Psychologists	5	83.3	
Type of Training in Body Awareness Or Use of Touch			
	Frequency	Percent	
Classroom Discussion	27	26.2	
Seminar or course	41	39.8	
Supervision	42	40.8	
Formal Training	41	39.8	

In terms of their clarity about the validity and use of touch in the psychotherapy there was a sharp divide between the groups. While eighty-five percent of those with training strongly disagreed or disagreed that they were unclear about the use of touch and its validity, 42.9% of those without training strongly agreed or agreed that they were unclear on this point, and 38.1% of those without training were not sure or neutral about touch's use and validity. Some respondents explained it in the following manner:

Taking this survey reminds me of how split I am about touch. I believe it can be helpful, but I'm also committed to practicing w/in the limits of my professional license. [Respondent reported formal training in a bodywork modality.]

When I consider touch, and we in Hakomi do a lot, I am again aware of my own ambivalence of using it and not because I think there is anything wrong with it, but I always worry about how it is interpreted by a client. [Respondent reported formal training in a bodywork modality.]

I tend to have a negative response to the use of touch in therapy, except occasionally with older people, so I felt a little old fashioned/rigid in my responses. However, I do believe that, with the exception of people

trained in specific body-based techniques, one has to be very cautious about the impact that touch can have on a client and the therapists' needs that may be involved. [Respondent reported no training in the use of touch or body awareness.]

Though participants from neither group said they always or almost always had a sense of doing something wrong or feared facing ethical or legal ramifications for using touch, 16.7% (N=16) did sometimes have this concern, 36.5% (N=35) had it rarely, and a little less than half (46.9%, N=45) never had a sense of ethical or legal repercussions. The majority of those with training, 60.7%, never had the sense of wrong doing while the majority of those without training, 47.5%, rarely had that sense.

Comparison of Attitudes and Beliefs of Therapists by Report of Training in the Use of Touch or Body Awareness in Psychotherapy
Table 3

1- Tending to the physical in psychotherapy is as important as tending to the emotional and mental processes ?

	Frequency (N)	% With Training	% Without Training
<i>Yes</i>	83	91.8	65.9
<i>No</i>	19	8.2	34.1

2- A belief that memories are stored in the body and affect the health and well being of clients informs some part of my work.

	Frequency (N)	% With Training	% Without Training
<i>Strongly Agree</i>	53	75.4	16.7
<i>Agree</i>	39	16.4	69.0
<i>Neutral/Not Sure</i>	7	4.9	9.5
<i>Disagree</i>	3	1.6	4.8
<i>Strongly Disagree</i>	1	1.6	0

3- My bodily reactions and those of the client are important indicators for me in the course of clinical treatment.

	Frequency (N)	% With Training	% Without Training
<i>Strongly Agree</i>	50	71.7	16.7
<i>Agree</i>	38	23.3	57.1
<i>Neutral/Not Sure</i>	11	3.3	21.4
<i>Disagree</i>	2	0	4.8
<i>Strongly Disagree</i>	1	1.7	0

4- I am unclear about the validity and use of touch in therapy.

	Frequency (N)	% With Training	% Without Training
<i>Strongly Agree</i>	5	0	11.9
<i>Agree</i>	17	6.7	31.0
<i>Neutral/Not Sure</i>	21	8.3	38.1
<i>Disagree</i>	26	31.7	16.7
<i>Strongly Disagree</i>	33	53.3	2.4

5- When I have used touch I have a sense that I am doing something wrong or will face ethical or legal repercussions.

	Frequency (N)	% With Training	% Without Training
<i>Always</i>	0	0	0
<i>Almost always</i>	0	0	0
<i>Sometimes</i>	16	10.7	25
<i>Rarely</i>	35	28.6	47.5
<i>Never</i>	45	60.7	27.5

Table 3 shows a larger percent of clinicians who had received training in use of touch or body awareness answered positively when asked about their attitudes and beliefs. Chi-square analyses were run to determine if these differences were significant. There was a significant difference in "Tending," "Body Reactions," and "Touch as Valid" (see Table 4). There was no significant difference in the variables "Body Memory" and training. The results of this analysis partially support the hypothesis that there is a significant relationship between training and attitudes and beliefs.

TABLE 4

Chi-Square Results 1: Training and Attitude

Variable	df	N	Value	p
Tending	1	102	9.248	.002
Body memory	-	---	----	-----
Body reactions	1	102	7.664	.006
Touch as Valid	1	102	17.049	.000

Use

Just over half (51.4%) of the entire sample reported rarely or never using touch in their psychotherapy practice. The other 48.6% reported using it at least some of the time. A portion (22.1%) of those respondents without training experienced using touch almost always or sometimes. Though many (70.5%) of those with training in the use of touch and body awareness reported using touch in their psychotherapy practice almost always or sometimes, some reported rarely (11.5%) or never (13.1%) doing so (see Table 5).

Respondents shared a range of opinions about their clinical experiences in specific instances with the use of touch: One long-time client, not particularly psychologically sophisticated and very sensitive, used to ask me regularly for a hug at the end of her session. For a long time, I acquiesced. Eventually, I began to feel less and less comfortable with the "routine" and tried to talk with her about ceasing the practice, mumbling something inchoate about "feelings need to be talked about, not acted on..." She was understandably devastated, had little comprehension of what I was talking about, and felt primarily rejected and confused. Today, I'd have done the whole thing quite differently, but I wouldn't have necessarily ceased the practice -- just processed it better! [Respondent reported no training in body awareness or the use of touch.]

I practice both psychotherapy and Rosen Method Bodywork. Touch is never used in psychotherapy. Touch is only used when the client has contracted to participate in Rosen Method Bodywork with this practitioner. [Respondent reported formal training in body awareness or the use of touch.]

There are times in a client's process that I use touch to support an already happening process. Ie: a client in a fetal position, touching (with permission), a foot so she knows she is not alone in her deep process. I rarely use touch, even though I was trained to, and always ask permission. I use touch less with men and gay women in my practice. [Respondent reported formal training in body awareness or the use of touch.]

My theoretical stance is that touch IS appropriate in some cases, and I have used touch with some of my clients. Social work ethics (NASW) include the use of appropriate touch. [Respondent reported no training in body awareness or the use of touch.]

I have only used touch w/ clients in a setting that structures the use of touch in the therapy, such as Hakomi training. In my "office" practice as an LPC I do NOT use touch. [Respondent reported formal training in body awareness or the use of touch.]

One client who was pregnant and emotionally rejecting. The client was able to realize her emotional conflict through the use of touch. As she became aware she was completely numb to the sensations of the baby inside her, she was

able to access her fears and sadness about being pregnant. By the following session she was letting her husband feel the baby move and genuinely bonding with the baby. [Respondent reported no training in body awareness or the use of touch.]

A majority (85.2%) of respondents reporting some level of training always or almost always incorporated body awareness into their clinical practice while three-quarters (78.6%) of the respondents without training reported doing so almost always or sometimes. Of those respondents without training, 21.4% rarely or never incorporated body awareness into their psychotherapy treatment (see Table 5).

Examples from respondents of their use of body awareness in treatment with clients:

I was meeting with a 9 year old girl who was very angry about her foster care situation and had started having anger outbursts in school, which were very uncharacteristic of her. She expressed frustration at not being able to feel the anger coming on. We acted out feeling angry and once she was able to recognize the feeling of anger in her body she could address it before it became an outburst. [Respondent reported no training in body awareness or the use of touch.]

I have a counter dependent client who uses a certain gesture to indicate that she is fine, and I pointed out this gesture to her, so that she can be aware of moments of pushing away feelings of need. [Respondent reported no training in body awareness or the use of touch.]

Therapists surveyed about use of their body sensations to inform their approach with clients showed similar results, with 83.6% of those with training almost always or always doing so, 73.8% without training almost always or sometimes doing so, and 14.3% of those without training doing so rarely or never (see Table 5).

Comparison of Use Tendencies of Therapists by Report of Training in the Use of Touch or Body Awareness in Psychotherapy

Table 5

1- I incorporate body awareness into my clinical practice.

	Frequency (N)	% With Training	% Without Training
<i>Always</i>	25.9	45.9	0
<i>Almost always</i>	34	39.3	23.8
<i>Sometimes</i>	31	13.1	54.8
<i>Rarely</i>	6	1.6	11.9
<i>Never</i>	4	0	9.5

2- In my clinical practice, I am aware of and utilize my own body sensations to inform my approach with clients.

	Frequency (N)	% With Training	% Without Training
<i>Always</i>	36	50.8	11.9
<i>Almost always</i>	32	32.8	28.6
<i>Sometimes</i>	28	14.8	45.2
<i>Rarely</i>	6	1.6	11.9
<i>Never</i>	1	0	2.4

3- In my clinical work I notice and talk with clients about their physical realities---

	Frequency (N)	% With Training	% Without Training
<i>Always</i>	16	23	4.8
<i>Almost always</i>	40	49.2	23.8
<i>Sometimes</i>	38	23	57.1
<i>Rarely</i>	8	4.9	11.9
<i>Never</i>	1	0	2.4

4- I have had the experience of using touch as an element in my clinical practice.

	Frequency (N)	% With Training	% Without Training
<i>Always</i>	3	3	0
<i>Almost always</i>	13	21.3	12.6
<i>Sometimes</i>	34	49.2	23.8
<i>Rarely</i>	8	4.9	11.9
<i>Never</i>	1	0	2.4

Helping clients to examine their physical reactions in the treatment room was reported by 72.2% of those with training always or almost always with the largest percent (49.2%) reporting almost always doing so. A majority (80.9%) of therapists without training reported incorporating client physical responses almost always or sometimes with the highest number (57.1%) reporting sometimes. Only 7.8% of the entire sample reported rarely doing this and 1% never doing so (see Table 5). One therapist who reported some training in body awareness and use of touch wrote:

I have worked in inpatient and outpatient settings with trauma survivors. I encourage my clients to find the place in their bodies where they feel a particular feeling the most and, when appropriate or requested, I will sit next to a client and, with their permission, put my hand on their hand that holds the feelings to help them feel like they are sharing the feelings with me.

Table 7 shows the type of touch used by therapists in the sample, according to gender and training. Socially ritualized touch, as in handshakes, is the most used type of touch by both therapists with training in use of touch and body awareness and those therapists without training. Those with training chose touch as technique as the second most used form of touch. Therapists without training were much more likely to touch inadvertently (54.7%) than were those with training (14.7%). Interestingly, only 57.3% of those with training said they use touch as technique (see Table 7).

Table 6 displays results of when sample respondents offered touch. Reports of when touch occurred during treatment were similar for both groups in all but three areas. Therapists with training were more likely to use touch when they thought it would help with client self-disclosure (41.1%) than those without training (0%). Therapists without training indicated that they used touch most often at the end of treatment (71.4%) than those with training (42.6%). Therapists with training rated using touch with clients at the clients' request higher (54.1%) than those without training. Both groups were just as likely to use touch at the end or beginning of a session and when a client is sad or anxious.

Some clinicians expressed their positions on when they offer touch as follows:

I never use touch other than a greeting handshake, or termination handshake or hug. Physical sensations are more a conversation topic. I believe strongly in discussion of physical sensations as being relevant to psychiatric state. I just do not believe that touch is my role. [Respondent reported no training in the use of body awareness or touch.]

I do NOT use touch as regular part of my clinical work. For me, touch is part of the "social framework" such as handshakes, guiding people down a hallway (holding child's hand), etc. My theoretical framework does not incorporate touch so when I do touch a client, I do have to consider if it is clinically appropriate - most of the time, I don't feel it is clinically appropriate. [Respondent reported no training in the use of body awareness or touch.]

Working a lot with female traumatized clients I have often used touch with the outcome that clients became more relaxed and in some cases could speak about difficult experiences why they were touched. At the same time they were able to put their body awareness into words. [Respondent reported formal training in the use of body awareness or touch.]

Table 4 shows a larger percent of clinicians who had received training in use of touch or body awareness answered positively when asked about their use of touch and body awareness. Chi-square analyses were run to determine if these differences were significant. There was a significant difference in "Body Awareness," "Use of Client Body," and "Actual Touch" (see Table 8). A chi-square analysis could not be run to determine if there was a difference in "Use of Own Body" since more than 20% of cells had expected value of less than 5, which violates an assumption necessary for the use of chi square. The second major hypothesis, that training in the use of touch and body awareness engenders more use of both among mental health professionals, was partially supported by the results of this analysis.

TABLE 6

When Touch Offered by Training and Gender

	Female		Male	With Training	Without Training
	N=91	N=12	N=61	Total Checked (%)	N=42
End or beginning of session	44.0%	50.0%		27 (44.3%)	19 (45.2%)
End of treatment, at termination	56.0	41.7		26 (42.6%)	30 (71.4%)
When client sad/anxious	30.8	8.3		17 (27.9%)	12 (28.6%)
For client self-disclosure	24.2	25.0		25 (41%)	0 (0%)
When client requests	50.5	41.7		33 (54.1%)	18 (42.9%)

TABLE 7

Touch Category by Training and Gender

	Female		Male	With Training	Without Training
	N=91	N=12	N=61	Total Checked (%)	N=42
Inadvertent-- not intentional	31.9%	25%		9 (14.7%)	23 (54.7%)
Conversation marker	38.5	33.3		22 (36%)	17 (40.4%)
Socially ritualized	75.8	83.3		48 (78.6%)	31 (73.8%)
As an expression of comfort	42.9	33.3		28 (75.9%)	15 (35.7%)
Touch as technique	31.9	50.0		35 (57.3%)	0 (0%)

Gender Differences

Women (N=91) and men (N=12) reported mostly comparable answers in attitude and actual use of body awareness and touch except in three broad areas. The subset of questions on attitude revealed no major differences between men and women in the sample. Women were more likely to use body awareness (61.5%). Fifty percent of the male respondents reported using touch as technique as opposed to the 31.9% of female respondents. The time at which touch was offered showed the most contrast between women and men. Women reported offering touch more during termination (F=56%, M=41.7%), and when client is sad or anxious (F=30.8%, M=8.3%) than their male counterparts.

TABLE 8

Chi-Square Results 2: Training and Use

Variable	df	N	Value	p
Body awareness		103	39.96	.000
Use of own body		---	----	-----
Use of client body		103	19.06	.000
Actual Touch		103	43.85	.000

Narrative Data

The general narrative themes that surfaced in the answers from clinicians in the study when asked in what kind of situation did touch occur are as follows: when offering specific bodywork, in situations of trauma and grieving, at termination, when client asked for a hug, with young children, at the beginning of a session, in culturally specific context. Some answered that they do not touch or that touch is not appropriate. Most answering this

question stated that they used touch in their general practice. Some who do use touch reported not doing so in a psychotherapy context and some acknowledged that touch is feasible under certain conditions according to NASW guidelines. Some of these comments are distributed throughout this chapter.

For the particular touch incident described in earlier statements, therapists were asked to describe what they attributed to either the negative or positive outcome of the incident. General themes were: unsure if the incident were positive, that clients felt connected; it was a planned touch; clients connected to a physiological sense of themselves; it was a corrective emotional experience; it enhanced and clarified the client's self-awareness; and the healing intention of the incident. Others described their experiences this way:

Negative outcomes

I believe I was too rule-bound in how I explained not wanting to hug. I wish I had been more reflective about my own personal comfort or discomfort and then disclosed a version of that. The clinical moment might have been useful had I been able to do so. [Reported no training.]

The negative outcome (her hurt and confusion) was directly attributable to my inept processing, largely, in turn, due to the rather doctrinaire nature of my psychodynamic training conflicting with my own better instincts and preventing my effective internalization of the role of physical contact in an authentic treatment moment. [Reported no training.]

The first client laughed about the gesture, and felt more comfortable admitting to certain needs. When I did hold the second client's hand for a moment, she became calmer because she felt more accepted, and we talked about it during her next appointment, as well as discussion of her waiting for me, etc. The whole thing was a crisis in the therapy. [Reported no training.]

Positive outcomes

People become aware of their body as having memory and history and are able to connect, heal, and release traumatic events and/or patterns that are no longer working with them in their highest good. [Reported no training.]

Clear patient therapist boundaries, clear exploration re: potential meaning of hug. Ability to process effects of hug in next treatment session. [Reported formal training.]

Every traumatic experience seems to involve mental, emotional, spiritual, "energetic" and physical components and memories, and to the extent that all are released, the healing is more or less thorough and permanent. [Reported formal training.]

Only a few therapists (26.6%) who reported using touch also reported using outcome measures to assess the effectiveness of their use of touch. Of those still fewer elaborated on the type of measure used. The general themes from the narrative data of this question focus on changes in client self-perception, changes in the therapeutic alliance, client feedback, and checking in with the client.

Overview of Results

The results of this study reveal a relationship between training in the use of touch and body awareness and attitudes and use among mental health professionals surveyed. It was found that those with training were more likely than those reporting no training in this area to have more affirming beliefs about the use of touch and body awareness and to use both more often in their psychotherapy practice. These results surfaced even though the majority of those without training used body awareness at least some of the time and held mostly similar attitudes about the use of touch and body awareness. Distinct divisions emerged concerning actual use of touch and clarity about touch's validity in the treatment room.

Overall, more respondents used body awareness than touch. Most (51.4%) answered that they rarely or never used touch in their psychotherapy practice. The most used type of touch was socially ritualized touch, as in handshakes or pats on the back. The majority of respondents offered touch at the end of treatment, during termination. These results are congruent with previous studies on the use of touch in psychotherapy.

DISCUSSION

A review of the literature revealed that the use of touch in psychotherapy is still very much addressed in terms of stark contrasts of positives and negatives and often met with ambivalence. Yet the literature also reflects a change over time in attitude among mental health professionals about the body and body awareness -- a change that may have led some mental

health professionals to seek out training in or dialogue about the use of touch and body awareness in psychotherapy. Although literature is beginning to appear that stresses training as an important element when incorporating touch or body awareness in psychotherapy, there is a lack of empirical data concerning those mental health professionals who do have training in the use of touch or body awareness.

The question guiding the current research investigated the effects of training in the use of touch and body awareness on clinicians' attitudes toward, and use of, both touch and body awareness in psychotherapy treatment. This question incorporated two hypotheses: 1) that training in the use of touch and body awareness engenders more use of both among mental health professionals; and 2) that training is also a significant predictor of a clinician's attitudes and beliefs about the use of touch and body awareness. This mixed-method study sought to understand any relationship between training in the use of touch and body awareness and the attitudes and behavior among those mental health professionals surveyed.

Current Findings and Previous Literature

The findings show that training in the use of touch and body awareness does affect how mental health professionals think about and use body awareness and touch in psychotherapy. The results of this research show a relationship between training in the use of touch and body awareness and positive attitudes about touch and body awareness as well as increased use of both in psychotherapy. Chi-square analyses found significant difference in three of the four questions in both subsets targeting actual use of touch and body awareness ($p > .000$ for each question) and attitudes and beliefs ($p > .000$, $p > .002$, $p > .006$) about both, thereby partially supporting both of this study's hypotheses.

Those mental health professionals surveyed who reported some level of training in the use of touch and body awareness were more likely to have used both body awareness and touch in psychotherapy, have more comfort and clarity about the validity of touch in psychotherapy, and less worry that the use of touch and body awareness is inappropriate. Training seems to produce a more thoughtful consideration of use of touch and body awareness and an allowance for touch as part of a treatment continuum as echoed by a number of writers on this topic (Greene, 2001; Leijssen, 2006; Milakovich, 1998; Petrucelli, 2007; Shaw, 1996; Smith, 1998a; Totton, 2003).

It is not surprising, then, that a larger percentage of clinicians who had received training in use of touch or body awareness answered positively when asked about their attitudes and beliefs and were also more likely to use touch and body awareness in their psychotherapy practice. Several authors and researchers (Durana, 1998; Kertay & Reviere, 1993; Smith, 1998a; Stenzel & Rupert, 2004) link training in some type of body-oriented modality, access to other mental health professionals with whom to process touch related incidents, or involvement in a theoretical framework that allows for touch or body awareness as valid treatment modalities leading to more informed and less ethically questionable usages of touch.

Interestingly, with over half (59.2%) of the sample reporting some level of training in the use of touch and body awareness, a little less than half (48.6%) of the sample reported using touch in their psychotherapy practice. Of the remaining 51.4% who reported never or rarely using touch, 14.6% of that number reported receiving some form of training in touch and body awareness. The original hypothesis that training would tend to make therapists more likely to use actual touch was only partially supported. It may be that anxiety about risks still constrains many from use of the modality that they have sought training in. Some of the narrative comments seem to suggest that being able to dialogue about touch and body awareness may increase the self-reflection that could lead to ambivalence and wariness due to more focused consideration of the issues related to the body in psychotherapy. The ambivalence among therapists who reported training in a formal body work modality was also salient in the narrative data, and is consistent with clinicians who are very keen on the use of body awareness treatment, but who do not advocate touch (Ogden & Minton, 2000; Ogden, Minton, & Pain, 2006; Rothschild, 2000).

Those who reported no training in use of touch or body awareness were slightly less likely to use body awareness, much less likely to use touch, and when they did use touch seemed unclear about why they used it, were unsure if it had been a positive experience for the patient, and did not know whether touch could be a valid intervention. These clinicians do use touch but with higher levels of ambivalence and added confusion about why and whether it is appropriate. The results of this study partially support the thinking that body awareness is a murky reality for most therapists not trained in a body-oriented modality and who have not had the opportunity to discuss these issues in a professional setting (Orbach, 2003b; Totton, 2003) and that therapists are not as comfortable with their own bodies as they are with the client's body as informational tools in treatment (Leijssen, 2006; Ventling, 2002). Strozier, Krizek, and Sale (2003) report similar findings on touch use among clinical social workers in terms of their sample's inability to clarify why they chose to use touch as well as their overall lack of exposure, through formal training or supervision, to the use of touch or body awareness concerns.

While training is a powerful influence on the use of and attitude about touch and body awareness in psychotherapy, it is not a predictor of whether or not touch will be used. In her study of the differences between therapists who touch and those who do not, Milakovich pointed to other aspects that influence therapists' use of touch, in addition to training in a body-oriented modality. Most notably, she highlighted the significance of therapists' personal and professional experience with touch (Milakovich, 1998). Though the current research did not ask about personal and professional experiences of touch and body awareness directly as did other research (Clance & Petras, 1998; Milakovich, 1998; Strozier, Krizek, & Sale, 2003), this researcher is aware that factors other than training affect how mental health professionals will work with touch and body awareness. In fact, it is reasonable to assume that there was possibly a predisposition among those who chose to participate in

this study towards more positive interest in body awareness, the body, and the use of touch by the very fact that they volunteered to take part.

Self-awareness and professional dialogue are both thought to be crucial components in the ethical use of touch and body awareness (Durana, 1998; Kertay & Reviere, 1993; Smith, 1998a; Wilson, 1992). The current research found that 86% of those with training in a formal body-oriented modality answered that they had received ethics information as part of their training and were less likely to fear legal repercussions due to use of touch in their practice. It is encouraging that those with formal bodywork training do feel ethically prepared to make use of that training in practice, even if some of them, as seen in the narrative statements, choose not to use touch for reasons related to ethics and the currently received wisdom about the proper scope of practice boundaries.

The type of touch most often offered is indicative of the influence of training in the use of touch and body awareness. Even with the noted ambivalence of those with training toward touch in practice, they did not report using inadvertent touch as a method, where clinicians without training choose it as the second most used form of touch.

Use of an online survey significantly increased the number of respondents for the sample, much more so than a mailing to the same organizations would have produced. The ease of making contact with organization representatives by telephone, sending them a request letter with a live email link that they could then forward to their list-serves made this process tremendously successful. If time had permitted, the sample could have been far greater. Being able to assure anonymity through SurveyMonkey.com's encrypted software was a very helpful asset, especially when working with a classically controversial topic. Lastly, an online survey was a cost-effective tool to gather data over such a short period from so many different places.

The strength of the sample was in its number, diversity of training, and variety of locations. Though the response rate versus rejection rate is impossible to calculate because once the request letter left this researcher there was no way of knowing how many people may have simply deleted the email, 164 people started the survey and from that group, 103 were used in the research analysis. As discussed earlier, some respondents left out crucial information or failed to answer questions, so that 61 of the 164 responses could not be used. The inability to cue or prompt participants about missing data is one disadvantage to a quantitative survey that might not have been problematic in a qualitative, face-to-face interview.

Apparently, based on the number of respondents in the short time that the survey was available online, there is enough interest in the topic to warrant further research. This study may have only tapped a very small vein possible of informants who may be accessible using online survey instruments. With this in mind, the sample seems to adequately represent the sought after groups: mental health professionals and mental health professionals who have training in the use of touch or body awareness. Due in part to the recruitment process, these numbers included an even range of diverse levels of training in use of touch and body awareness. That twenty-six out of fifty states -- including Washington, Georgia, California, Massachusetts, and Texas -- were represented is another strength of the sample. Though heavily weighted on the east coast, the geographic diversity of the sample offers some sense that results could apply nationally.

Although minimized in this study, researcher bias was an interesting component of note. On the one hand, it was clear because of full disclosure and researcher accountability that this researcher has a strong interest in the incorporation of body awareness, including touch, into the psychotherapy treatment room. It is also of note because some of the write-in comments suggested that an actual positive researcher bias was perceived in a contrary way, for example, one respondent wrote: "[I] wondered how questions seemed biased towards touch being considered a negative while I've always seen it as a useful therapeutic tool." Perhaps this response is also a positive -- in that the instrument was mistaken for leaning in the opposite direction from the one in which the researcher positions herself.

Limitations of Study

Even though there are many strengths of the study, it is also limited. Most notable is the sample's imbalance in ethnicity and gender. Caucasian women were by far the majority of the sample. This is due in part to the researcher's focus on the recruitment of therapists trained in the use of touch and body awareness for the sample. It was assumed that recruitment of general therapists would produce some level of ethnic diversity; unfortunately, this was a faulty assumption. Only 19 out of the 103 participants did not report being Caucasian. Similarly, only twelve out of the 103 respondents were male.

Additionally, the use of the internet survey offered some drawbacks, the major one being the limitation addressed above with regard to unanswered questions. An internet survey question can only be asked once, and if it is not clear or acceptably phrased, there is a risk that the respondent will not answer it or will provide an answer the question did not intend. Unlike the situation in qualitative research, the researcher does not have the freedom of explaining the question or of clarifying an answer, or simply reminding a respondent that an answer is still needed. Another drawback is that some recipients possibly dismissed the survey without attending to it because it was an electronic transmission without a researcher to give it a human appeal.

Another limitation of the survey is possible researcher bias. Prior interest in the subject matter and training and licensure as a massage therapist may have influenced the way in which the research reported here was conducted. A core assumption, based on personal and professional knowledge, was that there existed psychotherapists who have received

training in use of touch and body awareness to make up a portion of the sample. To that end, sampling methods sought to contact those clinicians as well as general practitioners.

Implications for Future Research

The results of this research support Strozier, Krizek, and Sale's (2003) observation that: "given the potential of touch in psychodynamic treatment, it would seem wise to address the intervention of touch in open dialogue within the educational, supervisory and/or training setting" (p. 58). Training in the use of touch and body awareness, whether in classroom discussions, in supervision during placement, in seminars, or through formal training in a body-oriented modality, is the best line of defense against ethical violations concerning touch. It allows students as well as practicing clinicians to, at the very least, become clear on why they do or do not incorporate touch or body awareness into their practice protocol.

The findings of this study suggest two perspectives of interest: that of clients of clinicians experienced and trained in the use of touch and body awareness and that of the mental health professional student in training. It could prove interesting to investigate the experience and outcome of clients diagnosed with Post-Traumatic Stress Disorder or Generalized Anxiety Disorder through the course of a yearlong treatment with clinicians trained in the use of body awareness and touch. The clients would be split into two groups: one receiving talk therapy only and the other body-oriented psychotherapy. Pre- and post-treatment measurements would be made of changes in brain structure and function, cardiovascular indicators such as cortisol levels and blood pressure measurements by way of neuro-imaging or stress level tests. The measurements could compare symptom and health indicator changes as a function of each type condition's treatment.

Another fruitful study revolves around the needs of mental health professionals in training regarding touch and body awareness. This study could involve an assessment of attitudes and behaviors of students prior to any training in the use of touch and body awareness and after a year-long period wherein students were afforded the opportunity to experience personal treatment in a body-oriented modality, whether primarily hands-on or a body-oriented psychotherapy, and professional training in the form of lectures and seminars taught from a variety of perspectives in the area of mind-body-spirit. The sample would be split into three groups: one receiving regular training and only personal treatment; another receiving regular training and only professional training in touch and body awareness; and the last receiving regular training along with personal treatment and professional training in touch and body awareness. This research could compare the affects of training in the use of body awareness and touch on self-awareness, clinical sophistication, ethics, as well as offer an idea of whether including some level of training in this area would prove beneficial to new generations of mental health professionals.

The use of touch and body awareness in psychotherapy is not an easily dismissed topic. In fact, as the public continues to influence the profession with ideas from other cultures and disciplines, as it demands more from us as a profession each day, it is only self-awareness on the part of clinicians and knowledge of the needs of clients that will afford us the tools for professional discretion, ethical conduct, and healing of the whole person in this highly technological age of disembodied reality.

APPENDIX
SURVEY TOOL

Use of touch in psychotherapy

Consent Form

Dear Participant,

My name is Anastasia McRae and I am a master's level student at the Smith College School for Social Work. I am conducting a research study to gather data for my master's thesis and for possible presentations and publications. I am investigating clinical attitudes and activities involving body awareness and touch in psychotherapy treatment.

I am interested in the use of touch and the use of body awareness as therapeutic techniques by mental health professionals. In order to participate in this study, you must be a licensed mental health professional—either a psychotherapist, psychoanalyst, professional counselor, or clinical social worker and have at least five years clinical experience. If you currently use a touch modality (ex. Hakomi, Rosen, Alexander Technique, Polarity, Healing Touch, the Rubenfeld Synergy Method, or a body psychotherapy method not mentioned here) in your practice, you must also be licensed and/or certified in that modality. The survey takes approximately 15-20 minutes to complete and includes demographic questions such as your age, race or ethnicity, gender and education level. The survey requires that participants read and write in English. The bulk of the survey asks questions about your clinical experiences using touch and body awareness as an element of your practice.

While there is no foreseeable emotional risk to you from participating in this study, it is possible that you will find certain questions in the survey thought provoking. It is assumed that as a seasoned mental health professional you probably have access to resources should you find the need to process your participation in this study.

You may benefit from being part of a study that offers the possibility to influence other clinicians' ideas about the nature of integrating body awareness into psychotherapy; suggesting ways of embracing a new way of working in the mental health field; and contributing to an area of clinical research that has been neglected. Compensation will not be provided for participation in this study. As this survey is being conducted completely online with encrypted software designed to protect the identity of the participants, your participation is completely anonymous and no specific answer can be traced back to any particular respondent. The link to the survey does not retain email addresses or ask that you give your name. The software program collects and initially compiles the data for further research and the researcher is given this compiled data in aggregate form. Only my research advisor, the Smith College School of Social Work statistical analyst and this researcher will have access to these materials. All research data will be kept secure in a locked location for three years, as mandated by federal law. After three years, I will continue to keep the materials secure and destroy them when they are no longer needed.

Your participation in this study is voluntary and you may decline to be involved in this study without repercussion. You may withdraw from the survey at any time simply by exiting the survey or closing the browser. I can be reached by email at amcrae@email.smith.edu. I welcome your questions and comments. If you have any concerns about your rights or any aspect of this study, please contact me at the above email or contact the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974. I hope you will decide to participate in this study.

You must read and electronically sign this informed consent form by clicking on the "yes" option below before being able to proceed with the survey. If you choose to consent, please print off this page and keep it in your records. If you click on the "no" option below, you will immediately be exited from the survey. During the survey, you may decline to answer any questions you do not feel comfortable answering. You have the right to exit this study at anytime prior to pressing the "DONE" option at the end of the survey. Once you have submitted your completed questionnaire, you will not be able to withdraw from this study since there is no identifying information on the surveys that would connect a particular survey to your responses and permit the information to be selectively deleted.

YOUR CLICKING THE "YES" BUTTON INDICATES THAT YOU HAVE READ AND UNDERSTOOD THE ABOVE INFORMATION; THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

Please print a copy of this page for your records by going to FILE at the top of this browser page then selecting the PRINT option so you can contact me later or use the referral numbers.

1. I consent to participation in this survey

- Yes
 No

Use of touch in psychotherapy

2. Tending to the physical in psychotherapy is as important as tending to the emotional and mental processes.

- Yes
 No

3. A belief that memories are stored in the body and affect the health and well being of clients informs some part of my work.

- Strongly agree
 Agree
 Neutral/Not sure
 Disagree
 Strongly disagree

4. I incorporate body awareness into my clinical practice.

- Always
 Almost Always
 Sometimes
 Rarely
 Never

5. In my clinical practice, I am aware of and utilize my own body sensations to inform my approach with clients.

- Always
 Almost Always
 Sometimes
 Rarely
 Never

6. My bodily reactions and those of the client are important indicators for me in the course of clinical treatment.

- Strongly agree
 Agree
 Neutral/Not sure
 Disagree
 Strongly disagree

Use of touch in psychotherapy

7. In my clinical work I notice and talk with clients about their physical realities--for example, the way they may hold their bodies; an irregular gait not due to illness or accident; particular gestures when any one subject is mentioned.

- Always
- Almost always
- Sometimes
- Rarely
- Never

8. I have received training in body awareness and its use in the treatment room either through coursework for my degree as a mental health professional, in supervision, or formal training in a bodywork modality.

- Yes
- No

9. What kind of training did you receive? (choose all that apply)

- Classroom discussions
- Seminar or course
- Supervision
- Formal training in a bodywork modality

10. If formal training in a bodywork modality, please name it in the space below.

11. How long was the training?

- 1 day or part of a day
- 2 or more days
- 1 week
- 2 or more weeks
- 1 academic term (quarter, semester)
- more than 1 academic term

12. Did the training involve personal treatment as part of your completion?

- Yes
- No

13. Did the training include information on professional ethics?

- Yes
- No

Use of touch in psychotherapy

14. Did the training include methods to help you integrate the modality into your psychotherapy practice?

- Yes
 No

15. I have had the experience of using touch as an element in my clinical practice.

- Always
 Almost always
 Sometimes
 Rarely
 Never

16. I am unclear about the validity and use of touch in therapy.

- Strongly agree
 Agree
 Neutral/Not sure
 Disagree
 Strongly disagree

17. I have or currently use the following types of touch with clients (choose all that apply):

- Inadvertent or not intentional, as in brushing against someone by mistake
 Conversational marker, as in a touch on hand or shoulder for emphasis
 Socially ritualized, as in handshakes or greeting hug
 As an expression of comfort or care, as in holding a client's hand, embracing with a hug, or rocking
 Touch as technique, as in a formal bodywork centered technique, i.e. Reichian

18. I use touch mostly with clients who are (choose all that apply)

- Under 5 years old
 5-10 years old
 10-15 years old
 15-30 years old
 30-50 years old
 50-70 years old
 70+ years old

19. I am more likely to touch a client, with their permission (choose all that apply):

- At the end or beginning of a session
 At the end of treatment, during termination
 When a client is sad or anxious
 When I think it will help clients with self-disclosure
 When the client requests (if it is clinically appropriate)

Use of touch in psychotherapy

20. I have used touch with clients and was able to process it with colleagues or supervisors.

- Yes
 No
 Sometimes

21. When I have used touch I have a sense that I am doing something wrong or will face ethical or legal repercussions.

- Always
 Almost Always
 Sometimes
 Rarely
 Never

22. Though I am clear about my theoretical framework's stance that touch in the context of therapy is inadvisable, I have used touch in my clinical practice.

- Yes
 No

23. In what kind of situation did this touch occur? Please describe in space below.

24. Based on your clinical experiences, can you describe a particularly notable therapeutic intervention, either positive or negative, that occurred as a result of touch as therapy between you and a client?

25. To what would you attribute either the negative or positive outcome of the above interaction?

26. Do you use particular measures to assess the effectiveness of your use of touch?

- Yes
 No

27. If so, please name them below.

28. How was it for you to take part in this survey? Did any particular emotions, thoughts, or concerns occur to you?

Demographic Information

29. Your Age

30. Your Sex

31. How you self-identify your race or ethnicity

32. Mental Health Licensure

33. Years in Clinical Practice

34. Theoretical framework or orientation

35. State of licensure

36. In which of the following settings do you practice

- Private Practice
- Community Mental Health Agency
- Hospice
- In-Patient Treatment, Adult
- In-Patient Treatment, Child and Adolescent
- Hospital Outpatient, Adult
- Hospital Outpatient, Child
- Other

End of Survey

Thank you for your interest and participation in this research study.

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Biography

Anastasia McRae, M.Div, MSW, is a recent graduate of Smith College School for Social Work, August 2008 (at which she won the Alumnae Persons of Color Grant for her thesis), and of Chicago Theological Seminary, 2006. Her clinical interests include psychodynamic and narrative therapy, relational psychoanalysis, Jungian analysis, and body-centered psychotherapy. Prior to going into private practice, she hopes to have the opportunity to complete a post-graduate fellowship with a focus on family and couple therapy; to work with various adolescent and young adult populations; and to begin training in a specific body-centered modality. Ms. McRae has also trained as a clinical massage therapist and personal trainer.

This research was completed as a Master's thesis in partial fulfillment of Ms. McRae's Master of Social Work (MSW) at Smith College School for Social Work. amcrae1@gmail.com

What's Under the Hood? Using What We Know From Brain Research to Design Creative, Clinical Mind-Body Interventions.

M. Laurie Leitch, Ph.D.

Abstract

This article presents one clinician's method of using the results of brain-body research to design multisensory interventions in psychotherapy. Using multisensory techniques in therapy enlivens the work as well as de-pathologizes the patient. Each of us has preferences for some senses over others. In large part, each individual's learning style depends on the way his or her learning organs are neurally linked. When learning new information or in stressful situations, we have greater access to those senses that are directly linked to our dominant brain hemisphere. In order to determine which senses are most useful in these types of situations, we create "Dominance Profiles," (Hannaford, 1997) which provide clues regarding how each individual internally processes sensory information. This article describes ways to utilize this information in order to de-pathologize certain behavioral dynamics and design interventions to enhance competency. The article also presents ways to enhance neural connectivity by accessing information from the different lobes of the brain.

Keywords

Multisensory – Dominance profiles – Neural Connectivity

Why might you ask a client to hold his breath to the count of seven? How could you make use of your observation that a client is twirling her hair on the right side of her head? How could it be helpful to know whether a client focuses on the details rather than the big picture in her journal-writing? In a couples session, when would you choose to have one partner write to rather than speak to the other about important issues? Each of these clinical decisions and observations draws upon the clinician's knowledge of the brain...that extraordinary and complex marvel that remains largely a mystery to many of us.

Few clinical training programs provide the knowledge about brain structure and function that can help us to design clinical interventions. Yet, learning more about "what's under the hood" can be useful in assessing various presenting problems as well as in designing and implementing creative interventions. Learning how to assess each client's unique way of processing information provides a way to de-pathologize the client's maladaptive behaviors as well as to offer effective strategies to help enhance the client's functioning. In working with couples or families, understanding each individual's processing style can be extremely beneficial in order to promote clearer communication in their interaction with each other.

I began incorporating information on the brain into my own clinical work when my curiosity about brain function was sparked by training in neurotherapy, a biofeedback technique in which electromagnetic energy is used to interrupt brain wave patterning in order to help the brain rebalance itself. While training, I became aware of how little I had been taught in my doctoral program and subsequent education about the lobes of the brain, other brain structures, and their role in shaping information processing. The more I learned, the more I realized that I had neglected to work with my clients in ways that 1) assess the client's unique information processing style, 2) enhance connectivity in the brain to promote healing and improve functioning, 3) guide me in the design and implementation of multi-sensory interventions, and 4) provide approaches that de-pathologize entrenched patterns of interaction and promote competency. As a somatic practitioner, I began to use these methods, and then I continued to work with my clients on their sensory awareness to show them the results of using these multisensory techniques.

I recently began seeing a lesbian couple, whom I will call Jill and Pamela. They came to me after two aborted attempts at therapy while they were living in another state. They were a pair who had partnered for difference: Jill was full of emotion, very expressive and dramatic, while Pamela was self-contained and logical. They came to therapy with a wide range of issues and disappointments that had characterized their nine year relationship.

When I work with couples, I always listen for the disabling beliefs they carry about each other; it didn't take long before I heard Jill's. She believed that Pamela "doesn't listen to a thing I say. I've told her so many times what she does that hurts my feelings and she doesn't listen and doesn't care." Before I began using brain function information in my practice, I would have looked for interactions in the session that indicated that Pamela did listen, encouraged Jill to share her feelings with Pamela in ways that were easier for Pamela to hear, assisted each of them in tracking their bodily sensations, etc. While I still rely heavily on in-session process and somatic awareness in designing interventions with clients, I now have more in my repertoire, and I suggested we create dominance profiles (Hannaford, 1997) for both Jill and Pamela.

Each of us has a particular dominance profile that shapes the way we process information and learn. Most of us are familiar with the right brain/left brain dominance pattern in which people who are left brain hemisphere dominant prefer logic, sequence, and reasoning from parts to whole; this was Pamela's brain dominance. And people who are right brain dominant are oriented to the gestalt or bigger picture, rely more on image and emotion, and process from whole to parts; this was Jill's pattern. While the above dominance pattern is commonly known, there are other, less-known dominance patterns that also shape the ways we learn and communicate (especially under stress). The different dominance patterns of Jill and Pamela were causing the two women to clash with each other.

In addition to having a dominant brain hemisphere, each, person also has a dominant eye, ear, hand, and foot. Combined, these form each person's dominance profile and reflect our individual neuronal programs. In psychotherapy sessions, these profiles can provide doorways to new and creative ways of working that help clients expand their views of themselves and their potential. Since there are simple ways to determine each person's dominance profile, it is an easy and effective tool.

I asked Pamela and Jill to fill in their dominance profiles (using a cartoon-like figure developed by kinesiologist Carla Hannaford). Pamela's dominance profile showed her to be left-brain dominant and left ear dominant. Because sensory organs are cross-lateral, meaning those on the right connect to the left brain hemisphere and those on the left connect to the right brain hemisphere, any sense organ (except the nose, which is not cross-lateral) that is on the same side as the dominant brain hemisphere will function less effectively under stress or in new learning situations. Most of us are familiar with the concept of cross-laterality through seeing people who have had strokes; if the left hemisphere was damaged by the stroke, the impairment shows up on the person's right side and vice versa. Because Pamela's dominant ear is connected to her right brain (which is not her dominant hemisphere), hearing is not her most effective mode of processing when she is in stressful situations or learning new things.

Once Pamela and Jill saw and interpreted their profiles, Jill (whose dominant ear is on the opposite side of her dominant brain and, therefore, can hear every detail, even under stress) recognized that it wasn't that Pamela wasn't listening or didn't care. She saw that Pamela lost optimal use of her hearing under stress. While she could still hear, she did not have full access to her hearing and fell into the category Hannaford calls, "auditorially limited." Using this knowledge, Jill began to write her concerns to Pamela during our sessions. In between sessions, they used e-mail to debrief fights. We tracked the changes in body sensations that each noticed with this new way of communicating under stress. Gradually, Pamela began to feel less stressed during arguments, which enabled her to increasingly rely on *hearing* Jill rather than *reading* what she had to say. Pamela's progression can be described as a pendulation from the use of one sense to another. Because touch and movement anchor her learning, Pamela found it effective to respond to Jill in writing. Since she is right handed, the touch and movement that are involved in the process of writing connect to her dominant (left) hemisphere. She is also right eye dominant, which makes reading easy for her, even under stress.

Optimally, all our dominant sense organs would be on the opposite side of our dominant brain hemisphere. However, this is not the case for many of us. While there certainly are many alternatives to using dominance profiles to help couples reconcile their differences and enhance communication, in Jill and Pamela's case, this method helped to immediately de-pathologize Jill's beliefs about Pamela and greatly enhance Pamela's ability to remember details that she had been trying so hard to retain. Once these changes were introduced, we used sensory awareness to help reinforce these new patterns. Not only did these changes help Pamela in her relationship with Jill, but they also helped her to communicate with me during our sessions and yielded excellent results when used during her high-stress job. While this was certainly not the only step needed to get on stable footing with each other, it gave early therapy sessions a big boost forward, de-pathologized the beliefs each woman had about the other, established somatic resources in the body, and generated a lot of laughter which, in itself, is a boost in the early stages of this type of work.

Although I have focused on Pamela's dominance profile in this example, I also used Jill's profile in ways that could enhance her integrative functioning over time. For example, I encouraged her to experiment with different types of journal writing. Since she is right brain dominant and right hand dominant, she accesses her left hemisphere when she writes. The act of journal writing alone is useful for her in promoting integrative functioning because it links her right and left hemispheres; I took it a step further, however, when I suggested she use skills that come from the left brain, such as focusing on details and describing sequences of experiences and her thoughts about them. Since she is right brain dominant, Jill's orientation would most naturally have been to the gestalt of an experience. By asking her to list details, sequences, and analysis, I helped her develop more "left brain fluency." While she initially found this exercise difficult, Pamela's interest in Jill's writing helped encourage her. Meanwhile, Pamela was already a journal writer of sorts; she often wrote lists of her goals and self-assessments. Had I asked her to experiment in her journal, I would have had her focus on her feelings and perhaps write with her non-dominant hand, which would help her gain more access to her right brain.

Another technique that incorporates brain function into psychotherapy involves using multisensory interventions to access memory. Since memory can be accessed from more than one location in the brain, we must ask: How can we maximize connectivity so that we have greatest access to each storage site? As we know that the specific location of different lobes of the brain are associated with individual qualities of the self, how can we draw fully upon what each has to offer? For example, procedural (e.g., handwriting) memories are stored in different places than episodic (e.g., remembering a person's name) memories. Short-term memory is stored in the hippocampus, while long-term memory is stored in multiple places. Areas that receive sensory stimulation from touch are different than those that receive sensory stimulation from sound and sight. Using multisensory interventions to heighten connectivity in the brain enables us to explicitly draw upon the many alternate pathways for processing information.

Have you ever squinted your eyes in order to "see better?" Squinting is effective because it screens out detail and activates the right brain (which reasons from whole to parts). With its gestalt orientation, the right brain is best suited to interpret incomplete information. When the squinting reduces the details, the right brain fills in the big picture. In therapy, when I ask a client to draw a part of herself that she struggles with, I suggest she use "soft eyes," meaning she gently squint

so the details become fuzzy. In doing so, she increases access to the right hemisphere, where emotions are primary. Since the right brain has no linear meaning of time (i.e. it is timeless), when right brain activity is heightened, the client also has greater access to her emotional content and to images of her early life.

Increasing access to this type of information forms a good foundation for somatic awareness work and the release or discharge of blocked traumatic energy.

Another way I might use my understanding of brain structure and function is to have my client trace her drawing, first with her right index finger and then with her left. Because tracing employs touch, it activates the parietal lobe of the brain, which is concerned with interpersonal relationships (among other things). The right parietal lobe focuses on others and their meaning to the self, while the left parietal lobe focuses on reportable self-awareness. Tracing with each index finger activates first the left parietal lobe (via the right index finger) and then the right one (via the left index finger).

Sometimes the emotional material linked with the client's right parietal lobe is so intense that he bursts into tears when he traces a drawing with his left finger. For this reason, I use sensory awareness to titrate the touch that connects to the right hemisphere in order to work with small gradations of activation. In other instances, a client might literally be unable to "make" her left finger trace the drawing. These responses help me assess how I can best use the mind-body patterns of the client to work efficiently, promoting sensory awareness and integrative functioning. For example, I might ask a client to choose three words that describe the part of herself that is represented in the drawing. This intervention activates her left frontal lobe, which is used in sequencing and word choice. Activating more areas of the brain yields a more holistic and integrative experience for the client.

Those of us who employ EMDR often use the floatback technique to help clients access early memories and/or images. The floatback technique provides access to the right parietal lobe, giving the client a sense of timelessness. The headphones often used in EMDR treatment send bilateral tones into the ears, activating the temporal lobe, the part of the brain that stores body memory. Sometimes I use the hand sensors in an EMDR session, which activate the parietal lobe through touch.

Multisensory interventions sometimes focus on very small observations in a session that can be elaborated into competency-based learning for the client. For example, Sam is a survivor of childhood sexual abuse and exhibits frequent dissociative symptoms. Together, we have found ways that he can use his knowledge of the brain to help him mediate these symptoms before he gets so "foggy" he can barely hear me.

When we first began working, I often saw him twirling his hair. One day, as he described a painful exchange that made him feel particularly vulnerable with me, I noticed that he was twirling the hair on the left side of his head. Since the left side connects to the right brain and he was already on right-brain overload, this didn't make sense to me. Rather than initially ask him to describe his "felt sense" of the hair twirling, I told him that if he twirled on the right side, he would be accessing his left brain, which, with its focus on control and structure, would be more calming for him. He laughed and said that he usually did twirl on the right side, but he had done it so much he had gotten a big bald spot there, so he switched sides. From that point on, he held a squishy ball in his right hand. When he felt the beginnings of dissociation, he squeezed the ball and counted each squeeze (counting activates the left hemisphere). Not only did this method enable him to stay present with me during sessions, but it also helped minimize hair loss!

When I saw that Sam was overloaded emotionally, I also had him close his eyes and hold his breath, activities that trigger a part of the brain stem called the Reticular Activating System (RAS), which acts as the brain's alarm; it puts all systems on alert, which heightens attention. While I used to think a client's closing her eyes during a session was an act of "resistance" or distancing, I now comment on how she intuitively knows what to do when she is emotionally overloaded. I then explore other ways her intuition guides her in self-management. When we return to her overwhelming feelings, she brings an enhanced sense of her coping strategies.

At various points in our therapy, I talk with clients about these brain structures and their functions, and together, we map out their dominance profiles. My waiting room has books and articles about the brain, and my clients often bring me brain-related cartoons. Clients are often as intrigued as I am about "what's under the hood." Although there is still so much of the brain's capacity that we still have to learn, our knowledge is growing by leaps and bounds. It is exciting to find ways to use this rapidly expanding knowledge base in the therapy room.

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Biography

Laurie Leitch, Ph.D. is a clinical trainer, researcher and psychotherapist. She has spent over 25 years working with individuals, couples, and groups using competency-based, mind-body psychotherapy. She is the Co-Founder and Director of the Trauma Resource Institute (TRI), a non-profit trauma training center that provides training in Trauma Resiliency Model (TRM). TRM is a trauma treatment appropriate in emergency settings, with complex trauma, and with adults and children suffering from long-term and acute trauma. She is also the Director of Research for the Foundation of Human Enrichment, provider of Somatic Experiencing training. Dr. Leitch has extensive experience providing clinical training and consultation in diverse settings. She has particular interest in "at risk" populations, including survivors of catastrophic events, and she provided treatment following 9/11, treatment and clinical training in southern Thailand after the tsunami, and treatment in Louisiana following Hurricanes Katrina and Rita. Dr. Leitch's research has included social program and

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