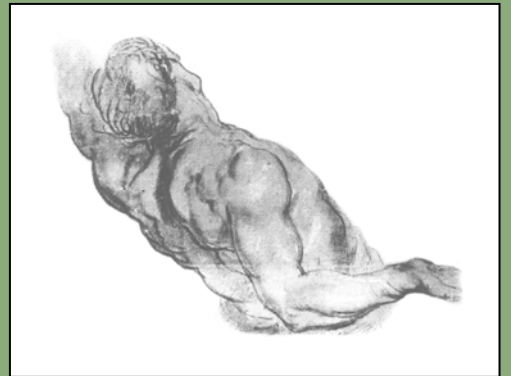


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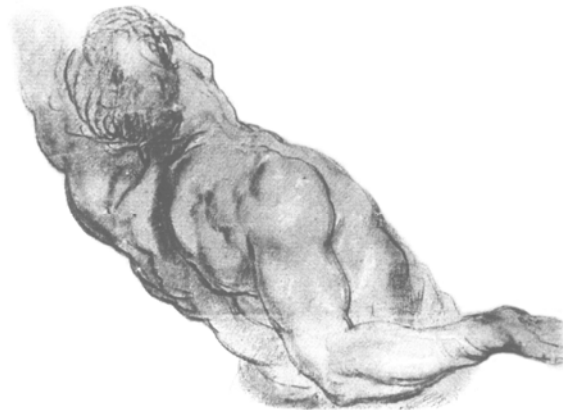


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USABP Mission Statement

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.

Letter to the Editor

(The following letter came from Michael Heller, whom Dr. Carleton had approached to co-edit a joint USABP/EABP Journal, published by both organizations with one American and one European editor. He is referring to the responses by various members of the Boards of Directors of both organizations/)

Dear Jacquie,

All the mails you are receiving stress the same issue. USABP and EABP are not willing to pay what it needs to publish. Not only the publishing, but also the editors of a journal. They are so happy you work for free they all pat you on the back. The field will not exist as long as there are not several respectable journals (Energy and Character is full of spelling mistakes) and books that criticize each other. This requires an investment. The schools should be involved in this effort, as they have some money. I also notice that the books that some of us write for nearly no money are not even bought by ABP members. They are often considered too expensive. Yet the law of the market is simple. If a volume does not sell beyond 3'000 volumes, it will be expensive. In the EABP, I published an EABP congress volume (the Flesh of the Soul) with my own money, and the book was not even on the table of the following three EABP. Again, it was considered too expensive. Bernard Maul has had a similar adventure in the past. Trainers who published in the book just distribute photocopies of their articles, without recommending the volume to their students. As if students in Body Psychotherapy should buy books of neurosciences, but not of body psychotherapy. For this purpose, I refuse to work on such a project if both editors of the journal are not paid something for their work.

Those schools that do publish and are recognized institutionally (mainly Bioenergy and Biosynthesis) prefer to act outside of body psychotherapy. In Switzerland Bioenergetic Analysis training has been recognized as a *psychodynamic* psychotherapy. It is the survival of the field that is at stake.

You deserve to be paid at least something for your work,

Michael Heller

To the editor:

I believe that body psychotherapy is about to come into the mainstream. I am writing an article for the Psychotherapy Networker Journal on Attachment Theory and in the process have interviewed many of the people involved (Marion Solomon, UCLA, Sue Johnson, Allan Shore, etc. with the final interview being with Dan Siegel) in its ascendancy as the psychotherapist theory at this time. In the process I attended one of Allan Shore's "groups" in Colorado and he shared his latest findings -putting together neuroscience with psychotherapy -which he's putting into another tome to come out in the spring. Shore says that we are in the process of a paradigm shift in which all members of our field from psychoanalysts to psychotherapists will have to change their perspective -if they haven't already- to mind-body, attunement therapy and emotional "enactments" as he is calling them -going to the root of the problem developed in childhood. These are all things that body psychotherapy has been doing all along. Attachment theory evolved out of psychoanalysis as did Reich and Lowen's work and body psychotherapists took it from there.

We are not on the fringe. I believe that our conference show that we are doing (and have been doing) this grass roots therapy that puts all those elements together that neuroscience shows work in change for clients. We should be presenting at Trauma conferences such as the one next spring put on by Marion Solomon and others at UCLA. In my interview with her about attachment theory, she said, " I started with Kohut and Self-Psychology, but have moved on using attachment theory and research and am now using Sensori-motor and I'm sure you are using your own version of body-mind therapy that touches emotion." So, we are on the cutting edge of a new paradigm. We only need to show what we are doing. The neuroscience is where we are and have been.

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The USA Body Psychotherapy Journal Editorial, Volume 9, Number 2, 2010

This Autumn 2010 issue of the USABPJ has a dual focus, related to and a result of the USABP Conference October 22-24, 2010 on *Unraveling Trauma: Body, Mind and Science*. It has become customary for the USABP to award prizes at each conference for the best research paper and best student research paper submitted, both of which are published in the USABPJ. Therefore, in this issue we will focus on the treatment of trauma in body psychotherapy followed by a thoughtful discussion of what is appropriate science for body psychotherapy, along with two examples of research in this field.

Each of our first two articles utilizes an interdisciplinary approach to the treatment of trauma. In "Facing the Trauma: How the Face Reveals and Processes Unexpressed Suffering," Sharon Stanley integrates emerging neuropsychological theories of attachment, fixed action patterns, trauma, and polyvagal theory with traditional wisdom for an embodied intersubjective approach to the processing of trauma using somatic psychotherapeutic practices. Utilizing polyvagal theory as a scaffolding, she explores the treatment of fixed-action patterns of facial expression. A brief clinical vignette illustrates how somatic practices of awareness, empathy, inquiry, intervention and reflection can touch deeply into the biological substrate of intense survival emotions, gently restoring the innate flow of information and energy through the body-mind.

In "Developing Sensitive Attunement: Contributions of Traditional Practices to Therapeutic Joining," Vivian Gay Gratton focuses on individuals who, due to temperament or trauma, experience heightened sensory processing sensitivity resulting in difficulty with attunement and attachment to others. Various diagnosed with PTSD, PTSD/DESNOS, ADD, ADHD, ASD, or mood disorders, all experience difficulty in affect regulation, attunement, and attachment. Drawing on three traditional somatic spiritual practices of aikido, music, and relationship with nature, Ms. Gratton describes her own experiences of how those practices affect both her ability as a psychotherapist to attune to her patients and how she utilizes them with four different child and adult clients. A thorough exploration of the neurobiology of attachment, affect regulation, early trauma, vitality affects, and entrainment provides the groundwork for her explanation of her approach.

Drawing on his 30 years as a Bioenergetic trainer as well as his psychodynamic background, Philip M. Helfaer offers some thoughts on the application of somatic/energetic principles and "group as community" practice to "Positive Development for Persons with Trauma Spectrum Disorders." Now a citizen of Israel, Dr. Helfaer envisions development of a program to alleviate the suffering of people experiencing a variety of traumatic stress syndromes and trauma spectrum disorders. In this article, he describes principles and practices of his long experience in somatics, interweaving them with ideas on how they might be utilized in a community-based program or course which would be neither "treatment" nor training, but an enriching, interactive experience for leaders and participants.

About 10 years ago, I wrote a brief article as part of my participation in an International Society for the History of Medicine Conference in Istanbul. I attempted to grapple with the issue of what constitutes evidence for complementary and alternative medical practices, among which I included body psychotherapy. In it, I quoted at some length from an article by Mike Denny, M.D. (Ions Noetic Sciences Review, June-August, 2002). I would like to do so again:

In REINVENTING MEDICINE, Larry Dossey, M.D. speaks of three eras in the history of healing. Era I is characterized by our conventional, causal, deterministic approach of statistical, empirical science as it has been applied to healing methods since the seventeenth century. Era II involves the inclusion of mind-body phenomena such as found in psychosomatic and various alternative techniques. This era postulates that the mind has causal powers of healing within individual human beings...They try to explain mind-body healing in terms of psychoneuroimmunology, skin galvanometer readings, or endorphins and other proteins circulating in the bloodstream, then they subject psychosomatic healing to techniques of standard, double-blind, statistical, clinical studies. In other words, although acknowledgment of mind-body phenomena is an advance in the care of the sick, it does not constitute a true shift of either consciousness or paradigm. Era III medicine attempts to include the strange discontinuities of quantum physics within healing methods. Proponents of Era III medicine focus upon the nonlocal, action-at-a-distance qualities of quantum particles as providing a rationale with which to support the theory that healing can occur between individuals at a distance.... (p.20)

I was again reminded of this historical perspective when reading an assessment provided by Courtenay Young. In this third of four articles on *The Science of Body Psychotherapy*, Young discusses what might be meant by an "appropriate science" for body psychotherapy. He begins by differentiating natural science from social science and elaborating the difficulties found in adherence to either. Illuminating that evidence points to the fact that the three factors most directly affecting the effectiveness of any psychotherapy are the quality of the therapist, the quality of the relationship between therapist and client, and the motivation of the client; with this, he seems to be approaching Era III. Phenomena such as the resonance between therapist and client, non-verbal communication, etc., are clearly inaccessible to measurement by "hard science" or even to an Era II approach. We must begin to recognize the self-organizing complexity of psychological systems as elaborated by proponents of a paradigm, taking into account chaos and catastrophe theory, self-organizing complexity, closure, and emergence characteristics as human beings and nonlinear dynamic systems. Young concludes that "the body is mostly a physical manifestation of something much larger, and less definable – a multi-layered collection of different systems and energetic exchanges ...inter-connected in ways that we do not fully know yet, or which even be to some degree

‘unknowable’ ...The synthesis of these connections is also much greater than the sum, and carries many more mysteries: there is finally the greater ‘something’ – currently way beyond measurement – than even allows us to carry a human potential, a spirit, or soul.” (from this issue)

The paper which won the research prize, entitled “The Effect of ‘Clearing a Space’ on Quality of Life in Women with Breast Cancer,” uses the accepted canons of evidence to measure the effectiveness of local and non-local utilization of the first step in Focusing, as developed by Eugene Gendlin. The three authors, Joan Klagsbrun, Susan L. Lennox, and Lauren Summers, conducted in-office and telephone consultations with 17 breast cancer patients, leading each through an agreed-upon protocol in an attempt to improve the quality of life of participants. Both qualitative and quantitative data demonstrated the effectiveness of this brief intervention. Research projects such as this and the one that follow are important, as Young points out, in helping body psychotherapy’s acceptance by mainstream psychology and medicine.

Jennifer Bruha captured the student research prize for her dissertation on “The Effects of Body Experience and Mindfulness on Body-Image Disturbance and Eating Disorders.” Her web-based study of 128 adult women, aged 18-50 allowed her to discriminate between anorexics and higher-symptomatology bulimics on one hand versus lower-symptomatology bulimics and those without anorexia on the other hand. She analyzed the two groups’ scores on measures of body-image disturbance, body experience, mindfulness, positive and negative affect, overall well-being, and life satisfaction. These measures allow her to draw interesting portraits of the contrasting groups and to speculate about various possibilities in cause and effect, with questions for further study and implications for treatment. For example, she found that individuals with anorexia and higher-symptomatology bulimia scored significantly higher in body-image disturbance and significantly lower in body experience and mindfulness, with more negative thinking and lower overall life satisfaction, than those individuals without anorexia but with lower-symptom bulimia. She speculates that individuals with eating disorders do not practice mindfulness because they equate being mindful with “feeling fat.” She explores whether this may be attributed to lack of learning, cognitive impairments, or willful choice, all of which have different implications for psychotherapy with this population.

While this journal includes the choices for what the USABP conference determined as its ‘best’ papers submitted, there is really no adequate way to define what it means to be ‘best,’ especially in such a complex and nonlinear domain. Each author included here illuminates vital aspects of this intriguing field, allowing us, as discerning readers, the unqualified opportunity and delight of our own assessment.

Jacqueline A. Carleton PhD
New York City

Facing the Trauma: How the Face Reveals and Processes Unexpressed Suffering

Sharon A. Stanley, Ph.D.

Abstract

Emerging research in the neurosciences has stimulated a creative interdisciplinary approach to trauma psychotherapy, a new paradigm (Schore, 2009a). Psychotherapists, faced with copious amounts of information related to the mind, brain, and body, struggle to integrate this new knowledge into clinical practice. An integration of emerging neuropsychological theories including *attachment theory* (Main & Hesse, 2000, Schore, 2008; Tronick, 2007), *polyvagal theory* (Porges, 2009a), trauma (Schore, 2002; Levine, 1996; Ogden, 2006; van der Kolk, 1996) and neurological *fixed action patterns* (Llinas, 2001), combined with traditional wisdom creates a strong theoretical scaffolding for the growth of new clinical interventions. Face-to-face encounters co-construct the intersubjective field and support processing of deep visceral sensations, feelings, and emotions. The metaphor of the polyvagal nervous system provides a theoretical frame of orientation for an embodied intersubjective therapeutic relationship and right-hemispheric processing of trauma using somatic psychotherapeutic practices. This article offers, as a response to the emerging new theoretical paradigm, a clinical perspective into a somatic model of trauma resolution with a brief case vignette.

Keywords

Attachment - Polyvagal theory – Somatic – Intersubjective - Face

An ancient tale from Sierra Leone (Beah, 2009) described how the people of a village, each day before sunrise, would gather at a nearby abundant river to fetch water, to bathe, and to engage in a daily face-washing ritual to ensure happiness. Together they washed faces—their own, and those of the very old and young—with the intention to wash away tears, sorrow, and unhappiness. Anyone who failed to wash or have his or her face washed “would cry uncontrollably all day and the village would be sad” (p. 37). This ancient practice shares essential principles with an emerging new paradigm for healing emotional suffering (Porges, 2009a; Schore, 2008, 2009c).

This article reviews aspects of this new paradigm and the adaptive value of emotions (Schore, 2009a), intersubjective therapeutic attachment relationships (Bromberg 2009; Schore, 2008), the polyvagal theory of the autonomic nervous system with the *face-viscera-brain circuit* of neural regulation (Porges, 2009a), research into the *still face* of mothers with their infants (Tronick, 2007), and *neural fixed-action patterns* (Llinas, 2001); after that, proposing a clinical response for practitioners, with somatically focused, right-hemispheric, intersubjective practices.

This paradigm invites practitioners to create clinical strategies; “new interventions are needed to strengthen social engagement behaviors and dampen defensive strategies” (Porges, 2009a, p. 20). Right hemispheric practices of somatic empathy, inquiry, intervention, and reflection (Stanley, 2009) are described to process implicit traumatic memories (Mancia, 2006). A brief clinical vignette illustrates somatic practices within an intersubjective relationship, shifting fixed action patterns in the face and supporting social engagement in a couple.

Early concepts of somatics emerged out phenomenology (Merleau-Ponty, 2002), with respect for one’s own subjective, lived experience and knowing simultaneously the subjectively lived experience of another *in the other’s own terms* (Stanley, 1994), a process known as intersubjectivity.

Somatics studies, “the body as perceived from within by first person perspective” (Hanna, 1995, p. 341) while using the mind to observe immediate sensory-motor, emotional, and imaginal experience. Somatic awareness opens the flow of sensory information between the brain, the mind, and the body (Behnke, 1995) and somatic practices target the physiological imprints of trauma in the body and allows for the integration of intense survival emotions (McNaughton, 2004; Levine, 1996; Ogden, 2006).

Trauma, Affect and Emotions

Intense affect involves survival emotions which remain active, yet dissociated, in the body-mind (Bach, 2009). Emotional affects are sub-neocortical (Panksepp, 2010) and are primary processes of the body with a “neural platform” in the autonomic nervous system (Porges, 2009a; Porges, in press). At the time of a traumatic experience, extreme or conflicting stimulation may overwhelm attempts to process intense stimuli; the memory of the event then becomes frozen in time, distorting incoming information and emotional processing (Bach, 2009; van der Kolk, 1996).

The face displays emotions with specific facial configurations (Tronick, 2007) and subtle, barely perceptible communicative cues (Schore, 2008). As the ancient tale of Sierra Leone implies, facial expressions of emotions are vital to life-enhancing social connections (Porges, 2009a; Schore, 2009b; Tronick, 2007). Our strongest emotions occur within attachment communications with the expressions of the face, the posture and gestures of the body, and the tone of the voice (Schore, 2009b).

Attachment Communications

An infant's arousal and affective states are regulated through rhythmical interactions with caregivers to form attachment bonds and emotional patterns of communication (Malloch & Trevarthen, 2009). "Through visual-facial, auditory-prosodic and tactile-gestural communication, the caregiver and infant learn the rhythmic structure of the other and modify their behavior to fit that structure" (Schore, 2009b, p. 4). Emotional communication requires visual-facial interaction, as the mother attunes to the rhythms of her infant (Schore, 2009b). Early attachment patterns endure in later relational communication interactions (Main & Hesse, 2000; Porges, 2009a; Schore, 2008, 2009b; Tronick, 2007) and the psychotherapist becomes a relational partner where interactions are implicit and non-verbal modes are rapid, subtle and out of awareness (Schore, 2008).

Attachment states of insecurity, anxiety, ambivalence, withdrawal, disorganization, depression and dissociation are physiologically rooted in the body (Porges, 2009a; Schore, 2008) with fixed action patterns (Llinas, 2001) and generate relational pain and suffering throughout the lifespan (Main & Hesse, 2000; Porges, 2009a; Schore, 2008; Tronick, 2007), and beyond through the dynamics of multigenerational trauma (Danieli, 1998). Adults with different attachment orientations have differential brain responses to facial expressions (Zang, 2008); thus early relationships affect how we perceive different facial cues. Trauma, within the early attachment relations and later significant relationships, disrupts the harmonious rhythm necessary for neural affective regulation, authentic facial expression, and effective relational communication. Emotions are expressed in nonconscious facial expressions, tone of voice, and unconscious gestures (Schore, 2009b), and trauma truncates this fundamental rhythm, depleting relational ability and social engagement (Porges, 2009a).

Trauma forms an implicit, body-centered memory wherein the emotional reactions of the past are experienced as if the threat is present in current time (Bach, 2008). The confusion of past traumatic events with present-moment lived experience can be differentiated in an empathic, intersubjective relationship, where the right-hemisphere of one is attuned to the right-hemisphere of the other (Schore, 2008). Somatic awareness, a right hemispheric perception, allows for spontaneous change where the body is experienced as one's own and dynamic, where sensations move along in time, restoring the organism toward wholeness (Behnke, 1995).

In psychotherapy today, intersubjectivity is considered a relational dynamic wherein "the reciprocal process of active involvement with the states of mind of the other person allows a patient's here-and-now perception of self to share consciousness with the experiences of incompatible self-narratives that were formerly dissociated" (Bromberg, 2009, p. 357). Facial cues to intense emotions and dissociated neural states that affect intersubjectivity may appear as a shift in color of the skin, a movement or fixity of the eye, twitching of facial muscles, the set of the jaw, a quiver in the chin, a repositioning of neck muscles, or a barely discernable change in the voice (Stanley, 2009). These subtle movements carry nonverbal messages directly from the right hemisphere of one person to the right hemisphere of the other, and profoundly affect one's sense of feeling and being felt by the other. These communications are carried instantly throughout the face-brain-viscera circuit, enervating the face, ears, eyes, larynx, pharynx, brain, viscera, heart, and lungs, and can spontaneously shift neural states (Porges, 2009a).

The Polyvagal Theory

The polyvagal theory of the autonomic nervous system identifies two discrete branches of the parasympathetic system; the ventral vagal and the dorsal vagal (Porges, 2001) as well as the sympathetic system. To sustain social engagement, the ventral vagal system must be activated. This finely tuned, responsive system is myelinated and directly connects the face, neck, eyes and ears; and the brain and viscera; the heart, bronchi and guts (Porges, 2009a). The dorsal vagal brain circuit generates immobilization allowing for deep sleep and prosocial engagement such as lactation and sexual intercourse (Porges, 2009a). The sympathetic system mobilizes a complex physiological arousal sequence, with high metabolic activation, to prepare for danger.

If defenses for life threat are insufficient, the dorsal vagal circuit of immobilization overlays sympathetic arousal creating a neural state of freeze (Schore, 2010); "immobility with fear" (Porges, 2009a). When *frightened to death*, imposition of the dorsal vagal immobilization on sympathetic defense mechanisms (Porges, 2009a) produces a terrified powerlessness. This "lethal" neural state reduces metabolic output, slowing digestion, respiration and circulation and is associated with dissociation, depression, and withdrawal (Porges, 2009a; Schore, 2008, 2009a).

The polyvagal theory offers clinicians a frame of orientation to comprehend the biobehavioral substrates of emotion. "All affective or emotional states are dependent upon lower brain regulation of the visceral organs (e.g., the heart) mediated through the autonomic nervous system" (Porges, 2009a, p. 3).

Face-Brain-Viscera Circuit of the Polyvagal Theory

The neural structure for social engagement, the face-brain-viscera circuit, can provide a vagal brake to defensive reactions (Porges, 2009a). With emotional communication through facial cues, traumatized patients can dampen defensive reactions and remain in the intersubjective relationship. The movement of the face influences how others respond. When regulated, people “make eye contact, vocalize with appealing inflection and rhythm; (and) display contingent facial expressions” (Porges, 2009a, p. 22).

The face-brain-viscera neural circuit, a myelinated ventral vagal system, allows for bidirectional and instantaneous transmission of information and energy between visceral organs, the brain, ears, and eyes, and the striated muscles of the face and neck. “Observable facial movement and concurrent subjective visceral experiences that characterize the expressions, feelings, and perceptions of emotion and affective state” have “profound positive impact of social interactions and interpersonal behaviors on the neural regulation of body state and behavior” (Porges, 2009a, p. 2). The neural state of social engagement directly influences the ability to regulate intense emotions and inhibit the decline into unhealthy metabolic states of defense and withdrawal characterizing the vagal brake (Porges, 2009a). Similarly, in the tale from Sierra Leona, attention to each face allows transformation from sorrow into happiness.

The Still Face

The *still face*, a research model that studies the effect of a mother’s intentional facial stillness on the behavior of her infant, lends valuable implications to facial expression, emotions and dissociative processes. Infants learn to regulate interactions through attention to adult facial cues. In laboratory studies, mothers were instructed to hold their faces still after a period of interaction with infants (Tronick, 2007). Initially, the infants attempted to seek their mothers’ attention, but after a few minutes, when unsuccessful, they withdrew into sadness and constriction with immovable facial configurations similar to the neural states of immobilization with fear (Porges, 2009a).

Tronick (2007) reports that infants of withdrawn mothers develop facial configurations that appear sad and depressed; they attempted and failed to regulate interactions. “Infants who experience neglect suffer under the constant demand to self-regulate... [T]he effects of chronic neglect may be more compromising because it limits the capacity of the child to engage with others and to be an active participant in a therapeutic process” (p. 374).

Conversely, this research indicates that intrusive mothers create consistent disruption of the infants’ activities. The infants turn away from their mothers as they learn a defensive style of coping; the facial configuration of this pattern is constricted and tight (Tronick, 2007) with fixed action patterns in the muscles of the face and neck, eyes and ears.

Facial Configurations and Fixed-Action Patterns

Fixed-action patterns are the firing neural pathways that carry habitual information and energy throughout the body and mind. Facial muscles record instinctive reactions to danger and life threat and produce fixed-action patterns of active protest and passive withdrawal (Llinas, 2001).

Traumatic experiences imprint the implicit memory system with fixed action patterns that inhibit the responsiveness of the social engagement system, providing obstacles to interactive, contingent communication in relationship with others (Llinas, 2001).

Facial and head muscles influence social cues and can reduce or increase social distance. “Neural regulation of these muscles can reduce social distance by making eye contact, expressing prosody in voice, displaying contingent facial expressions and modulating the middle ear muscles to improve the extraction of human voice from background sounds” (Porges, 2009a, p. 36). When the muscle tone of the face and neck has been reduced by fixed action patterns, a person can lose awareness of the social engagement behaviors of others (Porges, 2009a).

Fixed-action patterns predict mindless states, such as dissociation from body awareness and addictive trances (Mate, 2009), which, if created in moments of intense fear and terror, resist change, even in safe environments. The *qualia* of fixed-action patterns are the subjective sensations that generate feelings and constitute the core of conscious experience. “Neuronal activity and sensation are one and the same event” (Llinas, 2001, p. 218); awareness of incoming sensation, the *qualia* of human lived experience, allow for more accurate anticipation and prediction of safety in the environment and are a core component of somatic psychotherapy.

Integrating Emerging Theories

The psychotherapist’s challenge as a reflective scholar-practitioner (APA, 2007; Schön, 1995) is to integrate emerging theoretical knowledge and create new practice mechanisms to enhance spontaneous social engagement (Porges, 2009a), intersubjectively process intense emotions (Schore, 2008), stimulate engagement in the world (Porges, 2009a) and nature with profound wonder, curiosity, respect, and action (Sardello, 2008). The polyvagal theory and dynamics of the face-brain-viscera

circuit (Porges, 2009a) offers a frame of orientation for developing intuitive ways of assisting people suffering unbearable losses (Stanley, 2009) while the intersubjective field aids psychotherapists in attuning to the specific neural states of the patient and within which the therapist and patient can explore previously dissociated experience (Porges, 2009a; Schore, 2009a).

Psychotherapists using the polyvagal theory (Porges, 2009a) to decode neural states can discern the message value of facial communication, respond with accurate somatic empathy, then explore implicit traumatic memories within the scope of each patient's optimal arousal zone (van der Kolk, 1996; Levine, 1997) and specific windows of tolerance (Schore, 2010; Siegel, 2006; Ogden, 2006). An open, fluidly moving, soft face, combined with verbal prosody, may indicate a bid for social engagement. Constricted, fixed muscles of the face, jaw, eyes and neck suggests sympathetic arousal. Withdrawal, reflected in a still face, a flat tone of voice, and dissociation may indicate freeze states. Within the context of an embodied intersubjective relationship, the qualia, the sensations, of those memories begin to move and gradually dissolve fixed-action patterns (Llinas, 2001) of dysregulated neural states (Porges, 2010).

Somatic awareness of the intersubjective dynamics between the psychotherapist and patient reveal subtle shifts in skin tone, movements of the eye, face, jaw and unconscious postures of the neck and shoulders, in even the most still-faced patients. Close monitoring of muscles of the face and neck that do not move provides rich cues as to the nature of the trauma. The theory regarding the face-brain-viscera and its neural bidirectional and instantaneous connectivity (Porges, 2009a) invokes the possibility of modifying fixed-action patterns (Llinas, 2001) to restore regulation to the heart, the lungs, and the viscera, and re-engaging the social engagement circuit.

Somatic Practices

Somatic practices of awareness, empathy, inquiry, intervention and reflection provide alternative memory experiences that can directly activate muscles of the face, intervening in the face-brain-viscera circuit, immediately affecting the smooth muscles in the viscera, and creating a shift in neural states (Porges, 2009a). These dynamics facilitate alternative perceptions in the brain to allow previously dissociated aspects of the self to emerge and stimulate processing of intense emotions from trauma into adaptive responses (Bromberg, 2009). Over time, and with intention, psychotherapists can cultivate precise somatic awareness of the facial, auditory, gestural, and sensory cues to maladaptive neural states and become skilled at subtle somatic practices, such as face-brain-viscera interventions, to promote shifts in sensations that lie at the heart of emotions.

Somatic Empathy

Somatic empathy involves embodiment, attunement, resonance, and nonverbal communication. Wonder, curiosity, and caring can guide psychotherapists to feel into their own bodies and the bodily experience of the other "with heart and mind connected" (Stanley, 1994, p. 2). Face-to-face contact allows the patient to discern the intention of the psychotherapist, to endure and gradually transform unbearable sensations of trauma, the biological substrate of survival emotions (Panksepp, 2010). Somatic empathy animates intersubjective relationships and opens up the opportunity to process a trauma memory through subjective sensations of gestures and emotions (Llinas, 2001).

Somatic Inquiry

Somatic inquiry, a phenomenological approach to collecting subjective data, can facilitate therapeutic processing of significant face-brain-viscera phenomena and other expressions of trauma memories. Phenomenology "seeks to discover the consequential in the inconsequential, the significant in the taken-for granted" (van Manen, 1990, p. 8).

Somatic inquiry is respectful of subjective experience and allows psychotherapists to interact intuitively through states of unknowing and surprise at the unique dynamics of each person's lived experience. Therapists initiate a somatic inquiry by tuning into their own bodies to discern current sensory perceptions and simultaneously, gently inquiring into the internal state of the other. This embodied investigation can assist in attuning to the subjective neural state of the patient, and facilitating further resonance that can lead to deeper exploration of trauma phenomena and the restoration of adaptive neural states.

Somatic empathy and inquiry assist psychotherapists to perceive and participate in highly distressing states of the patient. Descending into states of defense and deep immobilization, the psychotherapist is able to *taste the poison*, to sense patients' suffering. As therapists listen carefully, and softly observe the patients' faces and bodies, they may enter into inquiry within their own bodies, feeling the visceral stirring, and finding resonance with the internal experience of the other. The therapists' embodied selves come to know, in a nonverbal way, the horror and terror concealed by the other as dissociated torment in order to survive.

Somatic Interventions

Intuitive somatic interventions can be explored for the “strengthening of social engagement behaviors and the dampening of defensive strategies” (Porges, 2009, p. 2) and facilitate processing the intense bodily-based emotions of trauma. Somatic interventions include invitations to notice and monitor particular sensations (Behne, 1995; Porges, 2009a; Levine, 1997), proposals to explore micro body movements (Da’Oud, 1995), oscillate attention between different right-hemispheric phenomena (Rossi, 1996), and encourage the patient to allow the face to express sensory activity of the gut, lungs, or heart, “giving the viscera a face” (Porges, 2009a; Quillman, 2009, personal communication).

Being Felt Through the Face

The human face is capable of expressing dissociated emotions held in the viscera from traumatic experiences (Porges, 2009a). The following case vignette illustrates dynamic somatic practices of face-brain-viscera neural circuit within the intersubjective field. The individuals have given their express consent to use the case vignette; identifying information has been eliminated.

Gordon and Sarah: Healing and Growing Together

Gordon and Sarah practice precise skills in verbally communicating left-hemispheric cognitive concepts, yet have had difficulty effectively communicating intense emotions.

This couple came into psychotherapy, in Sarah’s words, “To help Gordon with his childhood trauma.” After a year, Gordon had made progress integrating his early trauma, and Sarah now expresses confusion about her childhood. She believed that she had been raised without trauma, although her family of origin “strenuously” avoided emotional communication.

As we opened the session, both Gordon and Sarah expressed a deepening of intimacy in the relationship with less defensiveness and withdrawal. A new issue had arisen. Sarah reported, “As Gordon is recovering from his trauma, I find that I am more protective of him. This doesn’t feel right to me and Gordon objects, but it just seems to happen spontaneously.”

Sarah described a group activity in which she had spontaneously suggested that Gordon be included. When the leader said no, Sarah described how she felt shut down, and “went dead.” In that moment, I observed Sarah’s face drop into passive withdrawal, and she moved back in her chair. Unexpectedly, I felt a shock in my body. I asked Sarah what it was like for her when her request was denied. “I was so surprised,” she said, as she put out her hands as if to resist, and then dropped them to her lap in a gesture of defeat. We explored the gesture, and then I invited Sarah to observe her body, to notice her sensations and feelings.

After some time, Sarah reported that “nothing is there. It is dead.” Sarah’s face had become mottled with gray and some splotches of red. I recognized this skin tone as a possible shock reaction, *immobilization with fear*, and asked Sarah if Gordon could support her with touch. Sarah agreed, and I asked where she would want his touch. Sarah indicated that she wanted Gordon’s hands on her knees. With a gentle movement, Gordon put his hands on Sarah’s knees, and I invited Sarah to imagine what it might feel like to take in support from Gordon’s touch. Sarah reported that she could feel Gordon’s support as a “stream of love and light.” I asked where she felt that stream in her body, and she reported that it came up to her neck and then felt stuck, a possible fixed action pattern. I invited Sarah to imagine *what expression her face might make if the stream of love and light could come into the muscles in her face*. The small muscles in Sarah’s face began to spontaneously dance and I suggested that she simply allow the involuntary movement as she watched Gordon’s face. I observed Gordon’s face, wreathed in a broad, loving smile, and kindness shone out of his eyes. I felt the intersubjective field embrace the three of us.

Sarah interrupted the nonverbal dialogue and said, “This is just what it was like when my babies were learning to smile! They kept trying to move their faces when I smiled at them and finally they could smile at me. This is wonderful!” As Sarah attended to Gordon’s touch, shyly and softly gazing at him, her face reflected more organized gestures. Slowly, Sarah’s face came into attunement with Gordon’s face. Smiling within, I felt the growing intimacy. Suddenly Sarah’s face shifted and sadness swept over her as she spoke: “I just realized that my mother never has smiled at me or much at anyone. No one has ever done this for me before.” In a moment, the sadness left her face and the three of us entered a few minutes of silence. Sarah then reported emotions of gratitude, and I suggested that Sarah nonverbally express her feelings to Gordon. The couple enjoyed connection with a soft gaze as Sarah’s face became rosy and luminous.

As the three of us reflected on the session, we recalled Sarah’s protection of Gordon and her experience of freeze, Gordon’s touch and the restoration of life force within Sarah’s body and face. Sarah expressed fascination with the “direction” of this session and intended to go home to “face this issue” by attuning and resonating with facial movement in her interactions with Gordon.

Summary

This article attempts to integrate recent neurological theory and a glimpse of ancient wisdom regarding the human face with intuitive somatic approaches for therapists. The neural “platform” (Porges, 2009b) for traumatic memories are formed in the early attachment relationship with caregivers and may endure throughout the life span. Trauma leaves fixed-action patterns of defense and withdrawal on the implicit memory system, disabling the neural mechanisms of social engagement, the brain circuit that enervates the face, neck, eyes, ears, brain, and viscera. Without an opportunity to process intense emotions from trauma, these fixed-action patterns endure, affecting facial configurations and seriously eroding future relationships and the ability to be happy. In conclusion, somatic practices of awareness, empathy, inquiry, intervention, and reflection touch deeply into the biological substrate of intense survival emotions, gently releasing fixed action patterns and restoring the innate flow of information and energy through the body-mind.

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Biography

Dr. Sharon Stanley has educated thousands of health care professionals internationally in the principles and practices of somatic psychotherapy. Building on her research on empathy with traumatized youth, Sharon founded Somatic Transformation, a trauma model and professional curriculum. ST is based on emerging research in Interpersonal Neurobiology and a phenomenological, intersubjective approach to transform relational and shock trauma. Sharon participates in Dr. Allan Schore's Seattle Study Group and her work with First Nations, the study of Afro-Brazilian healing with on-going research into clinical practice has led to a fluid convergence of neurological research and professional skills. Sharon has a clinical practice on Bainbridge Island, Washington. sharonstanleyphd@gmail.com www.somatic-transformation.org

Developing Sensitive Attunement: Contributions of Traditional Practices to Therapeutic Joining

Vivian Gay Gratton

Abstract

Heightened sensitivity, due to temperament or trauma, often results in difficulty with primary and subsequent attunement and attachment. This disjoint is experienced as fragmentation not only in the individual, but also in the family and community. Research in neurobiology is revealing how the structure and function of the neurological system is affected by arousal and by failures in attunement. Psychotherapy, through intentional and relational work, provides an opportunity to repair failures in attunement and to achieve integration. Three traditional somatic spiritual practices, aikido, music, and relationship with nature, are examined to identify practices that can be incorporated into psychotherapeutic practice. Examples of application of these practices in therapy with children and adults who experience high sensitivity and rapid arousal are presented.

Keyword

Attunement, Sensitivity, Aikido, Music, Psychotherapy

Developing Sensitive Attunement

Introduction

Alex's mother had told him that someone would be coming to his class to help him. It was not hard to find this boy who was about to be expelled from preschool. He was running around the room as the teacher tried to organize circle time. When he did sit down, he scooted back and forth, jostling other children, upset that another child did not want to sit next to him. He sang louder and faster than everyone else — every song punctuated by very authentic-sounding train whistles. The teacher looked at me. I settled down a few feet behind Alex, reached deep into the earth and far out to the wild world beyond the room, seeking energy and space to meet and hold Alex in an environment that I too found irritating. Then I began to pass this energy through to him, and to open more fully to his energy. Over the next ten minutes he steadily scooted back and I scooted forward until, with his final scoot, he settled his back against my chest. We had come into a rhythm together, into attunement.

I would work with Alex and another boy, Ben, for the next two and a half years, most of it spent tromping through woods and creeks. Intent on finding ways that sensitivity could serve communication despite the challenges it presented to interpersonal connection, I enrolled in a graduate program in counseling psychology and began training in the martial art of aikido. This paper is my report on this multi-modal exploration of attunement. While the focus of this exploration is attunement with the highly sensitive, the practice of training in grounded and sensitive attunement extends to all efforts to connect with others, in and out of therapeutic environments. To be conscious in the world demands both sensitivity and groundedness, and it is an act of hope and commitment to train ourselves so that we may be conscious and present in relationship amidst the exquisite beauty and great pain around us.

Stern (2004) first used the term *affect attunement* in 1977, to describe the process by which a mother communicated to her infant an understanding of both what the child was doing and the feeling that the child was experiencing. This attunement was achieved through “selective and cross-modal imitation” (p. 84). Mother and child used tone, rhythm, touch, gesture, expression, and changes in timing and intensity in a dance of mutual excitation and regulation. This seminal work spurred ongoing investigations by many researchers into the nature of this formative caregiver-child intersubjective communication and how it related to attachment between children and caregivers and to child development.

Jaffe, Beebe, Feldstein, Crown, and Jasnow (2001) found that the dialogue between preverbal infants and adults had a rhythmic coupling that was coordinated by not only adult, but also by infant (p. 93). It became understood that children, from birth on, can detect changes and correspondences in timing, intensity, and form in the behavior of others, and that, as infants develop, their interest in the behavior of others changes (Stern, 2004, p. 85). Through this relational developmental process, children develop working models of self, other, and the intersubjective matrix. It is in the first years of life that the basic framework for understanding the intentions of others, of conveying personal intention, and of participating in shared intention is laid down.

Alex and Ben both experience great difficulties in the land of intersubjectivity and both are diagnosed with Sensory Processing Disorder (SPD). Alex also has a diagnosis of Attention Deficit/Hyperactivity Disorder (ADHD), and presents with Generalized Anxiety Disorder. Ben was diagnosed with Asperger's Disorder and Tourette's Disorder. These two very intelligent children have been a challenge to their parents, caregivers, and teachers since they were babies. It is common for SPD to be associated with learning disorders, particularly autism spectrum disorders (ASD) and ADHD (Wallis, 2007, ¶ 6).

(Autism spectrum disorders range from high-functioning to low-functioning, and include Autistic Disorder, Asperger's Disorder, and other less common disorders.) Sensory Processing Disorder is a diagnosis currently made by occupational therapists, based upon evidence of deficits in assimilating, integrating and responding to sensory signals from the five classic senses as well as proprioceptive (inner body movement awareness) and vestibular (balance awareness) senses. It is now being considered for inclusion in the Diagnostic and Statistical Manual (Wallis, 2007, ¶ 6).

Along with a rise in awareness and identification of SPD, particularly among children, there has been a growing interest in the designation, *highly sensitive*, as defined by Aron (2007) to refer to individuals with nervous systems that are "more sensitive to subtleties" and who possess "senses that are not necessarily keener (although they may be), but the brain processes information and reflects on it more deeply" (¶ 2). Clearly there is a large overlap between Sensory Processing Disorder and high sensitivity. In fact, Aron & Aron (1997) use *sensory processing sensitivity* (SPS), a term very like SPD, replacing the term 'disorder' with the less pathological 'sensitivity.' Meyer, Ajchenbrenner & Bowles (2005) used this same term, SPS, in a study correlating sensory sensitivity and attachment experiences of adults with Borderline and Avoidant Personality Disorders. For the purposes of this paper, the term *sensory processing sensitivity* (SPS) will be used to refer to people who have either diagnosed Sensory Processing Disorder, or who exhibit a high level of sensitivity.

In my clinical field placement I see four older adults with significant to severe childhood trauma in early attachment experiences, which include incest, physical abuse, ongoing death threats, and severe depression exhibited by both parents. Only one of these individuals meets the requirements for posttraumatic stress disorder (PTSD) in the Diagnostic and Statistical Manual, 4th Edition, Text-Revision (American Psychiatric Association, 2000, pp. 463-468). However, three would qualify for the diagnosis of complex posttraumatic stress disorder/ disorders of extreme stress, not otherwise specified (PTSD/DESNOS), or developmental trauma disorder, proposed by the National Child Traumatic Stress Network Workgroup on Diagnosis (van der Kolk, & Courtois, 2005, p. 387). This classification includes symptoms that include affect dysregulation, dissociation, somatization, and alterations in perception and relations with others (van der Kolk, Roth, Pelcovitz & Spinazzola, 2005, p. 389). The remaining client presents with depression. All of these adults present with high sensitivity that appears to have been present from early in their lives. It is difficult to parse how much of this sensitivity is inherited and how much is the result of traumatic attachment experiences, abuse, and neglect. Three of these clients have ADD, and one of these three also has ASD. Music is important, and dissonant sound is distressing to all of them. One has extraordinary sensitivity with animals. All have significant to high sensory defensiveness. These four clients can all trace sensory defensive characteristics, ADD or ASD, and/or mood disorders through their families.

There appears to be a great overlap between sensory processing sensitivity, ADHD, ASD, and trauma disorders. Despite this overlap, these different disorders are usually treated separately. Children with SPD and other diagnosed learning disorders are treated by special education specialists, while children with emotional disorders are treated by mental health specialists. Rarely is treatment for comorbid disorders integrated, and often the SPD, the learning disorders, or the mental health issues go untreated. Sadly, this lack of integration in treatment mirrors the individual's own difficulties with integration. Further research into the relationship between these disorders would benefit the many people who struggle with challenges in processing sensory input and with comorbid mental and emotional challenges.

Misattunement.

Much of current research in attachment and trauma focuses on the tragic failure to attune and the egregious abuse and neglect of children by parents or other caregivers. Siegel (2002) argued that parents with unresolved trauma are impaired in response flexibility and autoeotic consciousness (the awareness of self as a continuous being through time). In addition, he noted that the parents are often in a frightened, aroused state, and act out of this state. These behaviors, born out of parents' own developmental survival strategies, result in the intergenerational transfer of trauma and psychic disorganization (p. 117).

Another perspective is offered by Morgan, Wang, Rasmusson, Hazlett, Anderson, & Charney (2001) in their study of neurochemical responses to uncontrollable stress. They found that individuals differed *before exposure* in their vulnerability to uncontrollable stress. The question remains whether this vulnerability existed in infancy, or was acquired early in life through disorganizing attachment experiences as Siegel proposes. Possible evidence of temperamental vulnerability was presented in Anzalone's (2001) work with the classic "still-face" experiment, in which a mother engages with her infant for several minutes, then switches to a still, non-expressive face, with no talking or touching. Normally, a well-attuned, securely attached infant will become upset when the mother becomes still. Anzalone (2001) found the opposite was true for observed sensory-defensive children (p.23). A child's temperamental vulnerability could be compounded by disorganizing attachment or by an inability of caregivers to come into sync with a child whose needs, and expression of those needs, run counter to generationally and societally learned parenting practices. My experience with young and adult clients leads me to believe that sensory processing sensitivity makes one more vulnerable to uncontrollable stress. This suggested vulnerability might be the result of either differences in neurobiological structures or in the challenges that children with SPS pose to caregivers, or a combination of these two factors.

Individuals with SPS and those with attendant ADHD or ASD often, though not always, have "good-enough" parents. However, they may still have trouble with attunement with these primary caregivers. These difficulties may stem from the child's sensory defensiveness, as well as from possible parental sensory defensiveness and comorbid disorders. Parents may become overwhelmed by the work of responding to their children and of providing some protective interface between them and

the rest of the world. Aron & Aron (1997) spoke of the challenge of raising sensitive children: “Besides their childhood traumas, sensitive children are no doubt difficult to raise anyway, and much of the task of raising them probably involves helping them to contain and reframe their fears and sadness due to perceiving so much that is distressing and that goes unnoticed or unreflected by other children” (p. 363). The match of both a parent and a child with SPS can be either beneficial or deleterious, depending on the parent’s awareness and capacity to handle his or her own and the child’s sensory defensiveness.

Schore (2002) argued that trauma is fundamentally relational and cumulative, stating that “affectively charged traumatic memory is . . . a re-evocation of a prototypical disorganized transaction with the misattuning social environment that triggers an intense arousal dysregulation” (p. 21). While misattunement with a child’s first relationships plays a very strong role in lifelong difficulties with attunement, difficulties in coming into sync with peers and the greater social environment should not be overlooked. Classrooms are crowded and full of noise, and there are few opportunities for seeking out special, safe places. The social code expected by other children and by teachers can be very limiting in scope. Sensitivity around noise or cruelty to animals often leads these children to pull away or to strike out. Aron & Aron (1997) note that some people with SPS tend toward characteristics of “low sociability and high negative emotionality . . . the former as a strategy to avoid overstimulation, and the latter as the result of an interaction of the trait with aversive or socially unsupported early experiences involving novel stimuli” (p. 350). Meyer et al. (2004) found a relatively strong linkage between temperamental sensitivity and both Avoidant Personality Disorder (APD) and Borderline Personality Disorder (BPD) features, and were able to identify differences in responses to hypersensitivity between people prone to BPD features versus those with APD features. Those with BPD, although hypersensitive, tended to be physiologically hypo-responsive, and compensatorily more impulsive, while those with APD were more avoidant of stimulation (p. 654).

Both Alex and Ben suffered from ostracization and isolation at school. They both said or did inappropriate or odd things, or simply did not jibe with the other kids. They also both had a history of hitting other kids. The two boys were quite different from each other despite their shared sensitivity and impulsivity. Ben loped along from side to side as he walked or ran. He could go forever once he reached a steady speed. Alex zipped, zigzagged and stopped abruptly, then shot off again. Their speaking cadence mirrored their gates. Alex was mercurial in anger; Ben’s fury was slow growing and slow dying. The boys could make each other angry, but they didn’t make the other into a bad person. Sometimes I picked Alex or Ben up from school. There I saw how the other parents, teachers, and children looked at these boys and I was saddened knowing the years of school that they would have to endure.

My experience with clients and with others with sensory processing sensitivity suggests that avoidance may arise not only as a defense to overwhelming stimulation, but also as a way of holding safe what one experiences, but that others do not perceive or reflect. One adult client related to me his childhood experiences with the frogs at the neighborhood creek and his great distress at the torture of these animals by other children. He had had a relationship with the frogs. Another individual told me of the first time when she recognized her parents could not perceive what she could. It was a devastating moment, and one in which she realized she must keep what she knew safe, not just from being misperceived, but also from being negated by her parents’ inability to sense what she sensed. Martin Prechtel (2002), who as a young man traveled to Guatemala and became a village member and shaman, wrote of his childhood, “In my youth the things I thought, that I slowly found I shouldn’t share and what my quiet, animal-like soul felt and understood, left me stranded for human company in a kind of spiritual isolation” (p. 110).

Healthy Attachment and Affect Regulation

Attunement, and repairs of misattunements, are central to healthy attachment and to the ability of individuals to achieve affect regulation. Good affect regulation allows a person to have curiosity and creativity while also taking care of survival needs. Development of affect regulation is achieved through attunement or mutual regulation with a primary caregiver. Trevarthen (1990) stated that “the intrinsic regulators of human brain growth in a child are specifically adapted to be coupled, by emotional communication, to the regulators of adult brains” (p. 357). Zeedyk (2006) spoke of this intersubjective communication as a “corporal choir of visual, auditory, tactile, and kinetic modalities,” with exchanges following “a reliable pattern of ascending and then descending levels of pleasure, in which the building excitement reaches an interim climax that is followed by a brief period of repose, during which time each partner can regain control over their arousal level” (p. 322). These arcs of anticipation, climax, and denouement were given the term *vitality affects* by Stern (2004, p. 36) in his exploration of the present moment. Attunement is rhythmic, improvisational and synchronized. Lester, Hoffman, and Brazelton (1985) remarked that, in attunement, “synchrony develops as a consequence of each partner’s learning the rhythmic structure of the other and modifying his or her behavior to fit that structure” (p. 24).

Learning involves making many mistakes; both partners often get out of tune. The “good-enough” caregiver is able to repair misattunement readily and to reestablish attuned regulation of the child’s negative state following misattunement. This repair and retuning is made possible by the caregiver’s ability to be aware of and to self-regulate his or her own affect (Schore, 2003, p. 39). I believe that it also depends upon the caregiver’s ability to be aware of and understand the inner experience of the child. This is easier when the child’s resonance is similar to that of the caregiver and is more difficult when there is a greater difference in resonance between child and caregiver.

Ongoing studies of the development of self-regulatory capacities during early attachment experiences aid our understanding of what goes awry in the development of the self and offer insight into the workings of the therapeutic relationship. We change and grow through the process of attunement, not just in childhood, but to the ends of our lives. Siegel (2002) reported that neurobiological research suggests that the brain continues to develop throughout life (p. 89). It is this generative capacity which we rely upon when client and therapist work together to heal past traumas and to achieve greater regulation, integration, and flexibility. The process of imitation is instrumental in this healing.

Meltzoff & Moore (1994) proposed that “imitation is to understanding people as physical manipulation is to understanding things” (p. 96). When children or adults do not feel understood, they experience either the inability of others to imitate them, or their own inability to perceive imitation. In either case the result is isolating. Imitation is much more nuanced than simple parroting. Zeedyk (2006) proposed an expansion of the idea of imitation to include not only turn-taking behaviors, but also overlapping or simultaneous actions or states, as well as a variety of forms including: postures, emotional expressions, and sound. These “imitations” could be accomplished through rhythm, pitch, timing and intensity (p. 334). Imitation is an exchange of energy and information— a sharing of two minds through all of our expressive and receptive capabilities.

Why is imitation so important to attachment and affect regulation? In imitation the object of attention is self-oriented, and the attender is other-oriented. The process of imitation is reciprocal as both partners spontaneously switch roles. Through this attending and being attended to both partners cyclically extend curiosity to the other and allow exposure of themselves. This process builds engagement and boundaries, thereby allowing a sense of self and a sense of belonging to develop (Zeedyk, 2006, p. 332). When a person is in high arousal or sensory overload, it is much more difficult to attend to another or to be the subject of attention. Caldwell (2006), who works primarily with people with severe autism spectrum disorders, hypothesized that, for people with ASD, “the level of stress rooted in sensory confusion is what undermines the brain’s ability to function” (p. 280). I find this hypothesis to ring true with my own work with people with SPS and with less severe ASD. To enter into imitation with someone with SPS, it is necessary to stretch out of the familiar and comfortable and into the experience of hypersensitivity. In my work with Alex and Ben, it was often a very physical experience.

One afternoon the boys and I were walking back to the car after climbing to an overlook. Alex thought Ben was too slow, so was banging into him. Ben was banging back. Under this irritation was something we all shared — proprioceptive needs. Like most people with sensory processing sensitivity we each craved compression of our joints. Banging into each other provided this, while also expressing irritation and frustration. The danger was that all three of us were also sensory defensive. Sudden and unexpected touch could send us into overwhelm, and when the boys went into overwhelm, they struck out or ran off. I told Ben that I felt tired of walking. I needed a bump. He ran up to me and bumped me from behind. I went shooting ahead laughing. Then Ben wanted a bump. Then Alex. We bumped each other all the way to the car. Over the next year, we returned to the bump many times, and, as we did, we became more skillful, learning how to bump with the right intensity and timing for the person and situation. We learned how to invite a bump, announce a bump coming, and to refuse or avoid a bump. We imagined actually bumping people in all the daily situations in which this desire arose, and we talked about what we had to do to restrain this impulse. Then we bumped each other some more.

Another response to high sensitivity is to avoid contact. One adult client, Daniel, looks away frequently as we work together, particularly as the work brings up strong emotion, yet, when he looks at me, he is extraordinarily present. I wonder at how he has held onto this sensitivity and presence. I believe that looking away is what saved the sensitivity in his eyes, the same sensitivity with which he carries on a very nuanced conversation with his small dog that often comes to sessions with him. To join with Daniel, I must tune my sensitivity or he will be left stranded when he turns to look at me. Daniel’s avoidance does not feel like an inability to connect so much as a fear, grounded in life experience, that important others cannot connect with him.

A Wide View of Attunement

While research has focused primarily on affect attunement between child and caregiver, my experience in training attunement, and in working with clients to achieve attunement, invites an expansion of this definition. I recognize attunement as occurring in four realms: intrapersonal, interpersonal, group, and environmental, or universal. Various practices of training attunement may focus on one or more of these realms. For example, musical training can build the capacity to achieve resonance within the self, with another, with a group, and, sometimes, with the universe. In my first meeting with Alex, I drew upon a practice of tuning in with the environment that is common to many indigenous spiritual and meditative practices. This deeper, fuller tuning allowed a strong enough resonance, a deep drone and drumbeat, to hold and organize Alex’s and my own rhythms within the chaos of the preschool classroom. I use this same practice with adult clients in the therapy office. While the office may look less chaotic, the clients, and I, bring in energy that must be grounded and contained in order for us to use this energy for healing and growth.

The neurobiology of attunement, attachment, and affect regulation.

Research in the neurobiology of attunement allows us to look at what is occurring at the phenomenological level — in the moment of connection and missed connection. Our neurological systems are responsible for taking in information from

within and without the body and for producing responses to these signals. In order to understand how sensory processing sensitivity affects attunement and affect regulation, it is necessary to explore, at least briefly, the nature of the mind and its development. Siegel (2001) defined the mind as “patterns in the flow of energy and information” which can flow within one brain or between brains (p. 69). I would add the suggestion that this flow of energy and information can also occur between a human mind and other energetic systems, such as animals or the earth as a whole. Siegel (2001) described the relationship of mind, brain, nervous system and body as follows:

The processes of the mind emanate from the structure and function of the brain. The brain itself is an integral part of the central nervous system, which is fundamentally interwoven within the whole body The patterns in the flow of energy and information, the essence of the mind, are a product of both bodily (neurophysiological) processes and interpersonal interactions. (p. 70)

Integration, or lack thereof, is a key quality of mental function. Integration refers to the “ways in which functionally distinct components come to be clustered into a functional whole” (Siegel, 2001, p. 70). When integration is compromised, a person does not function optimally. Dissociation and dysregulation result from a breakdown in integration. Research in the neurobiology of attachment reveals that integration is achieved through the process of communication, and that emotion is key to this integration. To heal failed or traumatic attachment patterns, therapist and client are called upon to become aware of and to communicate emotions, a task which the client found and still finds very difficult and/or negating.

Communication is served through neural mechanisms such as mirror neurons and adaptive oscillators. Mirror neurons are neurons that fire both when an action is performed and when one observes (visually, auditorally, tactilely, or otherwise) an action performed. The mirror neuron system has another quality that is very important to communication; it is sensitive to goal-directed actions, or, intentions (Stern, 2004, p. 79). In other words, this inner imitating system picks up those actions that are the most charged with focused energy, or intention. Hence, intention, and especially shared intention, is crucial in the psychophysical conversation of therapy. The neural system also makes use of adaptive oscillators, which allow us to come into synchronization with incoming signals. These adaptive oscillators “act like clocks within our own body . . . and their rate of firing can be adjusted to match the rate of an incoming stimulation” (Stern, 2004, p. 80). In the “bumping” example, Alex, Ben, and I were learning to come into sync with each other’s rhythms. When we did not, the bump was more of a clunk, and an irritation rather than an enjoyable pulse in our physical conversation. We used both mirror neurons and adaptive oscillators to reach the enjoyable synchronization.

People who experience hyperarousal and affect dysregulation can have great difficulty with the experience and communication of emotion. Research is showing us that emotion plays a very important role in neural integration. Siegel (2002) reported:

Recent theories of the neurobiology of emotion suggest that the limbic region, which includes the orbitofrontal cortex, the anterior cingulate, hippocampus, and amygdala, has no clearly definable boundaries. This finding of widely distributed neural integration suggests that the functional integration of a wide array of anatomically segregated processes, such as perception, abstract thought, and motor action, may be a fundamental role of the brain. Such an integrative process may be at the core of what emotion does and is. (p. 96-97)

My client, Sandra, frequently reports antithetical emotional reactions to the same situations. She is often not aware of the dissonance, while I find it disorienting to listen to these contrary emotional experiences. There is a fundamental lack of integration, and only a nascent center or core. Our only foothold is with moment-to-moment experiences, which we can track, along with attendant emotions, slowly and carefully hooking up somatic experience, thought, and emotional experience.

Perception and Arousal States

Psychological health can be assessed by the qualities of neurological complexity and integration. Complexity, expressed as flexibility, creativity, emotional range, and openness, operates in the space between boredom and anxiety. Integration, the ability to connect disparate systems — right and left hemispheres, body and mind, past and present, separateness and connectedness — may be the process by which complexity operates. When a system cannot move toward complexity, it is stressed, and individuals respond to stress in one of two ways: moving toward greater rigidity and boredom or toward greater chaos and anxiety (Siegel, 2002, p. 5). Schore (2002) noted that:

[People with PTSD] show severe deficits in preattentive reception and expression of facially expressed emotion, the processing of somatic information, the communication of emotional states, the maintaining of interactions with the social environment, the use of higher level more efficient defenses, the capacity to access an empathic stand and reflective function, and the psychobiological ability to regulate, either by auto-regulation or interactive regulation, and thereby recover from stressful affective states. (p. 23)

Another client, Ann, stated at our first meeting that her goal was to be able to inhabit the middle ground between “shut down” and overwhelm. Like Sandra, this is narrow and challenging territory. We discovered that common grounding meditations put Ann into the experience of overwhelming emotional pain. She grounded into her pain. This was not supportive to her health and her therapeutic work. We then found that she could gain a base of support through connecting her heart center to her spiritual source. This brought a calming to her nervous system and more freedom of movement mentally and emotionally. However, when Ann was under greater stress, even connecting her heart to spirit was too much for her, quickly bringing on migraine symptoms. These experiences, along with Ann’s and my shared intention to find and return to this window of calm and freedom, have taught me how sensitive and focused practitioners must be when hovering near the border between healing resolution and unresolved overstimulation.

Studies of the brain structures of children who were abused revealed reduced development of the corpus callosum, the brain tissue that is responsible for transferring information between the two hemispheres of the brain (DeBellis, Keshavan, Clark, Casey, Giedd & Boring, 1999). Autism is also associated with a smaller corpus callosum. Piven (1997), in comparative studies of brains of people with and without autism found multiple abnormalities in size and proportion, which he attributed to “poor connectivity or communication throughout the brain.” He remarked, “I think this is part of an overall pattern showing that different parts of the brain are out of sync with each other. This makes you think that those areas might be disconnected functionally” (9).

Sensory processing sensitivity is highly associated with autism and with other learning disorders. However, it can also exist on its own, without comorbid disorders. Heller (2003) describes the range of sensory defensiveness:

The mildly defensive experience somewhat unstable arousability, get more quickly on edge and, as the day progresses, find it harder to recover until they feel exhausted. The moderately defensive experience more unstable arousability and more quickly ratchet up into overload and exhaustion. The severely defensive experience extreme arousability that precludes comfort and live in a state of overload and shutdown. As arousability becomes increasingly unstable, various forms of psychopathology and disease become increasingly inevitable. (p. 89)

I propose that, whether due to trauma or to temperamental sensory processing sensitivity, there is impairment in integration that is predicated on an overwhelming of the system, resulting in either greater dissociation and rigidity, or greater anxiety and chaos. Either of these two states indicates a lack of neurological integration. As sensitivity or trauma increases, neural connectivity decreases unless there is sufficient ground and environmental resonance to support management of the increase in information and energy experienced. I suggest that attending intently to the window between shutdown and overwhelm, the realm of greater complexity and freedom, will allow for greater integration, and hence, greater psychological and physical health. Healing happens when therapist and client are able to move back and forth over the borders of the window. To be able to access and open wider this window requires that both therapist and client train themselves in practices of grounding, centering, receptivity, entering, and joining. These qualities provide the base of support and the shared intention and curiosity needed to move while in frightening territory. Through training these capacities the client will develop the somatic awareness and facility needed to continue to regain balance and to access creativity and freedom in processing energy and information.

Training the Capacity for Sensitive Attunement

While attunement can be experienced in the realms of self, other, community, and universe, these experiences are not phenomenologically separate. Attunement does not start with the self and move outward, but is a continuous dance between different layers of systems. The individual touches the universal when grounding and centering. Dyads and small groups shift and re-form like children at a play structure, coming together and sliding apart and coming together again. The setting sun and the coming of evening alter the ways that we breathe and move. Although I may separate these realms to discuss separate practices to strengthen attunement, the deepest practice touches all realms in the same breath.

Intrapyschic Attunement Practice

Much has been written about the benefit of meditative and mindfulness practices for therapist and client alike. Diverse spiritual traditions share a common practice of cultivating mindful awareness through some form of meditation. Siegel (2007) proposed that mindful awareness practices draw upon aspects of the same neural mechanisms employed in infant-caregiver attunement. This proposal is supported by his recognition that both mindful awareness practices and attunement share a number of functions including: regulation of body systems, emotional balance, regulation of arousal states, attunement, empathy with others, and flexible responsivity, and that all of these functions occur within the prefrontal region of the brain, an area that is responsible for neural integration (p. 26-27). Neurobiology research is confirming what traditional spiritual practitioners have known for many centuries: meditation and mindfulness practices are essential tools for health and relationship.

Given the connection between attunement and mindfulness, it follows that individuals who have experienced deep, clear, and consistent attunement should have an easier time coming into mindful awareness. Those who did not have this experience would struggle more with regulation of their emotional states and somatic systems, and would also be challenged by interpersonal attunement. These same people may be drawn toward mindfulness practices though, as their conscious and unconscious impetus for wholeness seeks what will provide healing. Meditation practice is an important adjunct to many interpersonal therapeutic practices and is also a key component in Dialectic Behavioral Therapy (DBT), a therapy of choice for treating Borderline Personality Disorder (Lynch, Chapman, Rosenthal, Kuo, & Linehan, 2006, p. 465).

While aikido training is interpersonal in nature, it contains a number of intrapsychic practices that support the relational work. Primary among these are purification, grounding, and centering. Prior to partner training, aikidoka (aikido practitioners) practice both stretching and purification practices. While the stretching serves to warm up muscles, it also is used to bring focus to breath, center, and ground, and to enhance responsiveness in preparation for partner training. Traditional purification practices involve: gathering, grounding, and extending energy; becoming equally aware and energetically fluid in all directions; and focusing on particular qualities while doing breath or energy training. Because aikido techniques work poorly or not at all without sufficient grounding and centering, aikidoka receive immediate and frequent feedback during partner training regarding weaknesses and growing strengths in their internal practices. This allows for the continuous intercalation of intrapsychic and interpsychic attunement practices.

In my work with Alex and Ben, it was nature that provided the venue for intrapsychic attunement. While I never instructed the boys in sitting meditation, we did use the opportunities that nature presented. Crossing a log over a creek invites mindfulness and grounding, as does putting a hand deep into an underwater percolating spring. My adult clients are open to being led into meditative practices. One man, Eric, who has experienced PTSD symptoms for almost sixty years, accesses mindfulness most easily through song. While he came to therapy wishing to unload what was on his mind, he is beginning to find ways to use his great love of, and ability in, singing to manage his rapid arousal. Singing involves attention to breath, as does meditation. Singing is movement, and as Eric attends to the inner movement needed to generate song, he enters moment-to-moment consciousness. In my most recent session with Eric, he sang “Silent Night.” During this singing Eric’s energy state changed from face-contorting agitation associated with his memories to a deep stillness. His breathing, which is often strained, eased and steadied. A softness settled into him and flowed out into the room. The poet Rumi wrote “Go through the ear to the center/ where sky is, where wind/ where silent knowing . . . (trans. 1995, p. 253). Music takes Eric into inner attunement.

Interpersonal attunement practice.

What drew me to aikido was the opportunity to regularly practice interpersonal attunement with a variety of training partners. There was also the physical enjoyment of the art, one that allowed for a lot of proprioceptive feedback with less risk of injury than most contact sports. When I first came upon research in neurobiology, I was struck by the high correspondence between the processes involved in neurological development and integration and the practice of aikido. Siegel’s (2001) definition of the mind as “patterns in the flow of energy and information” which can flow within one brain or between brains (p. 69), reflected my experience of aikido, especially if “being” was substituted for “brain”, and if these beings included all life forces.

When we train body-mind to come into attunement, we come face-to-face with choices made earlier in our lives that have become habitual, shaping the patterns of our interactions and the structure and functioning of our bodies. These questions include: Can I travel to where you live? Can I allow you to touch me? Can we remain in contact despite our differences? Can we hold to our own centers and our connections to ground and universe while interacting intimately with each other? It is these questions that have become the focus of my study on the aikido mat and in the therapy office.

Losing and Regaining Balance

Early in my training I was working on the technique *irime nage* in which the nage (the one who receives the attack and does the technique) slips behind the attacker (uke), blending with the attack and drawing it out and down with a circular motion while simultaneously drawing the uke’s head into nage’s chest. The circular motion then swoops upward, until the uke is drawn up and away from the ground, at which point uke stretches out and slides down to the ground. (For references to Internet accessible videos of specific aikido practices, see Appendix.) *Irime nage*, like every technique, provides an avenue for transference to show up. With one nage I found myself going into a panic, my shoulders and neck bracing for a fight. Then we switched partners. As my new nage pulled me in, I gasped as a great wash of love and longing rolled through me and I lost sense of my feet. With each partner I lost my center, but in very different ways. I had dropped into two different attachment experiences and responses that lay in the world of implicit knowledge. Bit by bit I have been learning how to hold center and to open myself as I give myself to the practice of this technique.

Implicit knowledge includes emotional, somatosensory, behavioral, and perceptual memory, which is encoded within the mind-body. This knowledge is present at birth and is accessed without the process of recalling (Siegel, 2002). It is accessed through emotional and sensory-motor cues including sights, sounds, smells, and energetic experiences. That is why, in the course of ten minutes and without premeditation, I could powerfully access the experiences of fighting for self-protection and

of tumbling into my mother's arms. What was made possible by this experience in my training of attunement was: (a) the making explicit of the implicit, and (b) the rebalancing of my energy between other and self. While I could not give exact words and structure to the original experience, I could give story to the mirroring experience, looking to differences in the nages' techniques and energy as well as to the different intentions I brought to these two encounters to understand my different responses to intimacy and power. I could also make adjustments to my energy and intention that would help me stay safely in relationship throughout the technique. Staying in relationship in aikido is reinforced by the quickly absorbed knowledge that staying "center-to-center" allows for the greatest ability to respond to movement and, hence, to incur the least pain and fewest injuries.

Maai

Masciotra, Ackermann & Roth (2001), in their study of mutual attunement in the art of karate made the connection between the Japanese concept of *maai* and ways that we adjust and signal engagement with another. *Maai*, a blend of *ma* — spatiotemporal interval, and *ai* — harmony, is an essential concept within aikido as well as karate. Note that space and time are not separated in *maai*; rather, *maai* includes, at once, the experiences of spacing, timing, breathing, synchronizing and rhythmizing. Misattunements in *maai* are recognized as openings, and practitioners try to reduce openings to a minimum. This is not done by distancing or by thinking, but by remaining in moment-to-moment dynamic attunement. The nage gets into rhythm with the uke before the uke even moves. As a result, the nage does not fall into reactivity, but has the spatial-temporal freedom to enter into multiple possible movements that can blend with and resolve the incoming energy.

This opening of multiple possibilities is one of the keys to working with people who enter into arousal, whether this arousal is frequent, as with people with SPS or with pathology related to trauma, or less frequent, as is seen in adjustment disorders and crises. If practitioners can meet potentially disturbing energy from a position in which they can move easily and surely, then they have a better chance of helping clients reorganize toward creativity rather than survival. This moment-to-moment dynamic attunement is revealed as the well-timed response, a slight move forward or back, a change in vocal tone or rhythm, or a change in gaze. Through attention to *maai*, therapists can energetically model the management of energy that threatens to throw clients off balance, and the flexibility to quickly regain balance when thrown.

In the aikido practice of *jyu waza*, ukes may use any attack, and nages may respond with any technique. It is perfectly acceptable to start with one technique, find along the way that it does not work, and continue the flow until another technique arises. So it is with therapy. When clients travel along new response paths with therapists, it is akin to them learning a new aikido technique, a new response to an attack for which they may have previously known only one or two effective responses. The body-mind senses through the firing of mirror neurons how it feels to respond differently, thereby creating a template for recreating a healthier experience. Practice within or outside of the session helps to incorporate this new response into the repertoire of the client.

Vitality affects.

Morehei Ueshiba, the founder of aikido, directed his students, "Always practice the Art of Peace (aikido) in a vibrant and joyful manner" (quoted in Stevens & Krenner, 1999, p. 126). What does joy and vibrancy have to do with attunement? For anyone who has tried to hold on to a joyful experience, it is clear that joy happens in the present moment. Attunement happens in the present moment as well, and involves a vibrancy or aliveness that rises and falls again and again as the breath rises and falls in moment-to-moment awareness. Stern (2004) has determined that the present moment has duration of roughly 2-8 seconds, the duration of a phrase of music, poetry, or dance, and also of a phrase of communication between caregiver and child as they come into attunement. It is the duration of an experience that can be recognized as occurring in the present. Stern also noted that the present is temporally dynamic. He used the term *vitality affect* to refer to these temporally dynamic time-shapes that make up the present moment. These vitality affects are best described by kinetic terms, words such as rising, fading, sinking, exploding, reaching, and floating (pp. 33-36). He remarked:

We are immersed in a "music" of the world at the local level — a complex polyphonic, polyrhythmic surround where different temporal contours are moving back and forth between the psychological foreground and background. These temporal contours of stimulations play upon and within our nervous system and are transposed into contours of feeling in us. (p. 64)

Vickhoff & Malmgren (2004), in their discussion of why music moves us, recognized these vitality affects as the conveyances of emotion. They noted that people perceived high and low notes as spatially high and low, and that listeners tended to imitate the vitality affects of the music with their bodies. The sensorimotor dynamics of the musician and composer are transmitted to the listener, and this sensorimotor movement is perceived both as sensation and as associated emotion (pp. 17-22). Music literally moves us, and our movement creates a musical vibration that is perceptible to others.

The significance of this transmittal of sensorimotor dynamics for therapy is that the emotion that we are experiencing in the room with a client will be perceptible to that client through the vitality affects apparent in our voice, gesture, expression, and movement, as subtle as these may be. Expressions that run counter to our emotions will be picked up as contrary to other

signals we produce, and therefore will be perceived by the client as diminished coherence. The transmittal of emotion runs both ways, and the therapist also experiences, through the action of mirror neurons, the emotions of clients, as well as any lack of integration of emotion. If we are working with highly sensitive clients, their sensorimotor perception and internal imitation of therapists' emotions can be even stronger. Clients may respond in one of several ways to this perception: (a) they may experience the sensation and related emotion exquisitely; (b) they may experience the sensations and associate them with a different emotion; or (c) they may dissociate from the present moment experience, as a coping mechanism for being overwhelmed by the sensorimotor experience of others' emotions or of their mixed messages. To work with these clients requires a great deal of clarity and coherence, as well as attention to the reparation of out-of-synch attunement.

My client, Sandra, has very strong splitting and dissociating defenses to guard her from the present moment. Her affect can switch quickly, and there can be great dissonance between words and vitality affect, which can lead to my getting thrown off course. Upon considering how I would treat this energy on the aikido mat, my instinct was to slow time down, to hew strongly to a center column that reaches deep into the ground. I focus on drawing from this centering energetic pulse as I communicate with Sandra. In the most profound moments of our therapeutic work, when we are energetically joined, I often sense her movement toward "flying off." When I do notice this, I concentrate on settling myself just as I would if I had my hand on the wrist of an uke with errant energy. In this joining, we slow down and track sensations and emotions as they arise. With each new experience I let her know from this deep and centered core that I sense this experience, that it need not be pushed away, but simply observed as its vitality affect arcs through time and transforms into the next vitality affect. As this happens, we become surprised. It is unpredictable what will arise next. Letting go of expectation and patterned response allows surprise and wonder to arise. For someone who has protected herself from surprise due to a history of bad or overwhelming surprises, the sensations of wondrous surprise can be especially rich and moving. It is also a challenging journey as we can only stay in the present experience for minutes before a break is needed.

The Heart and Entrainment

It is a common practice in art and spiritual traditions to focus on a quality for a year. Last year I focused on wholeheartedness on and off the aikido mat. What I learned was that attunement was magnified as I entered into wholeheartedness, which had the qualities of both receptiveness and extension. The shifts that I noticed when focusing on wholeheartedness in my training included: greater flexibility in my joints and fluid responsiveness through my body and mind, more joy, a greater range of visual and tactile perception, easier blending, greater anticipation or intuition, quicker access and release of feelings, a sense of union with the universe, compassion and lightness with self and partner, increased energy traveling through me, and greater effectiveness with techniques. It became clear that I could perceive my partners' intentions most clearly when heart-focused, and that I transmitted my intentions most powerfully through my heart. As my awareness and intuition increased, I found much greater freedom of movement in the midst of the technique. I did not "push" the technique. This was a lesson that I could practice off the aikido mat and in the therapy room.

It has been reported that over sixty percent of the cells in the heart are neural cells, and the electromagnetic field that the heart produces is five thousand times more powerful than the electromagnetic field produced by the brain. This field is a constantly shifting torus-shaped spectrum of electromagnetic frequencies which cradle the body and which interact with electromagnetic fields of surrounding life forms (pp. 86-87). Buhner (2004) reported that energy and information most often is perceived by the heart first, and then flows to the brain. The heart also takes information from the brain about how to respond to input and further processes this response for greatest effectiveness and health (Buhner, 2004, pp. 82-83). My experience in aikido recalled my experience as a teenager guarding the soccer goal. My brain was too slow. I needed to respond before an attack was visible, to dive before I saw where the ball was going, I did this by tuning up my receptivity. The part of the body that I focused on to do this was the heart. This does not mean that the brain was not involved on the soccer field or the aikido mat. Visual and spatial processing as well as motor memory were put to work. Still, the focus on the heart made a big difference. I found that I could feel the rhythm of others and this informed my sense of the when, where, and how of their intentions. Entrainment, the phenomenon of one oscillating system coming into synchronization with another oscillating system was occurring (Buhner, 2004, pp. 59-62). Developing awareness of and capacity for entrainment — using my heart to extend and receive resonance, has served me equally well in athletics and in psychotherapeutic work. As electromagnetic as this sounds and is, this work is compassionate. It takes courage and caring to extend oneself beyond one's rhythm into that of another and to allow another to enter into one's internal heart resonance.

Robert Frager (1998), psychologist and 6th degree black belt in aikido, instructed, "If your energy is bigger than the attacking energy, then you will not go into reactivity" (personal videotape, 1998). McCraty's (1998) exploration of cardiac energy exchange between people shed light on the practice of empathy in therapy, as well as my experience in aikido and soccer. In this work, he found that as practitioners entrained themselves to clients' electrical waves, the practitioners' hearts could take on the disease patterns in the other. The practitioners then could use their somatic awareness to perceive the pattern, and employ their own somatic resources to alter this electromagnetic pattern back toward health and coherence. The client could then, if entrained by the practitioner's stronger coherent energy, follow the practitioner to greater integration and functionality (p. 359). This use by the therapist of themselves as an instrument of healing recalls practices in shamanism. Prechtel (1998) explains:

When an individual falls ill, something in his World House — Earth Body is being attacked, gnawed away, eroded, shed, burnt, dismembered, or is beginning to fade away for neglect. The shaman assesses the destruction and, after dealing with the cause, begins to rebuild the World House of that person's body by remembering all its parts back to life — by making it echo off the Original Flowering Earth. (pp. 278-279)

I believe that the capacities for resonance, for maintaining groundedness and coherence in the face of disorganized energy, for awareness of shifts in energy, and for accessing resources needed to bring disorganized energy patterns back to organization within the self, is what makes for excellence in supporting re-integration and healing for people who enter arousal easily. My aikido training and studies with people with high levels of mastery have shown me that these capacities for sensitive and grounded resonance are gained by focused, long-term training. There is something more to this training though, and that is its interpersonal nature. I may sense, through resonance, the sensorimotor quality of the disturbance. However, this sensing of the client's sensorimotor experience is slightly different and is echoing through a different body. I may associate a different emotion or different flavor of emotion with this sensorimotor experience, and I may have different preferred resources for responding to this experience. This muddy knowing, when my client and I can stay with it, is where the creative process in healing emerges. We explore the sensory experiences and the associated emotions and thoughts, then, together, begin to build resources that can allow greater wholeness and freedom for the client in responding to experiences. There is no set plan to follow. As in aikido, every technique is different, because every person and every situation is different. The collaborative creativity that allows new resources to emerge can only happen in the present.

There are dangers in resting in developed capacity for resonance or for centeredness and groundedness. The danger of developing the capacity to resonate without an equal or greater capacity to maintain center, ground and spaciousness is disease or disorganization within the therapist. Rothschild (2006), in her work on compassion fatigue, instructed that “we are most vulnerable to compassion fatigue and vicarious trauma when we are unaware of the state of our own body and mind” (p. 103). There also can be the danger of becoming smug in apparently magical perceptiveness, while losing focus on our ongoing healing and growth. The danger of developing ground and center without equally enlivening capacity for resonance is that of having solid technique but inability to move fluidly with the other and to effect change. Heckler (1984), a psychotherapist and 6th degree black belt in aikido, noted that overemphasis of ground “prevents us from being with others and moving through our obstacles” (p. 89). Overemphasis of center can result in a person who “can appear unaffected by outside forces, but there can be a loss of openness and flexibility” (p. 85). These dangers exist for client as well as therapist. People with sensory processing sensitivity can present on either side of the balance. They may be absorbed in their perceptions, lost in a world of their own, which may be expressed artistically. They may, on the other hand, overemphasize grounding, living a safe, but ultimately unsatisfying life.

Interpersonal Attunement with Sensitive Clients

The experience of highly sensitive people is often one of not being understood. If their parents, teachers, partners, friends, or therapists cannot sense what they sense, they will feel a familiar aloneness. The group of people whom I am referring to as “highly sensitive” is very diverse, from people with high-functioning autism to people who have PTSD, to those who experience very high sensitivity without comorbid disorders. Nevertheless, most of them have some degree of difficulty with attunement, particularly with people. Stern (2004) remarked that there is “a massive failure of intersubjectivity” with people with Asperger's Disorder (p. 93). This may be a result of some neurological feature of Asperger's Disorder, yet I notice that my clients with PTSD also show a great difficulty with intersubjectivity, though often with a slightly different flavor of communication breakdown than that which I experience with those with Asperger's Disorder. With all of these people I observe behaviors that belie great sensitivity. I agree with Stern that there is a failure in intersubjectivity, yet intersubjectivity is a two-way street. The person with Asperger's or PTSD or hypersensitivity has great difficulty finding a bridge to the other, and others have great difficulty finding bridges to them. It is for the want of these bridges that I believe it is very important that we train our resonant communication to have greater range and sensitivity, and that we train our ground and center to be able to hold the perception of more intense and unusual sensory-motor experiences and emotions, without going into fight and flight responses.

Most work with children with ASD and other “perspective-taking” problems is focused on bringing children back to accepted social functionality. This may work to reduce negative responses from others, however I have watched it backfire with Alex and with Michael, one of my current middle-school clients. Michael is very aware that everyone wants him to behave in a certain way. It is not his way. He is both sensitive and angry, sensing that he would have to give himself up to meet their needs. He has decided to quit speaking to and looking at most adults and peers. Mori (2001), working with a more severely cut-off child, “Moto,” reported on her seven-year weekly therapy with this traumatized “autistic” boy: “I attempted to tune into all [Moto's] subtle movements and turn to what he was looking at, looking together at the same things” (p. 162). Moto, in the first year of therapy, did not acknowledge his therapist's presence, talked in a monotone, and exhibited “many fragmented states of mind in rapid succession” (p. 161). Over time, the boy came to trust that what he experienced could be experienced by his therapist and, hence, could be made explicit. His therapist did not try to bring the boy to her world. She went to his world, observed it with him, and collaboratively enlarged the dimensions and the interconnectivity of that world

until Moto eventually could connect with others. This work was aided by work by another therapist to alleviate Moto's mother's Borderline Personality traits. Both therapies were essential to the success of Moto's integration.

Communal and environmental attunement through nature and music.

I took Alex and Ben to the wild lands because I knew that I wasn't enough. They needed to experience attunement with the natural world, to breathe the wild lands into their bodies. I needed to be in the wild with them as well. The sounds of running water, the tall trees and big sky gave me the ground and space necessary to maintain my own integration amidst the boys' often chaotic energy. It usually took about fifteen minutes for us to enter into wild mind. As we did, the strain of the school day slid off the children. Once they left the agitation of fight and flight, they could begin to heal their relatedness, first with the wild land, then with each other.

When we think of children or adults having difficulty with attunement, we often only consider other human beings as the subjects of attunement. Sewall (1999) wrote in her exploration of the ecopsychology of perception:

We commonly think of relationships in terms of other humans, drastically narrowing the potential field of relations. . . . A relational way of seeing the world places us fully within the field of our many relations, sensitive once more to the volume, the width, and depth of being within an animated landscape. (p. 124)

Cutting ourselves off from this rich web of relationship greatly limits our capacity for resonance and groundedness. The founder of aikido, Morehei Ueshiba, did not think of ground or purification or vibrancy as abstract terms. He rose each morning to greet the sun, practiced under waterfalls, farmed, and walked in the mountains. Inside or outside, he invoked the *kami*, the spirits of the natural world in his meditation and training (Stevens & Krenner, 1999). Alex and Ben were overwhelmed with the dissonant energy of the world. This energy was too big for the resources that they had within them. They needed to take in the energy of the natural world in order to hold what they were taking in each day. They also needed the welcome of the Earth, which did not judge them for their failure to connect within the realm of "normal." They, like the poet Wendell Berry (1980) needed to "come into the peace of wild things," where they could "rest in the grace of the world" (p. 178).

One day, Alex was impatiently waiting for Ben to finish tying his shoes. He picked up a stick and started whacking a tree. I directed him to whack on something that wasn't alive. He started drumming away on a wooden bridge. Soon Ben joined him with a couple of big rocks in the creek below. Then Alex switched to the air guitar and Ben took up on the bridge. I found a place in between and made sounds that could hold their two instruments in concert with each other. Ben was making whooshing sounds that mirrored the sounds coming from the trees high above us. Alex exclaimed, "I'm hearing a song!" Ben yelled, "I hear it too! I'm going to sing it!" He began to sing, "The wind is free! The trees are free! We are free! Everyone is freeeeeeee!" The boys sang and played for a long time. In a redwood glade by a spring-fed creek they turned the movement inside them, their emotion, into rhythm and melody and sent it out. This internal motion was fed by the motion, the aliveness, of the trees and the wind. I believe that the trees and wind, in turn, were moved by the boys' song. I know that I was.

Vickhoff & Malmgren (2004) strove to answer the question, "Why do we have music?" They argued that "music has the power to bridge the ontological cleft, manifest in self-consciousness, between ourselves and the world" and that "music by means of entrainment has the power . . . to give us reminiscences of paradises lost" (p. 21). This was the power of music I experienced when Alex and Ben were singing at the bridge. Music serves to connect us in the moment with other beings and life around us, including the wind in the trees. I do not think it is coincidence that my four highly sensitive adult clients are so deeply connected to music. They have difficulty with connections with others, but they have a deep drive to connect at an exquisite level. Music can meet them there. Composers and musicians strive to be true to emotion in their musical works. Listeners can perceive this veracity and feel connected, sharing direct experience with the musician, even if the song is recorded, and even if the composer is dead. This does not only connect the listener with the musician, but also to all who are moved by the song.

While it may not always be possible or appropriate to sing with our clients, an attention to music, and training in music, can greatly serve the work of therapist and client. Music, like dance, or martial arts, brings us to present experience, which is the only time in which we can change. Harmonizing and improvising with someone wakes us up to the notion that we are vibrating constantly, taking in and sending out waves of energy. Practicing, even with the car stereo, develops our ability to resonate. Practicing with another develops our ability to give and take energy, to go off and to regain balance, and to express and modulate our emotions while responding to the emotions of others. My singing practice is for me a practice of listening to the vibrations inside and outside of myself and then bringing them into form. I have found that when I sing for people, I would first sing the energy near their surface. The song develops, changes, and eventually resounds with the core energy of the person or group, reinforcing the coherent energy that exists at this core, and connecting it with other supportive energies. I am finding in my work with clients that these sounds are perceptible, even when I am not sounding them out loud. I can sense the vibration at the surface and at the core. I believe that as I gain capacity to hear and respond to these sounds truly, my own energy will align with the supportive vibrations needed to help understand and integrate disparate energies with core purpose. Recently, I received a shamanic healing session from a practitioner who studies intensively with Quechuan shamans in Peru. When spirit guides instructed her to sing a particular song, her voice temporarily did not work. The guides told her to sing it anyway

(without sound), that I understood music, and it would be fine. I felt the song. I think that our clients feel the song, too, especially when it is sung clearly at a propitious moment.

Conclusion

While the focus of this exploration has been on attunement with people with high sensitivity, this work applies to all people. The fragmentation of society and the deep fractures in our relations with the earth can only be integrated through greater sensitivity to the energy signals of all beings, as well as a greater capacity to align our centers with our purposes to live between heaven and earth. Those who are struggling with high sensitivity are alerting us to the critical need for healing throughout the world. Practices that serve those who suffer disease from fragmented connections will serve all who wish to live together in health and relatedness.

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Positive Development for Persons with Trauma Spectrum Disorders

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Abstract

The author describes a program in development oriented toward alleviating suffering and supporting positive development for people suffering from a variety of trauma spectrum disorders. It is based on the two pillars of body and community. The body orientation is *somatic-energetic*. In describing the program, the author also intends to describe the *energetic point of view of bioenergetic analysis*, and the concept of *group as community*.

Keywords

Trauma spectrum disorder - Bioenergetic analysis - Somatic-energetic - Community group - Veterans

INTRODUCTION

The primary focus of this paper is the description of a program in development. The description of the program is the context for three focuses. One is the idea that a group can have a strong therapeutic function when it is developed as a community. Second, I will describe some features of the somatic-energetic theory, technique, and processes that characterize bioenergetic analysis. Third, I have in mind questions about the nature of trauma spectrum disorders and what therapeutic action is useful in helping people with these syndromes.

The program is intended as a resource for individuals suffering from a variety of traumatic stress syndromes, or trauma spectrum disorders. I use the word '*program*' deliberately. Another word might be '*course*,' as in a *course* in a college. I am not emphasizing diagnostic categories, such as '*post-traumatic stress disorder*,' although the program is definitively designed for individuals suffering the effects of traumatic stress (either by their own definition, or that of a caretaker), and that would include P.T.S.D., Posttraumatic Personality Disorder (Classen, et al. 2006), as well as other syndromes. Although I avoided, for the moment, calling the program '*therapy*,' it is unquestionably designed to alleviate suffering and facilitate healing and positive life development, so in this sense, it certainly is a therapeutic program.

As a trainer in bioenergetic analysis, I have thirty consecutive years experience working in a way very similar to, but not exactly the same as, the program I am describing. Most of the individuals participating in the bioenergetic training groups are therapists, a highly self-selected group. At the same time, if I were invited to give an estimate as to how many of these people could be said to have been characterized by '*complex developmental trauma*,' I would be inclined to say, "A conservative figure is eighty percent."

The program I am describing here represents, then, a slight shift from what I have done up until now in two important ways. I envisage expanding the application of a familiar format to groups of people with whom I am not entirely familiar. These people would come from a variety of walks of life and be living with a variety of kinds of trauma spectrum disorders originating in a variety of circumstances. I do not have direct experience with a wide variety of such syndromes, and in today's world one does indeed find a huge number of people traumatized under a wide variety of developmental, socio-political, and natural circumstances.

Second, I am making serious modifications to the familiar format. For one thing, these modifications require a shift in role considerations which go very deep. For example, for this program, I might use the terms '*student-teacher*,' rather than patient-therapist. While this applies also in the case of a bioenergetic training group, the roles in therapy are usually conceived in different, professional, terms. In the new program, teachers relinquish their roles as '*expert*'. Here, we all face together a common reality, all have a common need to develop and learn, and all seek a strong positive movement in our lives.

Also, while the student in the new program might speak of healing (and I hope that he or she would), the teachers will not introduce the work in those terms, until the students have validated such terms, and the teachers will not offer themselves as therapists. The teacher will offer guidance in helping each participant find "what works for him/her." These distinctions are in the service of aiding the participant in his own learning and, from the beginning, finding the way that emerges from him/her-self. Anyone who has struggled with the role of a therapist, and what therapy is, will appreciate the potential implications of these shifts.

I believe this is an innovative program in the field of work with people suffering from trauma spectrum syndromes (developmental or adult trauma). One aspect that is innovative is the overall structure, its integration of the two "pillars" of the program which I will describe soon. Another innovative aspect is the conception of the nature of trauma and the therapeutic action relevant for it. This is discussed at the end of the paper.

Another innovative aspect of this program has to do with social factors of different orders. I envisage this program as what a friend of mine likes to refer to as a "disruptive technology." The meaning of this is that it impels a social group to view a given subject in a different light. I believe this program and its use could cast a new light on some of the problems associated with the therapy of PTSD and other trauma syndromes and the very nature of these syndromes. In doing so, other professional and institutional arrangements are suggested for treatment, rehabilitation, and their delivery. For example, while it seems self-

evident to many of us that somatically oriented therapies should be at the center of any trauma treatment program, these in fact seem to have little access to most academic, medical, or veterans institutions. I would be happy to be proven incorrect in this assertion.

The very definition of PTSD has a political significance. How the syndrome is established in the diagnostic and statistical manual affects funding for institutions and researchers and compensation to veterans and others. Further, just as Herman (1992) described years ago, the way in which a society provides for or relates to its traumatized members and how the various professions deal with trauma, depends upon the socio-political climate of the day. Nowadays, virtually never-ending wars bring into a country many traumatized former soldiers. This exerts an enormous pressure on governments to care for and compensate. On the other hand, making too much of this sad reality socially and politically could possibly create a powerful force for deterring war, reminding a population of the terrible price, mostly invisible, and mostly paid by the younger generation. This reminder is unbearable, and actually becomes a kind of social trauma in its own right.

There is a significant feature of the overall field of trauma studies and treatments that is important for the context in which this program is being introduced. The field is in fact quite fluid in some ways. While cognitive-behavioral techniques of various kinds are often considered state-of-the-art, evidence based techniques, there are several different approaches within the larger cognitive-behavioral domain, and these approaches continue to evolve (Follette, et al. 2004; Hayes, S.C. 2004; Monson, et al. 2007; Shedler, 2010). Paradigms are shifting.

In some clinical settings, the therapeutic paradigm involves an amalgam of various protocols (Follette, et al. 2004). The clinical process by which choices are made between various approaches and various aspects of different approaches lies outside the protocols of the specific therapies which make up the amalgam. What is the theoretical basis for these choices and the therapeutic process other than the clinician's sensitivity, creativity, and experience? An understanding of somatic-energetic process and theory can fill this gap, allowing for more holistic process. In addition, "third wave" (Monson, et al. 2007, p.47) cognitive-behavioral techniques are being developed which frankly include or are based on, not learning theory, but on conceptions such as mindfulness and acceptance (Follette, et al. 2004). These practices are in fact embedded (in theory and in practice) in bioenergetic analysis. The development of treatment/ education programs for individuals who suffer trauma spectrum disorders is still very much an open field and one in which there seems to be a clear space for the kind of program here set forth.

Epidemiological studies estimate very large numbers of people who are significantly affected by traumatic stress at any given time, and that the majority of people will be so affected during the course of a lifetime (Norris, Fran H., Slone & Laurie B., 2007). These figures themselves justify a consideration of any program, especially one involving groups, which will provide another avenue for people seeking relief.

The program I am presenting is an alternative and one that hopefully will stretch the field. It offers a new context in which to look at and learn about some very common forms of human suffering. I would like to understand more about what happens to a person when she/he is traumatized, either as a child or an adult. I want to learn more about these things, not just in medical or neurobiological terms, but in human terms. What happens to the individual as a person, whether the trauma is in childhood or adulthood? Can we learn more about alleviating suffering, and can we introduce into our lives greater possibilities for positive life development?

AN OVERVIEW

I use the term "trauma spectrum" (Scaer, 2005) disorder to refer to the wide range of suffering, disturbances, illnesses, painful conditions, and life disruptions manifested in a seriously large proportion of today's populations and which are understood as developments that follow exposure to traumatic stress experiences of various kinds. PTSD is only one such condition. The extensive list of the sources of traumatic experience is all too familiar: combat, terrorist activities, sexual and domestic violence, loss of a spouse or sudden death of a close connection, medical trauma, motor vehicle accidents, refugee and displaced person status, political imprisonment, torture, starvation, exploitation under totalitarian regimes or occupied territories, and, of course, various forms of physical and sexual abuse of children, and exploitation of children as slaves and soldiers. So goes the trail of sorrow and tears that flows over today's world. Shouldn't we call this "the age of trauma?"

This new program rests on two pillars: body and community. The program offers a milieu for the alleviation of the suffering associated with trauma spectrum disorders or syndromes, for facilitating personal development, for the learning of skills for sustaining continued personal responsibility for development, and for establishing a mind-body-emotional conception of the positive possibilities for life.

I believe it has several distinctive features, which, in combination, offer a new view of working with and learning about those who suffer from trauma spectrum disorders. The program is best conceived of as an "education," as if it were a "course" in a college, rather than as a therapy. The leaders are educators, facilitators, or trainers, more than, or equally as much as, "therapists." The ideal goal is for participants to find their own ways, their own meanings, and their own tools for positive development, not alone, but in community and with guidance and support.

The features of the program can be summarized as follows:

- ❖ We come together as a group and develop as a community. Each of us depends on the others.
- ❖ Within the community we learn about ourselves through our bodies; we find tools for support, calming, and grounding, in our bodies; we find processes for integration in our bodies; we learn how the resources of our

bodies guide and lead the process of freeing from the past, and moving into a positive way of life in the present; we learn about the healing potential of pleasure in the body.

- ❖ We learn the few basic relevant biopsychological facts about the nature of our traumatic condition.
- ❖ We learn in and from the relationships that develop in the group; we learn an equalitarian mode of relating between peers, between students and teachers; we learn self-respect and respect of the other.

SOME BACKGROUND

A somatic-energetic approach to treatment of any kind is not intuitively grasped by a clinician or practitioner who has not experienced such work. Like any deep therapy, it needs to be experienced to be grasped. For those who practice such work, it is the most natural thing in the world to view the body oriented therapies as the mainstay of treating people afflicted with trauma spectrum disorders. Here, I wish to convey an impressionistic description of what I choose to name *somatic-energetic* work. This description is based on my understanding and experience in practicing and teaching bioenergetic analysis.

The most obvious feature of a therapeutic session in bioenergetic analysis is that the client at some point will be engaged in a non-verbal process, a movement, a focus on respiration, or simply a focus on body-awareness. The therapist or teacher looks at and observes every nuance of bodily expression with just as great attention as is given to listening to the words of the patient or student. In our groups, we engage in bioenergetic “exercises” together; moving, breathing, and experiencing our bodies, without talking, although often with sound and emotional expression.

What I imagine to be unusual, say to a traditional verbal therapist or to a cognitive-behavioral therapist, is the conception that healing, awareness, and integration can proceed non-verbally. Through all of my own professional development and education, such a conception was not just foreign, it was unknown. My first two degrees were in philosophy (Cornell University). I believed in the life of the mind! I turned to the study of the life of the mind in psychology, (Ph.D., clinical psychology, Harvard University). I still lived the life of the mind, the intellectual life.

I also had many useful years of psychodynamic therapy. So my shift from a psychodynamically oriented therapist to a bioenergetic analyst was a major transformation. It started first with training in family systems therapy. My trainers got me up out of my analytic chair and analytic position, and into action amongst, with, and around a family unit. I was quite shocked initially. This stuff was disturbing!

Even more disturbing – and enlightening! – was a visit to the Esalen Institute in California, a year or so after completing my degree. Here, for the first time, I experienced various bodily oriented practices, including yoga, tai chi, sensory awareness, gestalt therapy with the focus on the body, and rolfing. After the first week, I had a massage. I cried deeply; I felt a healing. I walked by the ocean. Even the rocks seemed alive. I spent a few months there. My body came alive, my emotions opened up, and my world view expanded.

After the Esalen experience, I took up the study of bioenergetic analysis (around 1970). I found it to be the most developed and professional of the body modalities then available; and I believe it still is. I was drawn to the expansive, open, aliveness of the work. The teaching and standards were professional; theory and practice were observationally based; and there was an ideal of a clinical position grounded in contact with one’s own body and empathic resonance with the other. I saw that there was an ongoing development of the therapeutic technique. Indeed it was abundantly clear that the therapeutic technique and theory were in need of much further development. All of this seemed analogous to the only other in-depth therapy I was familiar with, psychoanalysis.

As it turned out, the journey, whose first steps were taken in 1970 on the coast of the Pacific Ocean in California, has continued now for forty years. The benefits for me personally have been extensive, even life saving. Some thirty years ago, I began training others in bioenergetic analysis, first in Massachusetts. Subsequently, I led training groups in Norway and then in Israel, where I am now a citizen.

FORMAT OF THE GROUP

Before proceeding further with the “soul” of the work, I want to give a picture of the format of the group that is at the heart of each program. What I mean by “format,” in this context, has to do with the basic practical arrangements for any given course. I recommend a group of from eight to twelve participants, meeting for eight two day workshops, probably weekends, with two leaders and one or two assistants. If weekend workshops are not feasible, flexibility is called for, and other schedules can be framed. In any case, the duration of the course should be established at the start.

The participants should have in common the type of source of their traumatic experience; e.g., women dealing with sexual abuse, either from adult life or childhood; men also should have their own group for dealing with sexual trauma; military personnel returning to civilian life or recuperating from horrifying battle experiences; victims of terroristic attacks or sudden traumatic losses; and so on.

A workshop day can be from 9:30 in the morning to 5:30 in the evening. Participants should be encouraged to remain quiet during evenings of workshop days, to stay with partners, family, or friends, quietly, so that the experiences of the day can stay with them in a calm way. Going out, socializing, or going to entertainments may be enticing as a means to escape from

difficult feelings, but such activities will suppress feelings and end up further igniting already sensitized neural networks, adding to disturbances rather than calming them.

A lunch break is very important. Lunch should be a communal ritual, as in a family, with shared food at the site of the workshop. A nice way to do this is for each person to bring some portion of the food.

A group should be encouraged in the development of its own rituals. For example, prayers or blessings over meals, or at the beginning and end of a day, are spiritually meaningful and deepen community. Rituals, like the meal together, deepen community, quiet over-excitation, and soothe the limbic system. Regularities in the format can take on ritualistic aspects, such as beginning each day with body awareness and movement, returning throughout the day to an awareness of breathing and grounding exercises, and structured, contained ways of verbal sharing.

I recommend a “buddy system” for the time in between workshops. Buddies are to check in with each other at least once a week. Buddies should rotate every month. Check-ins are preferably by telephone, rather than e-mail. Face to face check-ins are alright, if urgently needed, but usually not necessary. Buddies should help each other not succumb to resistances such as wanting to flee from the group, antagonistic or persecutory feelings in relation to other participants or leaders, or feelings of giving up. Another important feature of the buddy system that contributes to community is that it gives each individual the opportunity to care for another, in a limited, bounded way. This contributes to a sense of well-being and belonging.

GROUP AS COMMUNITY

A group is not necessarily a community, and generally, groups may or may not evolve into a community. In our courses, we deliberately foster development of the sense of community. In a community, each is receiving and contributing in equal measure. The trainers, their curriculum, and course goals are seen as the framework or boundary principles that establish a container. The difference in roles does not entail a difference in status. The teachers are present in the same way as students, “body and soul.” We share a common reality. The teachers are there as teachers only because and as a function of their own experience and learning about their own traumas.

I have always been impressed how our bioenergetic training groups almost always evolve into community. They become a very rich, deep milieu for learning and for personal development. There are deep ties between participants, participation becomes a source of identity, and “The Group” takes on a significant meaning as an internal object in the mind and life of participants. Teachers foster the development of community by assuring that each member has equal place, and each member is respected in his or her individuality. Further, mutually shared exercises require the support of others and convey that each person is needed, and we each rely on the presence of all the others.

As much as anything, the very nature of the experiences occurring in the training or course milieu fosters community. The primary learning is experiential, focus is on the body and bodily expressions of character, and on emotions and current personal reality. Group exercises also facilitate community. Moving, breathing, “energizing,” feeling together as a group – all these foster community (Dingfelder, 2010).

Since our purpose is to understand the current functioning and development of each person, participants have the opportunity, to the degree they are safe and comfortable, to share themselves in profound ways. In the community, it is possible to momentarily open defenses to a degree, even to the point of surrendering to the parts of oneself that are personally unacceptable or socially non-functional. This can be a great relief. Shared emotional experiences at this level also create a network of bonding. Almost always, a shared sense develops that being in the group offers an opportunity to be more directly in one’s own and other’s human reality than usually occurs in daily or professional life. The course experience is treasured for that reason.

Leaders are there to sustain clarity of goals, boundaries, and guide the overall course of learning. Leaders help regulate and contain strong emotional experience. Leaders can also guide participants to find for themselves meaning and therapeutic significance to otherwise painful emotional experiences. While leaders or trainers may be seen as having an expertise or level of knowledge and familiarity in relation to the kinds of emotional and interpersonal events occurring within the milieu, it is clear that their purpose is to use that experience to guide trainees in their own learning. Leaders recognize equality between themselves and participants.

There is a didactic portion of the workshop for presenting basic information on the psychobiology of trauma. However, the essential learning is based on and related to immediate experience. Since the subject of study is the self – in all its somatic and psychological complexity – the approach to study has to have a non-pressured rhythm, a sense of existential being, compassion, and a here and now timeless quality. Such learning cannot be hurried. There is no test to cram for, no fund of information to be memorized. Concepts, schemas, and theory are in the service of seeing, understanding, and sorting out experience. This type of learning becomes the basis for a shared set of values, enabling a unique “culture,” and deepening the meaning and sense of community.

The BODY and LIFE PROCESSES

Within the milieu of the community the focus is the experience of the individual. The milieu of the community facilitates, supports, and even creates forms and ways of experiencing not otherwise readily available. The community milieu is usually good enough so that the experiences generated within it provide the basis for individual learning, developing, and healing traumatic injuries. The community also is the holding milieu for interventions that focus directly on the individual. Individual interventions have two common forms within the group. A teacher may work with one participant while others witness. Participants may work in dyads or triads, one acting as “therapist,” the other as “patient,” a third as observer, with trainers or assistants supervising and witnessing the various dyads or triads. In our groups, these interventions will most commonly have a somatic-energetic focus, with narrative “sharing” at some point.

I will give an example of what some of the somatic interventions might be like. This example forms part of the background I began describing earlier, and it comes from my first experiences as a trainer. Participants invested emotionally in the group as in a community and often had powerful emotional experiences over the course of a weekend. I did not know much about trauma psychology at that time (1982), but I had a very strong impression that I expressed to myself in the words, “These reactions look like post-traumatic reactions.”

The experiences I’m referring to would emerge as a result of the work with the body (“energetic” work): work with respiration, the use of basic bioenergetic movements and positions, such as grounding (Lowen & Lowen, 1977/2003), and the observational study of the body, its flow of energy, aliveness, and its blocks in the flow of energy. We practiced “reading the body,” seeing how present functioning and past experience are reflected in the form and motility (capacity for movement and feeling) of the body.

When the focus for an individual became both alive enough and precise enough, he or she might have a strong emotional “breakthrough” or reaction. This was the result of a deeper contact with the self. A person would have the feeling of experiencing the pain, sorrow, and rage of some aspect of a developmental experience. In the safety of the group, deep emotion could find expression, containment, and resolution. These experiences would be very freeing for the individual and also for the group.

These experiences are “energetic phenomenon” in the following sense. The body (or “energetic”) work had, (a) allowed a deeper somatic-energetic contact with the self, and (b) had allowed the release of a quantity of energy, in the form of emotion, movement, and sound. Everyone present *senses* the behavior as a deeper contact and as a release of energy, and everyone has the sense that this quantity of energy had been contained, or held, in the body in potential form through the years. It is also clear that the energy has been contained by the individual’s characterological defense, and even that it has been used in the service of characterological defense. It also seems evident that the energetic potential had originated in aspects of a traumatic experience which had not been discharged or integrated at the time. These several qualities were evident to us as observers.

Observation of these types of energetic phenomena were first recorded in therapy by Wilhelm Reich in 1933 (Reich, 1945), and it is a type of observation that is still a focus for body-oriented therapies of all kinds. These are the same kinds of responses described as releases of energy from previously undischarged autonomic freeze responses (Scaer, 2001, 2005; Levine, 1997). The bioenergetic view also attributes an essential core function to autonomic reactivity in these responses, as did Reich, from the beginning of his work (Reich, 1961).¹

The developmental origin of these experiences is understood as having been traumatic stress for the individual during childhood. This means that the experience is of an overwhelming kind that the child can not do anything about, and there was no relationship in which the emotions were held and discharged through expression and communication. Under these conditions, the experience threatens safety and integrity, and it becomes an internalized, threatening object. The child has to use its own developmentally limited resources to manage the experience, and it also has to use biological resources to adapt to the internalized object. Energy and aggression must be used to build defenses and coping mechanisms in relation to the internalized object. These will allow the individual to eventually develop some degree of emotion-regulation and self-regulation, although there will be residual distortions, deficits, anxiety, and problems in coping. In addition, the internalized object affects the conception of the self and the perception of others. In this way the trauma is the core of the formation of a neurosis (Angyal, 1965) or a character neurosis (Reich, 1945).

Body-oriented therapists often refer to the workshop experiences described above as “body memories” (Rothschild, 2000). These experiences are in fact memories, although they are not expressed as a verbal narrative. They are referred to as “body memories” by virtue of the fact that they are stimulated, evoked, or prompted by stimulation of the body or the senses, and by raising the energetic level of the body through respiration or movement. There is no implication of some kind of memory system residing in the body, outside of normal brain neurology.

As our work in bioenergetics developed, we learned to use somatic-energetic techniques to facilitate integration and healing with a wide diversity of characterological formations and energetic phenomena. Containing and calming ongoing chronic reactivity of various kinds, for example, is especially relevant for trauma spectrum disorders. In our practices as bioenergetic therapists and in training programs we have worked with these “complex developmental traumas” for many years.

¹ A detailed description of the development of Wilhelm Reich’s conception of energetic phenomena is found in Helfaer (1998/2006) and Helfaer (2009).

THE ENERGETIC POINT of VIEW and LIFE PROCESS

Working with the release, identification, and integration of “body memories” is only one paradigmatic illustration of how we observe participants from a somatic-energetic point of view. I will describe briefly a few other aspects of that point of view, including further description of energetic phenomena.

First, I want to consider the nature of traumatic experience. A simple, relevant definition of traumatic experience is that it is a “biospheric event” (Angyal, 1965), an interaction between the organism and its environment, which impinges on the person in a way that he or she cannot manage within the limits of basic life patterns or functions. It is an experience he or she “cannot do anything about.” What makes an event “traumatic” is not what it *is* but what it *does* and this cannot be predicted before the event (Angyal, 1965). Angyal understood that a trauma is the core of neurosis; Reich also saw traumatic experience at the heart of neurotic character formation. As I conceive of the bioenergetic point of view, traumatic experience stops the individual’s life movement (Helfaer, 1998/2006).

For the relevant aspects of “life movement,” Reich (1945) coined the striking phrase “the expressive language of the living,” referring to the spontaneous bodily expressions he observed as he worked character analytically with people. While this expression is non-verbal, it nonetheless has graphic emotional meaning which everyone can understand because we all have similar bodies and expressive functions and the inherent capability for mirroring and empathy. Alexander Lowen (1958/2006), Reich’s student, and founder of bioenergetic analysis, spoke more simply, but with equal aptness, of “the language of the body.” The expressive language of the body in its various manifestations can be considered “energetic phenomena” (Helfaer 2004).

A discussion of magical or mystical ideas about energy is unnecessary. Here, it is simply important to point out that amongst serious scientists and scholars within diverse fields, the concept of energy is a given: Schore (1994) in the field of affect regulation and the origins of the self; Siegel (1999) in neuropsychology and the relational development of the mind; and Rizzuto, et al., (2004), and Meissner (1995) in psychoanalysis. Siegel (1999, p.2) for example states, “the human mind emerges from patterns in the flow of energy and information within the brain ...” What we have in bioenergetic analysis as part of our way of looking and seeing is an “energetic point of view” (Helfaer, 2004).

First Reich (1945) and then Lowen (1958/2006) described what can be understood as the general principles of the flow of energy in the body, and the energetic phenomena (movement, feeling, affect) that go with it. The significance of this kind of description is that it is an observational tool essential for seeing and understanding the person in front of one, for understanding one’s self, for understanding relationship, and finally for initiating appropriate interventions in a therapeutic setting.

Essentially, the phenomenology of energetic expression is a fundamental aspect of the experience of the self. To be “in one’s body” or “in contact with one’s body,” is to experience the body’s energetic state. The pervasively used concept of grounding is in fact based on what Lowen described as a pendular swing of energy between head and tail as the individual stands upright, with feet on the ground (Lowen, 1958/2006).

There is a vast common vocabulary pertaining to this aspect of the self. Consider one affect domain that is universally present in everyone and that often has a particular place in the experience of anyone who suffers in a trauma spectrum state: this is *shame* (Schore, 1994; Helfaer, 2007). There are many behaviors we understand as ways of avoiding or protecting ourselves from shame: hiding, rage, blame, contempt, avoidance, and so on. On the other hand, the many ways of speaking of shame are expressions of the body state that is its basis: wanting to sink into the ground, a sinking feeling, a burning shame, humiliation, a feeling of failure, inferiority, and so on. All these words describe a kind of shift in the energetic flow of the body: a contraction, a drawing in, a freezing, a stopping. The hanging head, and collapse in the body of a shamed person, expresses this in the “language of the body.” Such an expression contrasts markedly with the “standing tall” of someone in a state of expansive pride, success, well being, or happiness. This vocabulary of the energetic state is only spoken authentically when one is in contact with the body experience.

It is typical of shame that the experience is divided into a somatic component and a mental component. This involves not “shameful thoughts,” which are in fact shameful experiences, but all the reasons, rationalizations, arguments, self- and other- accusations, and so on, that may accompany shame. The issue here is that over-involvement with the thoughts, (“the head”), diverts awareness from the body state of misery. From a bioenergetic point of view, the cognitive aspect is not causal, it is a defense or adaptive function. The body misery is primary, and the body is the most effective locus for release, relief, healing, and “treatment.”

The mindfulness developed in bioenergetic practice is a body mindfulness, and it is based on contact with the energetic condition and flow in the body. Because of this, mindfulness can be a tool for managing disturbing affective and energetic states, including states of over- or under-arousal.

CURRICULA, the BODY, and SUFFERING

The core of the life of the group, the soul of its experience, on any given day of its meeting will center around somatic-energetic processes and experiences. Such experiences can be organized for the whole group, or for dyads, or triads.

These experiences are very carefully planned and organized, and they have very specific functions. They will be organized to address specific forms of general issues present for the group. Some of the important general issues will usually include:

1. Calming down either hyper- or hypo- arousal. The use of somatic-energetic exercises can be utilized to establish a more balanced cycling between sympathetic and parasympathetic autonomic processing in relation to how the individual is affected by, or reacts to, stimulation from within the organism or from the outside. The effectiveness of somatic-energetic techniques in regulating such common stress experiences as irritability, anger, depression, anxiety, and feelings of stress can then be experienced by the individual. This can be the basis for an increased confidence in the ability to self-regulate. The somatic techniques used can be taught in such a way that the participant can use them in daily life. This work involves use of familiar bioenergetic exercises and processes such as grounding, work with respiration, establishing boundaries and containment, and discharging tensions and aggression (Lowen & Lowen, 1977/2003).
2. Establishing the capacity for contact with the bodily (somatic-energetic) self. This kind of learning is ongoing and essential for helping the individual establish a more regulated, less stressed, and more fulfilling way of life. Contact with the self via the body allows one to identify one's own experience, feelings, and thoughts; to learn a regulated form of self-expression, of either positive or negative emotions; and, in the long run, it establishes a stronger sense of self.
3. Establishing the sense of the integrative capacity of bodily experience. This learning takes place "by itself," so to speak. It occurs when a sense of integration follows a non-verbal, somatic-energetic experience. Participants discover that they do not necessarily have to struggle in their minds to "understand," and that a sense of integrative wholeness is not the product or outcome of a cognitive, mental process. Rather, one is likely to discover that following an integrative somatic-energetic experience, a "solution," or "understanding" of some aspect of the self emerges on its own.
4. Learning about bearing pain and suffering. It is not the goal of a therapeutic or healing program to "overcome" the deep personal pain in the individual's life. It is possible to change our relationship with the pain, painful realities, and suffering. We can learn how our defensive operations are self-defeating and energy consuming. We learn that "surrender" or "acceptance" does not mean "succumbing" to death or humiliation. Such are the difficult learnings everyone must discover in their own ways. When the individual can experience, bear, express, and share his or her pain – *as his/her own* – healing and change have the chance to begin. Community context and bodily grounding are enormous aids in feeling, bearing, containing, expressing and – ultimately integrating in some fashion – unbearable experience. Terror, fear, grief, humiliation, shame, and terrible emotional pain, as well as more complex, negative disturbances to identity, reside in most post-traumatic reactions.
5. Towards calmness, peace, and pleasure. Happiness is not a given for most people, and most people have lost what probably should be a natural aptitude to live life with some calmness, peace, and pleasure. This is certainly most often the case for people suffering effects of traumatic stress. It is often as if life can never again feel good. Somatic-energetic work and experiences are one of the best reminders that life perhaps can feel at least a little better. If I am going to feel good, I have to feel good in my body. Often, one immediate effect of bioenergetic exercises is to feel "relief." This is an important beginning.

Each group is approached as unique, and the "curriculum," while having similar processes and approaches in all cases, will also have unique issues requiring unique approaches. In addition, there is distinctive planning for each session, depending on the group's experience, functioning, and development. While the core of the course centers around somatic-energetic experience, there is also verbal sharing. It is important to learn to share verbally and, at the same time, stay in contact with the self, stay grounded, contained, and not dissociate by entering into an unconnected mental space. Finally, as noted earlier, there will usually be a small didactic portion on most days, a kind of psychoeducation, concerning the biopsychology of trauma.

DIFFICULT MATTERS

Difficult matters abound in our work, however we go about it: pain and suffering of the worst sorts; grievous injury to self, body, and soul; grievous and inconsolable loss; seemingly destroyed lives and dreams; unbearable experiences of terror, horror, and evil; bodies left in terrible states of tension; and people re-living destructive experiences.

There is another type of difficult matter, in some ways not as terrifying, but in other ways even more difficult. This has to do with the terribly complex, confusing, and convoluted developments of the mind, personality, and body that often evolve over time following exposure to traumatic stress, either in childhood or adulthood. Complexities of behavior and bodily dispositions stimulated the nineteenth century explorers of hysteria, Charcot and Janet, and Breuer and Freud. Following in

their tradition, Scaer (2001, 2005) discusses a variety of medically complex dispositions, behaviors, and pain syndromes which he relates directly to psychoneurological developments arising from traumatic experience. Here I want to mention a few psychological difficulties that I do not find addressed in the literature and which are the subject for future work.

1. The traumatic identity.
2. The nature of aggression.
3. Brutalization, internalization of violence, internalization and reliving of violence.
4. Desperation.
5. Humiliation.

Some or all of these issues will surface in most groups. The individual subjected to brutality may become “brutalized” in the sense that being brutal in return is a kind of defensive outcome. The bullied child may become the bully; the soldier allowed to brutalize the other loses empathy, becomes harsher, armored, callous, and may lose contact with his own life (Elizur & Yishay-Krien, 2009).

In addition to the shame, humiliation, and sense of failure that may be engendered by traumatic experience, the individual secretly holds a negative sense of identity that can be degraded to the point of feeling inhuman, “beyond the species” (See “The Hated Child,” in Helfaer 1998/2006). This happens particularly as a result of childhood trauma, but it can be fostered by adult trauma as well.

While the traumatized individual may be considered aggressive, it is usually a self-defeating form of destructiveness that is involved. In fact, the traumatized individual may be “broken,” in body and spirit, in such a way that he/she does not have the constructive capacity for aggressive movement towards his or her own goals. The movement is stopped.

Desperation is often the outcome of various kinds of traumatization, in childhood, and later. Desperation is not the same as anxiety. It is a form of chronic arousal arising when movement is stopped, there is an ongoing sense of lack of safety, and a deep conviction of the impossibility of ever meeting basic needs for contact, love, and sexual intimacy, or even rejoining the human community. I believe that profound humiliation often underlies desperation.

THE BODY and LIFE PROCESSES: FROM FEAR TO PLEASURE

The organismic, somatic-energetic point of view informs our way of looking in bioenergetic analysis and in courses for trauma spectrum disorders. Another paradigmatic example of this point of view is found in Reich’s early work. He reported finding a profound fear or terror under the layers of character defense, after the energy of the traumatic memories had been discharged. Many contemporary traumatologists also see fear, terror, and horror (Lowen, 1972/2005) in the core of post-traumatic adaptations.

In the several years following his first descriptions of the release of energy in “body memories” resulting from systematic application of character analytic technique, Reich found a different set of energetic phenomena (Reich, 1945, Ch. XIV, “The Expressive Language of the Living”). These pertained not only to fear, anger, and traumatic memory. More importantly, they led in the direction of further release and freedom from guilty fixation on the past, towards an increased potential for pleasure, sexual feeling, and a general sense of well-being in the person’s present life.

This set of observations related to regularities in the organization of muscular armor, (the chronic muscular tensions or holding underlying character formation), and the energetic phenomena observed when holding is released. Armor is seen to be arranged segmentally. Seven segments encircle the body at right angles to the longitudinal axis of the body, from head to toe. The segments are defined functionally, not anatomically. Systematic release of segmental armor allows fuller respiration and a flowing motility, as if a wave of energy travelled the length of the body and back, a full-body pulsation. The pulsatory quality of this phenomena is based on precisely the same pulsation as that of the heart, the intestines, and any single cell. In simple terms, the fuller the pulsatory quality of the body, the greater the capacity for a relaxed sense of pleasure and well-being.

Thanks to Reich’s genius, we can glimpse here the complexity of human organization! Simple pulsation underlies all aspects of mental, emotional, and somatic functioning, and their interrelationships. This pulsation also has its own forms of organization and functional principals, and interventions are available (in bioenergetic analysis) to directly address the pulsatory functioning of the organism and person. Understanding these energetic phenomena enormously deepens our understanding of the person in front of us and broadly enhances the possibilities of helpful interventions or guided learnings.

This basic knowledge is relevant in arranging somatic-energetic work in such a way as to direct it towards not only helping people calm down, but to ultimately help them increase the capacity for goal directed action, relaxation, and pleasure. It is no easy matter to move from tension and arousal to relaxation and pleasure. Hyper-arousal is not an energized state, it is a state of tension, as is hypo-arousal. Calming down means relaxing, and in a state of relaxation, one can be energized in the calm way that permits pleasurable states. Pleasure heals.²

² For a further description of bioenergetic analysis, as well as a description of other technical aspects of the program, please see “A Course of Treatment for Trauma Spectrum Disorders,” at www.bioenergeticanalysis.org.il.

IMPLEMENTATION

I believe this program is suitable for survivors of any number of categories of trauma. I cannot think of any group for whom, tailored in the right way, the program would not be suitable.

I believe this program would have considerable value for military veterans with PTSD or other trauma spectrum syndromes, and it could also be a vehicle for assisting veterans in their transition back to civilian life. The first steps in implementing the program for veterans would probably mean establishing an institutionally supported professional training. We are currently looking into this in Israel.

There are several other populations, related to the type of traumatic experience encountered, for which this program would have a useful application. Groups should be composed to have a relative homogeneity in regard to type of trauma. The distinction between those suffering from complex developmental trauma and those suffering from traumatic spectrum syndromes as a result of recent experience is only important as another criterion for group composition. In fact, it is important to formulate a view of traumatic stress syndromes in which the basic congruencies between these two categories are evident.

I, and most of my immediate colleagues, have in-depth experience in work with individuals with complex developmental trauma. These are often individuals who have experienced early relational disturbances and have also been exposed to a disturbed traumatic developmental milieu subsequently. As I mentioned earlier, in the professional training groups in which I taught, a large majority of us could be said to be characterized by complex developmental trauma and some degree of Posttraumatic Personality Disorder (Classen, et al., 2006).

In Israel there are two unique categories of such individuals. One category, not unique to Israel only, is the second generation Holocaust survivor. Another is the “survivors” of the children’s houses of kibbutz fame. As far as I know, this is no longer a practice. But I know individuals, now in their mid-forties who were taken from their parents virtually at birth, put with other babies, and raised apart from parents by the women who were put in charge of them. While some children did reasonably well on this regime, for others, it is a horror story, and the resulting somatic-energetic-relational and psychological struggles are terribly painful and limiting.

Finally, I believe there is a great need for this program for other groups, such as women who survived rape or domestic violence. Here, again, there are practical problems of developing therapists or trainers and finding or developing appropriate settings.

SOME SUPPORTING CONSIDERATIONS

Finally, I want to offer a few considerations in support of the program I have outlined and a few broader considerations as well. My considerations here apply especially to the case of military veterans, but they are also applicable to other groups.

The program addresses a complex problem and creates a complex set of processes. It really involves experiential learning about adult development, a conception which will be, in all likelihood, unknown, and even alien to most participants. Students will be able to incorporate an emotional-bodily awareness and knowledge of themselves and their own process of development. The program also invites students to make a commitment to somatic-energetic-emotional practices which encourage the integration and facilitation of developmental processes. Although these concepts are not articulated as such initially, or maybe at all, they do imply that students are immediately placed in a highly developed position.

In our societies, education seems to have little to do with individual personal and emotional development. I am thinking of development that leads towards a sense of individual self-hood based in the somatic-energetic processes of the person. That the program is somewhat at odds with the general social orientation might be a good thing. The program might also then be a small force towards creating a kind of shift in the social perception of trauma and traumatized individuals, and indeed, perhaps in the overall psychotherapeutic field.

In 1970 there arose in America the social phenomenon named the “rap group.” These were groups of Vietnam Veterans who got together and “rapped,” i.e., talked with and to each other without the presence of an institutional authority, expert, or therapist about their experiences and what was happening in their lives. The program I’m describing here has some similarity. It will be a group of equals with the common goals of going on with life under new and different conditions. In addition, it will also be informed by knowledge of adult personal development, therapeutic change, somatic- energetic emotional work, community formation, and the psychoneurology of trauma.

Consider PTSD in military personnel, for a moment. Now I want to present a disturbing analogy. In Saudi Arabia, there has been introduced a fairly successful program for rehabilitating individuals who belonged to extremist terroristic groups (Stern, 2010). As a group, returning veterans have a psychological profile that – disturbing as this may be – bears some basic similarity to the Saudi “clients.” All military veterans have been indoctrinated into the legitimacy of certain forms of violence; they have or are given an ideology that justifies that violence; they become a member of and identified with both a small work unit and the larger military force devoted to war.

The Saudi rehabilitation program for terrorists is very extensive (and, no doubt, expensive), a full immersion, for some months, involving rehabilitation services, transition services, and post-release services, integrating the individual into society. What this demonstrates is just how extensive are the requirements for the rehabilitation of people with profiles like these, and with the added complication of trauma spectrum syndromes.

Once out of the military, veterans are no longer a member of a close, small unit, and they are expected to revert to a pre-military form of social functioning. This is a difficult transition, at best, and one that in itself may contribute to the development of a trauma spectrum disorder. The research of Elizur & Yishay-Krien (2009) reveals the power of group dynamics in the combat units. It shows the degree to which the platoon becomes a kind of family unit requiring complete loyalty, even in the face of perpetrating brutality on civilians.

While the program presented here does not come anywhere near comprehensive rehabilitation as in the Saudi program, it does provide a new close community with which to identify. Within the milieu of the community, traumatic experience can be integrated, personal development can be facilitated, and core aspects of the person, such as identity, relational skills, and skills for self- and emotion-regulation can also be addressed.

I believe these are important considerations, supporting the idea of the program, as a kind of education or rehabilitation. They also support the conception and the use of the community. A final consideration also supports the conception of the community in the program. Finding membership in the community may help to modulate the avoidance which is inherent in most trauma spectrum disorders.

Other considerations support the application of the other “pillar” of the program, the somatic-energetic orientation. I mention only two, very briefly. Again, considering avoidant behaviors, these can be addressed with somatic-energetic interventions, similarly to overarousal.

The somatic-energetic concept of *contact* was mentioned earlier in the discussion of emerging body memory and the discharge of energy that went with it. In the process of focusing on and energizing the body, the individual makes a deeper contact with him/her-self. The relevance of this concept can be seen by considering prolonged exposure therapy (PE), one of the most used cognitive-behavioral therapies. In PE therapy, one of the requirements for modification of the “fear structure” is that it is “activated” (Foa, Hembree, & Rothbaum, 2007, pp. 12-13). I believe that this means that the individual is in contact with him/her-self in such a way as to experience the fearful attitude, without necessarily living it. This means, essentially, *to be in contact with this aspect of the self*.

Contact, a somatic-energetic concept, establishes the possibility of a bridge between bioenergetic analysis and the cognitive-behavioral approaches. It also establishes the possibility for a more secure basis for the application of PE protocols. For that matter, *contact* can also establish a similar bridge between bioenergetic analysis and psychodynamic therapy.

To develop these considerations obviously requires another paper. Even more importantly, enough therapists need to be willing to learn this approach, conduct groups, and begin outcome studies. Hopefully, presenting this material is a small step towards laying the foundation for that development.

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The Science of Body-Psychotherapy Today: Part 3: Appropriate Science.

Courtenay Young

Abstract

In the first of this series of four articles, I looked at the history of 'science' in body psychotherapy (mainly the work of Janet & Reich), and in the second article, I looked at what the current situation is with regards to the science of psychotherapy and that of body psychotherapy. In the third part of this series, there is a discussion of what might be meant by 'appropriate science' for body psychotherapy; and in the fourth & final part, I shall make an examination of new areas of science and research that are increasingly impinging on the field of body psychotherapy.

Keywords

Definitions of Science – Science in Psychotherapy – Body Psychotherapy – Appropriate Research Methods

Appropriate science

The use of the word 'science' with reference to body psychotherapy, directly brings up the question of what do we mean by that, here, and what is the appropriate 'science' for this particular branch of study, knowledge and skill.

There are two distinctly different approaches to science (within the human sciences) that are often confused: it is therefore important to differentiate between 'natural science', which uses the scientific method in the objective and rational study of nature and objects and which forms the basis of all the applied sciences; and 'social science', which studies human aspects of the world, using the 'scientific method' – derived from natural science - in more qualitative ways. In studying subjective and inter-subjective aspects of society, this latter branch is sometimes called the 'soft science' and there is a degree of 'scientism'¹ that exists, which tends to discriminate, not just against this particular type of science, but also against other interpretations about societal life (religious, mythical, and spiritual) as being 'non-scientific'. With the increasing 'medicalization' of psychotherapy (through government, psychiatry and the health insurance companies wanting fixed diagnoses, regulation, RCTs, efficacy studies, etc.), there is a tendency to give priority to the first type of natural science, but this choice brings a whole raft of other problems that are often 'conveniently' ignored by the august bodies that try to control and regulate these professions.

There is a huge debate about the relevance of effectiveness studies versus efficacy studies in psychotherapy (Young, 2010). As an adjunct to this, we also have the views of an eminent researcher, such as Martin Seligman (1995), who states:

I no longer believe that efficacy studies are the only, or even the best, way of finding out what treatments actually work in the field. I have come to believe that the "effectiveness" study of how patients fare under the actual conditions of treatment in the field, can yield useful and credible "empirical validation" of psychotherapy and medication. This is the method that *Consumer Reports* pioneered...*The efficacy study is the wrong method for empirically validating psychotherapy as it is actually done, because it omits too many crucial elements of what is done in the field.* . (p. 966)

But it is really not an 'either ... or' situation, so if you are interested in designing a research project in body psychotherapy, you may well need to read the whole article.

Dehumanization and the role of the observer

Firstly, the 'natural science' approach tends to de-humanize the object, the client or patient. There are further theories that explore the possibility that there can be no such thing as a repeatable experiment in the 'social sciences' as the observer, however far removed from the subject, still has a significant impact on the result. For these reasons, the more humanistic psychotherapies tend to avoid 'natural science' and veer towards the 'softer' versions of the 'social sciences', focusing more on a view of the person's 'self' in relationship to society as a way of examining ourselves and responding appropriately.

¹ Scientism: (1) An exaggerated trust in the efficacy of the methods of natural science applied to all areas of investigation, as in philosophy, the social sciences, and the humanities. (2) An exaggerated trust in the efficacy of the methods of natural science applied to all areas of investigation, as in philosophy, the social sciences, and the humanities. (Webster, 1983)

One implication of this view holds that counseling and psychotherapy *cannot* be separated from the social conditions and context in which practitioners and their clients operate (Pilgrim, 1997). It has also been empirically shown by several meta-studies, that what is primarily significant to people (the clients of psychotherapy) is the relationship between their mental health and life stress, family issues, gender, class, race, age and thus any study or the ‘science’ of this should look at relevant social research. There is therefore no place for ‘natural science’ here.

Language, training and skill-base

Psychotherapists of all sorts sometimes fall into the trap of trying to avoid such ‘scientific’ discriminations – subject / object - by adopting forms of pseudo-scientific language, which confuses the issue even further: and – contrarily – some psychotherapies also have very little scientific basis, load themselves up with (pseudo-) ‘scientific’ language, and yet are still operating in something similar to a belief system; so this sort of criticism is not totally unfounded, as we shall see.

We must, nowadays, also consider this aspect from a wider perspective. In a review of the historical trends of psychotherapy within Asian countries (Tseng et al., 2006), the authors illustrates the efficacy of multiple healing systems and an integration of mind, body, and spirit in their methods, a practice only recently being supported in Western practice. Other studies from non-Western cultures show: widely differing patterns of diagnosis; different levels of intervention, treatment and recovery rates; the effects of different psychological ‘norms’ (like parent-child relations); the impact of different traditional thought and philosophy; and different psychopathologies. These sorts of studies force a re-examination of our basic ‘Western’ concepts and those interested (as we are all supposed to be) in multi-cultural studies and culturally competent psychotherapy would do well to consider this. We – in the West – despite our excellent ‘science’ – do not have hegemony on the truth.

Empirical science

From those early struggles and discriminations, already described, psychoanalysis and psychotherapy, including body psychotherapy, gradually began to develop their own form of empirical ‘science’ (the type of science that relies on practical experience), initially with the extensive use of case histories.

The case history is an examination of what was actually happening in the intense - and necessarily private - therapy session, continually relating these events back to theory, and thus making a reflective, but very subjective, bridge between theory and practice. This type of qualitative ‘science’ has a degree of usefulness through its capacity for demonstration, and thus some degree of validity, and it has become increasingly respectable and accepted.

However, as a discipline, or as a profession, we must not and should not rely solely on this form of study. So, other forms of ‘scientific’ studies, primarily outcome research and some social research, have since been used – essentially to back up the case history. However, this is also ultimately insufficient. Therefore other types of ‘science’ (wider specific & quantitative research, meta-studies, better effectiveness studies [outcome research], efficacy studies, randomised control trials, etc.) cannot be ignored for much longer.

Some of the changes that have happened in the last 100+ years have taken psychotherapy somewhat further away from ‘hard science’. Briefly, the rise of behaviorism in the 1930s and 1940s, tried to put a scientific objectivity into psychology, but, in so doing, the humane and humanistic aspects were partially lost and the people involved became ‘subjects’. Masses of psychological studies were done, many on (or by) psychology students, who are not necessarily representative of the wider population. The pendulum then swung the other way (briefly) and the needs of the individual became paramount and ‘policies’ and ‘studies’ based on quantitative research were sometimes deemed inhumane.

Now, we are swinging back again and UK governmental programmes, like the ‘Increased Access to Psychological Therapies’ (IAPT) (Layard, 2006), are being designated only to treat mild to moderate anxiety and depression. The ‘treatment’ will consist of “managed self-help”, consisting of one (or two) face-to-face session(s) followed by some back-up telephone conversations. There are large volumes of people with this sort of diagnosis and, with between 5,000 and 10,000 new ‘psychological therapists’, each only having about 12 weeks of training, some initially positive results have been seen. Similar programs are also being ‘designed’ to ‘help’ people to get back to work as quickly as possible ... but often there is an “or else”. This is not ‘proper’ psychotherapy, as it is based (erroneously, but perhaps deliberately) on a medical / behavioral model, nor is it good ‘science’ when it contradicts the available evidence, focuses on economics, and only uses one ‘method’ of psychotherapy (Nel, 2009).

Science in psychotherapy

There are now essentially two different directions with regard to science within psychotherapy: an objectivist approach, and a constructivist approach (Botella, 1998). Cognitive Behavioral Therapy (CBT) has tended towards the objectivist approach, which might account for its ‘success’ in establishing itself as the main ‘evidence-based’ psychotherapy, and – even though its origins were very ‘behavioral’ and ‘objective’ – it is currently much less so, and has recently ‘softened’ considerably towards the ‘social sciences’. Interestingly, it is also nowadays incorporating ‘body-oriented’ techniques, like EMDR and mindfulness

practice. The ‘natural science’ medico-biological model generally supports this perspective and the mental health/psychiatric perspective, both essentially trying to find organic causes for most psychological disorders, and therefore essentially looking at effective ‘treatments’ for these disorders. The softening comes with an increase acknowledgement of the social environment, so we now have a ‘bio-psycho-social’ model of psychological problems.

On the other hand, the post-modern or constructivist approach inherently links phenomena with experiences and discourses: attempts are made to create a form of a ‘narrative’ to understand: why the person has ended up in this situation; has adopted ‘defence mechanisms’ or ‘survival techniques’ (rather than neurotic character-structures), which may now have become redundant or dysfunctional; and how they can move forward into a better situation. There is a movement away from the language and presumptions of ‘illness’ that are embedded within medical or pharmaceutical language, and towards a much more social, or even personal, perspective.

Psychology vs. psychotherapy

By linguistic definition, psychology is more a study of the psyche, whereas psychotherapy attempts to heal the psyche. Many psychologists (by training) have also become excellent psychotherapists, and there is something to be said for psychotherapists to have a relevant training in psychology. But they are also fundamentally different.

It is, of course, nonsensical to try to define concepts such as intelligence, memory, language, emotions, or consciousness only in objectivist terms. The fundamental differences in these two approaches, as well as the split between ‘natural’ and ‘social’ science, will ultimately determine the type of study, research and approach to the science of ‘psychology’, the different science of psychotherapy, and thus ultimately to the appropriate ‘science’ for body psychotherapy. One approach tends towards positivistic and quantitative approaches, with assessment and psychometric tests; the other tends to focus on case studies, outcome research, examination of the therapeutic relationship, and much more qualitative components. This latter course will need to borrow tools from other ‘sciences’: anthropology (conversation analysis), sociology (grounded theory methodology) and literature (narrative analysis), as some of their scientific bases, but must not fall into the ‘trap’ of trying to be the (natural) ‘science’ that it is not.

Psychotherapy has not properly taken up this challenge, nor has it fully developed tools of its own, and – as a result – the ‘science’ of psychotherapy (and thus also of body psychotherapy) is still considerably depleted and diminished, partially subsumed and confused by the ‘science’ of psychology and also that of medicine. It is difficult to take an effective stance against the almost overwhelming weight of ‘evidence’ from the other side.

In contrast, CBT adopts a more objectivist approach and thus aligns itself closer to the more acceptable (scientific?) ‘natural’ sciences. This is not just a philosophical argument: it has huge political and practical implications in terms of general understanding, social and political acceptability, and – most poignantly – health funding. But neither is it an “*either ... or ...*” situation: this is another trap in our thinking. We must try to consider it from the point of view more of a “*both ... and ...*” perspective: both have a value, and neither one nor the other is the only answer.

The growth of ‘treatment’ of mental illness by either modern psychiatry (using mostly medication); ‘mechanical’ methods like ECT and lobotomies (some of them contentious and some of them barbaric); or behavioral reward systems, some also quite dubious (viz: young offenders, and Lovaas’ ABA treatment of autism); have complicated and confused the picture of ‘science’ within the field of mental health, as each of these has claimed ‘efficacy’ and each has ‘shown’ itself to be ‘scientific’ in various ways and at various times.

We also have a whole systemic structure of academics being forced to write ‘research’ papers in order to maintain their tenure (“publish or perish”); doctors and hospitals effectively competing against each other in a commercial market system; and double-blind trials and treatment studies of pharmaceuticals, frequently being ‘paid for’ by the larger drug companies (often through not-for-profit ‘foundations’ largely financed by these companies, with accompanying tax benefits) so that some part of their basic integrity is potentially severely compromised; so – in all of this – the one-on-one individual psychotherapist has had little chance of being able to demonstrate his or her own efficacious practice, especially in a little-known and marginalized discipline like body psychotherapy.

Psychotherapy vs. psychotherapy

Thus the ‘science’ of psychotherapy (and of body psychotherapy) has been severely distorted and even further depleted. In order to prevent a further decline, I firmly believe that our professional associations have to have a significant and essential role to play here. The individual psychotherapist (of whatever discipline) has little chance to make an impact by themselves, unless they are uniquely established with a Ph.D. and links to a reputable university, perhaps with a parallel private practice (viz: Kächele, 2001).

Practitioners – and this also applies to body psychotherapists – seem to be notoriously reluctant to use outcome research, despite the external pressures to do so and less than 1/3 of ‘normal’ practitioners (US psychologists) choose to monitor any outcomes, despite the beneficial effects on their practice (Lambert & Hawkins, 2004). We need to find ways to mobilize ourselves and overcome this sort of resistance: and – since most of us are coerced into being members of a

professional association (for that modality), let them carry the can and they can use our membership fees to ‘prove’ that particular method ‘scientifically’.

As a result of all this, there has been something of a counter reaction: an increasing focus on the particular methodology of the modality of psychotherapy. The ‘skill base’ of the ‘practice’ of psychotherapy has been emphasized and the focus has instead shifted more towards ‘craft’ or ‘skill’, rather than towards ‘science’ and ‘measurement’ (Young & Heller, 2000). Whilst the emphasis on quality has been extremely beneficial over the last 100 years, this trend has also been slightly detrimental to psychotherapy, as a whole, and body psychotherapy in particular, especially when (or if) one wishes to (or is required to) establish any sort of scientific quantitative basis for efficacy for this aspect of the profession. By contrast, CBT – which has an already established ‘evidence-base’ – is considered by many to be very formulaic, and has even been computerized. But what that will do for the therapeutic relationship is anyone’s guess! Certainly, computerised CBT is probably not enough, though it may be a useful adjunct (Young & Kazim, 2009).

There is another point: psychotherapies differ widely in their application. Psychoanalysis and psychodynamic psychotherapy tend to favor the long-term approach (weekly sessions over 2 years are not uncommon; some analyses extend to 5 years); CBT and solution-focussed therapies tend to favor a short or mid-term approach (6-12 sessions). It is therefore very difficult to compare outcomes if the parameters are so different. Governments, health boards and insurance companies are loath to fund the provision of long-term ‘treatments’. Ironically, some of the humanistic psychotherapies’ theories tend to favor a long-term approach as they consider they are helping the person in their ‘growth’ rather than help with the ‘treatment’ or ‘cure’ of a specific ailment or diagnosis.

As we (in body psychotherapy) have veered further towards the humanistic (psychology) sphere, where we gained more general acceptance in the 1960’s, ‘science’ was also seen then as something of an anathema: objective, uncaring, mechanistic, and irrelevant to (or interfering with) the very intense human-to-human therapeutic relationship. This can be equally erroneous, seeing as some of these humanistic psychologies can be seen as something of a belief system, and even a few of them have been (possibly correctly) been identified as some sort of sect.

As mentioned, one branch of psychotherapy in particular, CBT, has put a lot of effort and energy into supporting its ‘evidence-base.’ As a result, this type of psychotherapy is now being largely accepted as ‘the treatment of choice’ by insurance companies and by governmental health services across Europe and America, despite numerous comparative research studies and meta-analyses that clearly demonstrate that no method of psychotherapy has been shown to be more effective than any other method. (Smith & Glass, 1977; Smith et al, 1980)

Whilst that is a negative conclusion, what does show up to be effective is: (a) the quality of the therapist (Wampold, 2001); (Wampold & Brown, 2005); (b) the quality of the relationship between therapist and client (Norcross, 2002), and (c) the motivation of the client. Even though these ‘scientific’ findings thus cut across the ‘evidence-based’ popularity of CBT, the myth perpetuates because it is based on qualitative science, rather than objective science.

Another myth, that psychotherapy has to be ‘scientific’ (without defining the type of ‘science’) now begins to set the agenda for all other psychotherapies, and so everybody has to be ‘scientific’, using or competing with the already established ‘yardstick’ set by ... CBT. As this rat-race progresses, it is being fuelled by economics: those who pay for psychotherapy treatment demand efficacious results, and results obtained as quickly as possible, so that they have to pay less. The insurance companies and the national health services have thus latched onto the CBT ‘step-by-step’ awareness and behavioral change approach to the extent that we now have insurance companies in America identifying certain diagnoses from DSM-IV as being worth of 3 or 4 sessions of psychotherapy, and other (more complex) diagnoses being funded for 10-12 sessions. Sessions or treatments that go beyond that point are “*not ‘scientifically’ supported*” and thus, beyond these points, therapy becomes a matter of professional indulgence, or personal choice, and therefore will not be paid for. Economics is thus ‘using’ false ‘science’, and so we have another distortion being built into the field. This situation will tend to perpetuate itself.

However, there is some hope. The value of the various forms of qualitative research is being increasingly recognized: we have already noted effectiveness studies, but “grounded theory” research (Luca, 2010) provides a more rigorous development. Grounded theory (Glasser & Strauss, 1967; Strauss & Corbin, 1990) is a system wherein the theory is developed from the data, rather than data being sought to support the theory. In this, it is not significantly different from phenomenology and ethnology, though it provides a clearer structure, as they all help the researcher to find meaning through the collection and collation of data, and the searching for themes, before a theory is properly developed. “*What differentiates grounded theory from much other research is that it is explicitly emergent. It does not test a hypothesis. It sets out to find what theory accounts for the research situation as it is.*” (Dick, 2005)

Of course, this type of research might not be very popular in a field where there is already a plethora of unsupported theories, backed by ‘bits’ of scientific findings that have been used (often out of context) to ‘prove’ the extant theory. But there have been several attempts to apply grounded theory as qualitative research in psychology and psychotherapy (Rennie, et al. (1988); Elliott, Fischer & Rennie, 1999; Fassinger, 2005), though – of course – nothing has yet been done (to my knowledge) to apply this methodology to body psychotherapy.

As more of a ‘fringe’ mainstream, body psychotherapy is particularly vulnerable here: so much so that many body-oriented psychotherapists have had to practice under a different flag of allegiance, wearing their psychologist’s hat, or as a massage therapist, or not being particularly explicit about their actual method of treatment. It is easy to understand the pressures that exist on them, as individuals, but it is also very detrimental to establishing body psychotherapy as a ‘scientific’ mainstream when many of its practitioners are working ‘undercover’. Again, the professional associations probably need to be much more proactive here.

Body psychotherapy seems to have taken, instinctually or deliberately, as a result of criticism, opposition or opportunism, generally a more person-centered, process-oriented path and this, as well as other factors, has created a different philosophical and epistemological basis for the profession. There has generally been, as mentioned, much greater reliance on clinical refinements and (some) qualitative research (see Young, 2010), and it is only recently that this type of work is becoming more acceptable 'scientifically'. However successful a strategy this has been, there are new dynamics that might require a broadening and strengthening of this, and a 'both ... and ...' type of adoption of an alternative strategy.

Initial acceptance of body psychotherapy

When the European Association of Psychotherapy began to try to establish psychotherapy as an independent profession in Europe in the early 1990s, it was declared, from the start, that all of psychotherapy had to be 'scientific'. There was, and is, considerable opposition to the establishment of another profession from the 'vested interests' of the other two well-established professions: those of psychology and psychiatry: hence the emphasis on 'scientific psychotherapy'. To this end, the EAP developed a set of criteria that every modality or mainstream in psychotherapy has to answer, and the answers have to be scrutinized and accepted, before that particular modality or mainstream is fully accepted within the EAP (see Appendix 1). David Boadella (interestingly a very respected body psychotherapist) headed up the committee that formulated these questions, the "15 Questions on the Scientific Validity". They were based on the book, "*Psychotherapies: eine neue Wissenschaft vom Menschen*" (Pritz, 1996), which consists of numerous contributions by distinguished psychotherapists from Austria, Switzerland, Germany, & England and is "*without doubt the best single book on psychotherapy as a human science, in any language*".

I give this piece of relatively recent history as it steps away from the research laboratory, and from the market-place, and from the established hierarchies, politics and vested interests, already mentioned. These questions were determined from within the profession and both objectively and pragmatically. They are available on the EAP website (www.europsyche.org), and many different modalities of psychotherapy throughout Europe have now gone through the process of establishing the scientific validity of their method or modality by these criteria, which in itself provides quite an interesting 'body' of science. There was, which is also interesting, quite a substantive resistance initially to answering these questions, and even to thinking about what we do, as psychotherapists, from this particular perspective.

With body psychotherapy itself, a very peculiar political situation arose. European Association of Body Psychotherapy, as the professional association representing body psychotherapy, decided to go through the 'scientific validation' process in 1999-2000 and, as one of the representatives and the main author of the EABP's submission, I deliberately chose to focus this document towards establishing **the scientific validity for the whole 'mainstream' of body psychotherapy** – i.e. for all the variety of body psychotherapies. The main part of the submission (answers to the 15 Questions) ran to over 23,000 words (about 50 pages), with an additional 38 appendices. It is still available on the EABP website: www.eabp.org.

However, because of some complex politics and personalities within the EAP at the time, an additional requirement was laid onto body psychotherapy – different from any other mainstream: that each modality within body psychotherapy also had to answer these '15 Questions' independently. This undemocratic and somewhat discriminatory exception was because some of the other psychotherapies feared (possibly with good reason) that any generic acceptance of body psychotherapy might 'open the door' to all the numerous modalities and individualistic methods within body psychotherapy, some of which are (quite frankly) unproven, quirky, idiosyncratic, radical, iconoclastic and possibly dubious as to whether this is a proper psychotherapy, an elevated body-therapy, or even a sort of sect.

As a result of the process of a number of body psychotherapy methods going through answering the '15 Questions', it is fair to say now that a general level of confidence has been re-established within the EAP about body psychotherapy, and about the EABP's internal checking processes, and so the 'restriction' on body psychotherapy has recently been lifted so that, as the representative of the mainstream, EABP now has the 'right' to establish which are the 'scientifically valid' body psychotherapy modalities within our own aegis. How we actually do this is the next step to determine. Whilst this is essentially a political process, it is also very relevant to the science of body psychotherapy and how it is applied today.

So it is, perhaps, also interesting to note, that the body psychotherapy modalities of Hakomi (Kurtz), Unitive Psychotherapy (Stattman), Biodynamic Psychology (Boyesen), Bodydynamics (Marcher), Emotional ReIntegration (Bolen), Character-Analytic Vegetotherapy (Reich), and more recently Psychotherapeutic Postural Integration (Painter + Gestalt), have all now been accepted as "scientifically valid" body psychotherapies by this process. This last body psychotherapy is specifically interesting as it is where a 'body therapy' method (Postural Integration) has added on (or 'integrated') Gestalt psychotherapy, plus some Jungian concepts, to form a new type of body psychotherapy.

Many of the actual submissions of the 15 Questions for these modalities are also posted on the EABP website, especially those that went through EABP as a 'gateway'. Additionally, three or four other forms of body psychotherapy: Biosynthesis (Boadella), Psycho-Organic-Analysis (P. Boyesen), Concentrative Movement Therapy, and Bioenergetics (Lowen) have all been accepted independently within the EAP by a similar process. Given that about 13 different body psychotherapies have now answered these same 15 questions, we have the basis for a wonderful meta-analysis, were someone interested in doing it.

Politically, this selective process also (significantly) contrasts with the European Association for Psychoanalytical Psychotherapies, that went through the '15 Questions' process without any such restrictions, with the result that (the modalities

of the) Freudian, Lacanian, Jungian, Adlerian, and Kleinian psychotherapies did not have to write such submissions independently.

However, what this (largely political) process means is that to our peers, we can talk a common (non-jargon idiosyncratic) language; we can demonstrate that there has been scientific writing about these methods; that there has been some reasonable research; that there is a reflective linking process between theory and practice; and so on.

The science of body psychotherapy

Maybe this is the beginning of a comprehensive epistemology about body psychotherapy: I hope so, as it is long overdue. And so I believe that much further work is needed to define the actual parameters of (the science of) this ‘field’: parameters that also need to be reasonably flexible to allow new entrants, as well as to firm up the scientific basis of body psychotherapy.

Body psychotherapy in Europe particularly has occasionally been ‘plagued’ by ‘bad press’ from some groups (or ‘sects’) that have called themselves ‘a psychotherapy’ and yet have used mind-altering techniques (sleep deprivation, group pressure, social isolation, and some body-oriented abreactive techniques). Both Scientology and Rebirthing have been accused of doing these sorts of things in the past, and political feelings about this sort of methodology have run very high, especially in some countries (like France). The press generally love to jump onto something like this.

Within the profession, one (seemingly) well-established school of ‘body psychotherapy’ was rejected when it tried to apply independently for scientific validation through the process described above, on the grounds that it seemed to be more of a ‘sect’ than a proper psychotherapy. This ‘rejection’ (or the external ‘peer’ acceptance that something was not totally ‘kosher’) then opened the door to some previously repressed complaints about abuse within a training programme being able to be made more public. This particular case later went into a criminal investigation and the head of the school was subsequently prosecuted and imprisoned.

There are also earlier examples of ‘sects’ – like those from within the Bagwan Shri Rajneesh movement – using (or abusing) ‘encounter groups’ and techniques like ‘abreaction’ or the “*discharge of repressed emotions*” in violent ways: also of trying to distort (local) political processes. Experienced psychotherapy group leaders who had ‘converted’ to this sect, led abreactive, expressive, confrontational, and similar, groups that eventually began practising something akin to violence in therapy (Boadella, 1980).

There are also many accounts of abuses of therapy in Russian psychiatric words during the period of the Soviet Union and there are additionally many other types of abuses of the power relationship that exists in psychotherapy and other professions (Rutter, 1990). However, because of the potential contact with the client’s body, body psychotherapy is particularly prone to exposure in this field. The USABP has therefore felt it necessary to put a specific paragraph about the use of touch in psychotherapy into its Code of Ethics.

The contentious ‘issue’ of touch

With respect to professionalism, body psychotherapists probably need to assert that they are about the only people who are ‘qualified’ to touch, as they have been trained to do so appropriately. With respect to ‘science’ there is a bigger question: very few can ever doubt the potentially beneficial and therapeutic effects of touch (Field, 2003).

On the psychotherapy front, it took more than ninety years before mainstream psychotherapy (in the UK) began to reclaim its ‘body’, taking the UK Council for Psychotherapy Conference in 2004 entitled “About a Body: Working with the Embodied Mind in Psychotherapy” (Corrigal, Payne & Wilkinson, 2006) as the point of this re-acceptance. So the mind-body split epitomised by Descartes’ “I think, therefore I am.” is only now just beginning to heal. Psychotherapy is beginning to accept and integrate its ‘body’ and body psychotherapy is also just beginning to integrate its ‘mind’ and apply itself again to science.

Up until now, there has been very little ‘hard science’ done within body psychotherapy. There are a couple of specific studies posted on the EABP website under ‘Research’ (see Appendix 2). The various founders of the body psychotherapy modalities (with a few exceptions) have tended to draw on other peoples’ ‘science’. For example, Gerda Boyesen’s work on “psycho-peristalsis” was based on Bülow-Hansen’s well-established empirical physiotherapy techniques, and, then ‘scientifically’ backed-up by Setekliev’s totally independent studies of the firing patterns of smooth musculature of the intestines (Setekliev, 1964, 1980). David Boadella followed this with an article on firing zones and muscle tone, based on earlier American research work in physiology (Boadella, 1981). The scientific research was drawn on by the body psychotherapy method, independently and sometimes unknowingly, and was used to substantiate a different empirical finding. However, this is still a form of ‘science’.

There are exciting new possibilities for this type of ‘science’, especially nowadays, with the relatively recent development of neuroscience within the last 15 years. Therapists of all sorts are increasingly discovering the clinical relevance

of neuroscience. For example, the website for the Dana Foundation is one of the respected and authoritative gateways to the very latest information about the brain (www.dana.org).

Body psychotherapists can also draw on excellent 'science' done by other non-body-psychotherapists, such as the work of Tiffany Field in her seminal book on the research on touch (Field, 2003); Damasio's writings (Damasio, 1994); Allan Schore's work on affect regulation (Schore, 1994); Kirstin Moberg's work on oxytocin (Moberg, 2003); Candace Pert's work on the emotional component of peptides (Pert, 1999); and Steven Porges' work in the polyvagal aspects of the Autonomic Nervous System (Porges, 2001). This is where mainstream 'science' can really inform body psychotherapy. But this is not, repeat not, the 'science' of body psychotherapy. We need to look a little further. And we also need to discover how body psychotherapy can inform science.

Hopefully other writings on the science of body psychotherapy will establish some of this more clearly. Some research work has also been published in recent body psychotherapy journals (viz: Pettinati, 2002; Luskin et al, 1998 & 2000). It is perhaps significant that this latter piece of much quoted research was (a) not done by body psychotherapists, (b) did not have a Part 2 and (c) was summarized: "The research provided evidence for treatment efficacy; however most apparent was the requirement for further controlled research."² It seems we are not the only ones with these sorts of problems. Within psychology, neuroscience is now helping to re-establish something of a more 'unified field' approach to the human and his/her body, and recent discoveries in psycho-neuro-immunology further assist this trend. Whilst these developments are very exciting, there is much work that still needs to be done to translate these 'pure' or 'hard' scientific findings into useful clinical approaches within psychotherapy, and especially within body psychotherapy. That is our current task and challenge. More recently, some people from different modalities of body psychotherapy are developing excellent, sound, published and accepted work in the field of trauma (Rothschild, 2000; Ogden, 2000; van der Kolk, 1994). This sort of work needs to be extended to other fields. There are several other factors that can affect the 'field' of body psychotherapy and which should be considered as potentially pertinent.

Besides the effects of any psychotropic medication that our clients may be prescribed, we all need to consider the increasing impact of complementary and alternative therapies. Studies show that our patients/clients often use these, and do not necessarily tell us about these (Elkins et al, 2005), so – are the beneficial effects of our therapy being affected (positively or negatively) by our clients using other mind-body therapies: physical practices (Yoga, Tai Chi, etc.); regular spiritual practice; special diets or vitamin supplements; etc? This could skew any research findings.

We are also seeing increasing changes in the basic psychotherapeutic relationship that we would be foolish to ignore. There are many implications in the use of modern technologies. One direct impact is that there is a growth in telephone, e-mail and 'skype' psychotherapy sessions that obviously affects the proxemics, the body language, the somatic resonance and so forth that are significant for many body psychotherapists. There are many other impacts, as well.

Totton (2009) argues that, whilst neuroscience reflects on the biological basis of body psychotherapy, and that we have also incorporated aspects from the 'relational' sciences (Cornell, 2007; Soth, 2005), there is a third field of 'science' that we can draw on: that of the social sciences, as we live in a social (and somatic) world. Totton's well-researched article makes its point and hence is mentioned. There are many similar articles, but most are not from within the field of body psychotherapy.

Finally, it would really help if we all adopted a single 'title' for referencing purposes. Material is stashed under lots of different headings, from Bioenergetics to alternative therapies to psychosomatics. In my attempt to create a bibliography for body psychotherapy, currently running at 4000 + entries (Young, 2009), finding the basic source material is not the real problem: there is plenty of material 'out there'. Deciding whether research (such as above) is relevant to body psychotherapy is much more problematic. This is also part of the science of body psychotherapy. This brings this thread of development up to date now.

Disowning the body

The body has been significantly disavowed in many different aspects of society, aside from psychotherapy. There are many reasons for this denial, and it is, by no means, a new phenomenon: it might even extend back to the growth of patriarchy 6,000 years ago. Reich wrote about some of these aspects in *Character Analysis* and later, very graphically illustrated, in 'Listen, Little Man!' (Reich, 1948, 1972) He ascribed the basic rejection of the body to an accumulative reaction of repressive forces within the person's body creating a quintessential fear of libidinous free movement.

The rigidities of the body that Reich spoke about have mostly been experienced as a social 'norm' for so many years that there is a basic denial of, and a phenomenological resistance to, the open acceptance of the body within society: this open acceptance can be experienced by an individual as being natural and wonderful. However, this is also unacceptable on a wider level as it conflicts with several long-held social rigidities. Instead of these feelings being able to permeate all aspects of society, there have grown up various distortions in people's relationship to their bodies. Over recent years, the body has been seen as:

² <http://www.positivehealth.com/permit/Updates/rudalt3.htm>

- A repository of sin by various religious groups
- A disgusting sexual object by the Victorians
- Holding baser impulses to be sublimated by Freudian analysis
- A disposable asset to the military, especially in World War I
- Something to be medicated or fixed by the medical profession
- A dysfunctional object incapable of bearing a child unassisted
- Something to be perfected and controlled through diet and exercise
- Something exploited by multinationals selling medicines, alcohol, cars & cigarettes
- Something to be transcended by belief, prayer, drugs, free love, or meditation
- An object of scientific research by biology and neuroscience, and
- Something (more recently) to be used politically by suicide bombers.

These are all phenomena of the profound separation (disassociation) between mind and body. To have body psychotherapy accepted as a valid aspect of mainstream psychology, we are going to have to contest with, and overcome, some of these long-held perceptions. Reich experienced some of these reactive components of mainstream society when he pointed out their 'defects' in the sex-clinics of Vienna & Berlin in the late 1920's; when he had a vicious newspaper campaign against him in Norway; and when he was subsequently persecuted in America, in the 1950's, for supposedly selling a 'cure' for cancer and had all his books and journals burnt.

When we examine the 'science' of body psychotherapy, we may also encounter some of these reactive social forces. You cannot 'split' the atom 'safely' however scientific you are, because when you do, you release the immense force (energy) that binds the molecular particles together. Similarly it is difficult to 'challenge' these long-held positions, without encountering their rigidity and resistances. On a slightly more positive note, Damasio writes:

(1) The human brain and the rest of the body constitute an indissociable organism, integrated by means of mutually interactive biochemical and neural regulatory circuits (including endocrine, immune, and autonomic neural components); (2) The organism interacts with the environment as an ensemble: the interaction is neither of the body alone nor of the brain alone; (3) The physiological operations that we call mind are derived from the structural and functional ensemble rather than from the brain alone: mental phenomena can be fully understood airily in the context of an organism's interacting in an environment." (1994, p. xvi-xvii)

On another more positive note, various branches of psychotherapy are now including aspects of the body in their theory and practice. Cognitive Behavioral Psychotherapy now accepts Eye Movement Desensitisation & Reprocessing (EMDR), especially for trauma work, and is including Buddhist 'Mindfulness' practice (for example, Segal et al, 2002). Clinical Psychology also now accepts a bio-psycho-social model, and psychoanalysis accepts somatic counter-transference as a legitimate therapeutic technique. However these disciplines may not accept something that is fundamental to body psychotherapy: the mind-body unity. We, as body psychotherapists, hold this as fundamental. But we are also going to need to 'prove' this as valid. Additionally, however 'scientific' any evidence might be, it will also not be accepted unless people are prepared to examine it with an open mind.³

We also have to have the courage to risk declaring our conviction that these methods of ours actually work. We may soon be forced to. In Europe, the 'requirement' of any profession is now to demonstrate both its effectiveness (qualitative research), but also its efficacy (quantitative research), and all professions are having to define what the 'functional competencies' of their profession are: this is a fairly precise definition of what that particular professional should be able to do, and the demonstration of those functional competencies will be what is required to complete the professional training. This should be the 'Occam's Razor' that gets around the differentiation between who can do psychotherapy, as if anyone – be they a psychologist, psychotherapist, counselor, psychiatrist, social worker, or even massage therapist – can demonstrate that they can perform the functional competencies of a psychotherapist, then they are, de facto, a psychotherapist. The profession is defined by its functional competencies, and its practitioners by the demonstration of these, and not what bit of academic paper you have or haven't got, or how long you have studied in the university of wherever.

There will be a common 'core' set of competencies, that all psychotherapists (irrespective of their modality) will be expected to be able to do, and then each mainstream or modality can establish the 'specific' competencies for that branch of psychotherapy: the competencies of a Gestalt psychotherapist will (of course) differ slightly from the competencies of a family psychotherapist, or a psychodynamic psychotherapist, or a body-oriented psychotherapist. There will also be some 'specialist' competencies that one would expect a psychotherapist to be able to do when working with (say) children, or the elderly, or refugees, or with people in prison, or who are terminally ill. For each competency, there is a knowledge-base, a set of

³ In the 1840s, Oliver Wendell Holmes and Ignaz Semmelweis discovered this (to their cost) when they advocated theories of simple hygiene as a cure for puerperal fever. They were both separately persecuted and ridiculed.

performance criteria, and some evidence requirements: what do you need to know, what do you need to do and what do you need to show – to demonstrate that competency.⁴

This is another form of ‘science’ – a commonly-held, pragmatic, demonstrable, skill set that clearly defines an area of professional activity. We will be challenged in this process both to hold on to the ‘craft’ and ‘skill-base’ of body psychotherapy that currently we are very good at; as well as to be able to demonstrate the ‘science’, both qualitative and quantitative; and – to complete the triangle – establish the practical effectiveness (competencies) of our profession. If we do not do this, then we will drift down away from being an accepted professional branch of psychotherapy, more towards a nice set of theories that have not been properly proved or established.

As regards the rest of psychotherapy, there is an idea that is increasingly put forwards nowadays, that there are new forms of mainstream psychotherapy that include the body; this is something of an incorrect anachronism. The body was at the centre of psychotherapy when it first started, and then Freud and his followers deliberately chose to leave the body out of psychotherapy. Whilst this was largely personal and political, it had profound ramifications. Hopefully the pendulum is now beginning to swing the other way. We may be able to benefit from that swing if we can properly demonstrate our knowledge and theories.

Conclusion

In scientific study, our bodies, in themselves, cannot provide any of the answers: neither do our minds, by themselves. We are inside them; our experience is paramount and our perception is limited: yet science requires an objectification and analysis. Separated, our bodies and minds are considerably less than all of that which makes us human. Only when the mind-body unit is fully complete, with a degree of awareness, can we begin to find some really significant answers. Only when we fully include the mind and the body as an inter-functioning whole, as a unity, do we begin to get a sense of something much larger than ourselves: then we get a sense of the ‘circle’ in which we sit; or the environment or ‘field’ in which we operate: the multi-dimensional hologram, or the nature of our existence. This is the true study of the human being.

However, when we try to demonstrate or prove this to others, we may need to think carefully to whom we speak. Socrates spoke of how *“the unexamined life is not worth living”* and was persecuted because he dared to question some of the essential tenets of the state, and the democracy of that time. He ‘discovered’ that he was probably the wisest man in Athens (as the Delphic Oracle stated) because, whilst men who were considered to be ‘wise’ and thought of themselves as wise, seemed to know nothing when he questioned them empirically, he knew that he knew nothing, and was therefore wise. However, in his ‘scientific’ discovery, he made several very prominent men look rather foolish and this led to accusations of wrongdoing, and (like Reich) a show-trial, and his subsequent death.

Pure science is one thing. Scientific recognition, another totally different concept, actually depends on the mind-set of the recipient. We therefore have to be exceptionally ‘centered’ about what we are saying and to whom; we must very clear about how we speak about the scientific aspects of body psychotherapy; we may decide not to let politics, or social implications and reform, creep into the dialogue – or we may decide to challenge the ‘mind-set’ of some of our critics. We will inevitably have to ‘face’ some opposition – and it may be prejudiced and/or political in its own right – and there is nothing we can do about this. We will need to be absolutely sure of our ‘ground’ – our science, the appropriateness of that science, and the efficacy of our methods.

What body psychotherapists carry collectively is something quite fundamental: we are aware that the body is mostly a physical manifestation of something much larger, and less definable – a multi-layered collection of different systems and energetic exchanges. These are all inter-connected in ways that we do not fully know yet, or which even may even be to some degree ‘unknowable’, and some of which we cannot even name, let alone describe. The synthesis of these connections is also much greater than the sum, and carries many more mysteries: there is finally the greater ‘something’ – currently way beyond measurement – that even allows us to carry a human potential, a spirit, or soul.

And then there is still another layer: the greater ‘field’ in which all of these systems operate and which motivates these systems. We believe in this; we are sure that it works; we use these perspectives, and the methods we derive from them, regularly and effectively with our clients. And ... we might now need to begin to take a degree of responsibility for this. Very shortly we will need to be able to demonstrate clearly why and how this ‘body psychotherapy’ – for lack of a better word ‘works’ for us. We need to provide some sort of ‘evidence’ that this is the case; we need to be able to ‘show’ – in a variety of ways – that these perspectives are valid and these methods are ‘sound’ and ‘safe’ and some of these ways of showing (natural science) may be alien to us, but are still necessary, if not required; we will also need to utilize ‘appropriate’ forms of science, in order to do this without betraying our own perspectives; we will need to provide ‘proof’ that these methods are effective, efficacious, and possibly even economic.

We are also going to have to acknowledge that – to date – body psychotherapy has not yet done very much of this.

⁴ In 2009, the European Association of Psychotherapy (EAP) proposed a 3-year project along these lines to establish the ‘functional competencies’ of a European psychotherapist, as part of the development a “common platform” for psychotherapy across all 26 EU countries.

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Biography

Courtenay Young originally trained in Body Psychotherapy about 30 years ago. He currently works as a counselor and psychotherapist in the NHS in and around Edinburgh, Scotland, as well as having a private practice. He co-edits both the International Journal of Psychotherapy, and the Journal of Body, Movement and Dance in Psychotherapy. He has just completed a book: "*Help Yourself Towards Mental Health*" (Karnac, 2010) and has also started to edit the English-American edition of the massive "*Handbook of Body Psychotherapy*" (edited by Gustl Marlock & Halko Weiss: published in German, 2006, by Schattauer). E-mail contact: courtenay@courtenay-young.com

Effect of “Clearing a Space” on Quality of Life in Women with Breast Cancer

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Abstract

This pilot study (N=17) explored the effectiveness of a body-oriented psychosocial intervention called Clearing a Space (CAS) on the quality of life of women with breast cancer. The format was six weekly 40 minute CAS interventions delivered individually with a wait list control. Our hypothesis was that these interventions would improve the quality of life for the participants. There was a post-intervention exit interview that produced qualitative information on the participants’ evaluations of the experience. Both the quantitative and qualitative data demonstrated the effectiveness of this brief intervention.

Keywords

Focusing - Complementary and alternative therapies – Cancer - Clearing a Space

Introduction

Focusing is a body-oriented process of attending to subtle inner cues that successful therapy clients naturally use. Developed by Eugene Gendlin in the 1960s, it is a method that accesses meaning that is carried in the body by attending inwardly to somatic experience (Gendlin, 1981, 1991).

Clearing a Space (CAS) is the first step in Focusing and also can be used alone as a freestanding stress-reduction method. Following a CAS protocol, participants are guided to sense what concerns or burdens their body is carrying in the present moment and imagine sequentially placing each issue outside of the body or at a distance. This allows participants to experience how they would feel in the body without those burdens. Participants then spend a few moments in this “cleared space,” which typically results in a sense of physical relief and psychospiritual well-being. (Grindler, 1991; Klagsbrun, et al., 2005; Pettinati, 2002).

Over 80 research studies since the 1960’s support the efficacy of Focusing in psychotherapy (Hendricks, 2001). Previous studies of body-based Focusing interventions have shown that subjects achieved an improved ability to process and resolve emotional and psychological issues in their life (Grindler, 1991; Klagsbrun, et al., 2005).

Focusing has been linked to emotional benefits for people with physical illnesses and physical pain (Klagsbrun, 1999, 2001; Pettinati, 2002). Similarly, mindfulness has demonstrated improvement in psychological function, a reduction in stress symptoms, and enhanced coping and well-being in cancer patients (Ott, Norris, & Bauer-Wu, 2006). Focusing and meditation are both examples of complementary and alternative medicine (CAM), methods, which 80% of women with early stage breast cancer have chosen to use to improve their quality of life (Wyatt, Sikorskii, Wills, & Su, 2010).

The benefits of a Focusing intervention are of potentially great relevance to persons with cancer. Research on the treatment of cancer patients has demonstrated the need for interventions that address the social, emotional and psychological needs of individuals and families dealing with this life-altering and life-threatening disease (Carlson & Bultz, 2003). Holzner et al. (2001) presented data suggesting that five years after initial treatment and beyond, women with breast cancer are still in need of psychosocial support. Studies have shown a high prevalence of distress, i.e., fear, depression, anxiety, insomnia, etc., in patients across all stages of diagnosis, treatment, recovery and remission. In addition to biological correlates, social isolation and disruption along with the stress of receiving care and making significant life changes, may contribute to the prevalence of depression and other symptoms of distress in cancer patients (McDaniel, Musselman, Porter, Reed, & Nemeroff, 1995; O’Leary, 1990).

The most common psychiatric disorder experienced by cancer patients is major depression, with prevalence rates ranging from 13% to 56% (Croyle & Rowland, 2003). Depressed cancer patients experience more decline in quality of life, more rapid symptom progression, and increased mortality, pain, metastasis, and medical utilization than cancer patients who are not depressed (Ciaramella & Poli, 2001; Parker, Baile, DeMoor, & Cohen, 2003; Spiegel, Bloom, Kraemer, & Gottheil, 1989; Spiegel & Giese-Davis, 2003).

Studies have affirmed that psychosocial interventions can help alleviate distress and improve immune functioning in cancer patients (Fawzy, Fawzy, Arndt, & Pasnau, 1995). While researchers currently disagree as to whether psychosocial interventions improve survival rates, a number of meta-analyses have shown other beneficial effects of psychosocial interventions with cancer patients. A 1995 meta-analysis of forty-five studies of adult cancer patients found significant, positive effect sizes on outcome measures of emotional adjustment, functional adjustment, and treatment/disease-related symptoms in adult cancer patients (Mayer & Mark, 1995). A more recent meta-analysis of 37 controlled studies evaluating the effectiveness of psychosocial interventions for quality of life in adult cancer patients reported an overall effect size of .31 for

the 3120 cancer patients suggesting that psychosocial interventions are indeed beneficial (Rehse & Pukrop, 2003). (See also, Newell, Sanson-Fisher & Savolainen, 2002).

Method

In this study, each participant was guided through the CAS protocol by a Focusing coach in six weekly half-hour sessions, administered in person during sessions one and six and over the telephone during sessions two through five. In each session, the coach guided the participant in the CAS protocol and then completed a post-CAS checklist to score the degree to which the participant was able to place her difficulties aside and reach a “cleared space” during that session. (See Appendix for the complete protocol). In addition to the checklist, which was completed after each session by the Focusing coach, the participants filled out the following four instruments both before the treatment began and after the treatment sessions were complete: 1) The Functional Assessment of Cancer Therapy-Breast (FACT-B), 2) Grindler Body Attitude Scale, 3) Inventory of Attitudes 32-R, and 4) Brief Symptom Inventory (BSI). Using a waitlist control group, these four instruments were administered to the participants before session one and after session six and after six weeks for the waitlist controls. In addition to the quantitative findings, qualitative data were gathered by the Focusing coaches both during the six CAS sessions and during exit interviews conducted several weeks after the conclusion of the interventions.

Participants

Seventeen out of the initial group of 24 participants completed the study. All were Caucasians ranging in age from 43 to 65 years of age. Twelve had spouses or partners and four were divorced. All but two had one or more children, with three of the participants coping with school-aged children at home. Sixteen were college graduates, six with graduate level education. They ranged broadly in the length of time they had been dealing with their cancer, cancer stage, and their course of treatment. Five had stage I cancer; six had Stage II; two had stage III; and the balance were unknown. Nine of the participants had been diagnosed within three years preceding the study, and eight been diagnosed from 4 to 9 years prior.

Results

Quantitative Findings

It was hypothesized that the intervention would result in improvements in the participants’ quality of life, as measured by the four instruments listed above. A statistically significant difference was found for the FACT-B measure between the participants and control group (Table 1).

Table 1

FACT-B Treatment versus Controls by Time

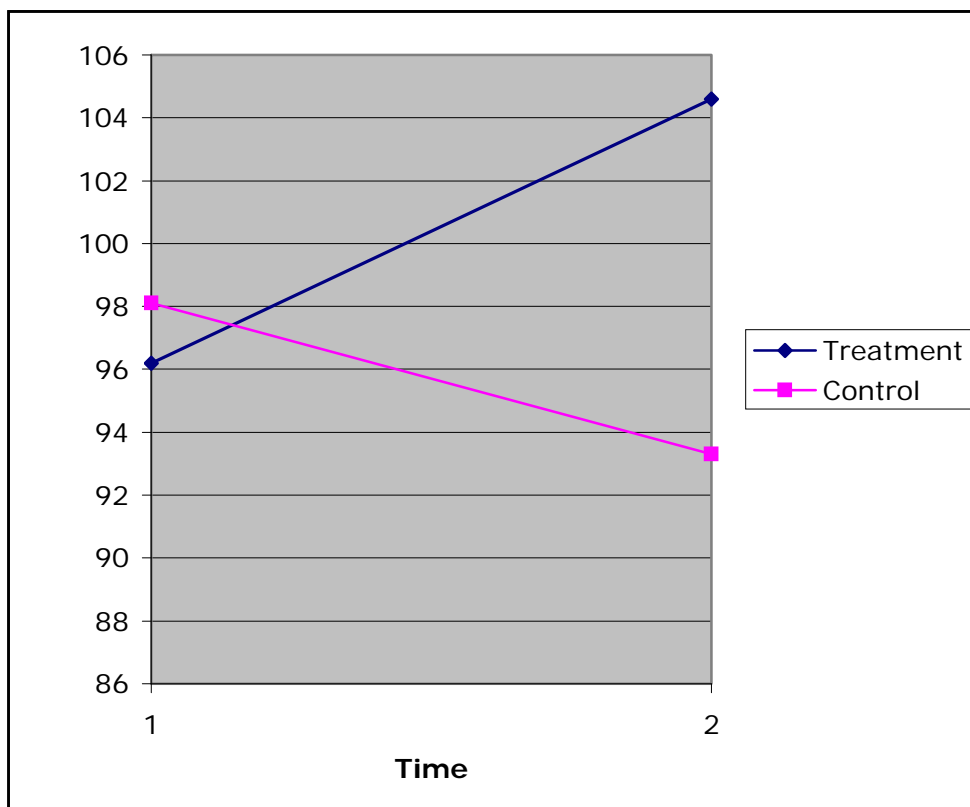
Condition	T1 Mean (SD)	T2 Mean (SD)*	T3 Mean (SD)
Treatment	96.2 (25.89) (N=11)	104.6 (23.03) (N=12)	-
Control (N=5)	98.1 (17.64)	93.3 (20.3)	112.7 (17.89)

* p=0.03

Figure 2. FACT B TOTAL by Time for Each Condition

Functional Well-Being	Not at all	A little bit	Somewhat	Quite a bit	Very much
I am able to work (include work at home)					
My work (include work at home) is fulfilling					
I am able to enjoy life					
I have accepted my illness					
I am sleeping well					
I am enjoying the things I usually do for fun					
I am content with the quality of my life right now					

The FACT-B is a 44-item self-report instrument designed to measure several facets of quality of life in patients with breast cancer, including physical, social, family, emotional, and functional well-being. Figure 1 shows the questions contained in the FACT-B instrument. The other measures showed no statistically different results between participants and controls. *Figure 1.* Text of a Subtest of the FACT-B



A second important finding was that there were no statistically significant differences between the delivery methods. Participants achieved equivalent scores on the CAS checklist whether the intervention was delivered live or by telephone. In their exit interviews participants reported they preferred having their CAS sessions on the telephone as frequently as they did in person.

Qualitative Findings

Thirteen of the 17 women who completed the study participated in exit interviews several weeks after their last CAS session. All of them reported that they benefited from the CAS process and intended to continue to use it. The major changes the participants noted in their exit interview were a greater sense of calmness, enhanced emotional self-regulation, improved coping,

increased mental clarity, greater overall well-being, and a sense of empowerment in dealing with the fear, anxiety, and other issues related to their illness.

Case Report

This case report describes the experience of a participant named Linda (pseudonym), a 55-year-old woman with Stage III breast cancer diagnosed approximately three years before the study. Prior to the study, she had used a variety of alternative, complementary, or mind-body treatments, including acupuncture, guided imagery, herbal medicine, hypnosis, prayer/faith healing, and support groups.

Throughout her six sessions, Linda focused on her bodily sense of feeling tense, knotted up, jumpy, worried, and exhausted from dealing with all of her doctor’s visits and medical procedures. In addition to these chronic bodily experiences, she was weighed down by concerns about a close relative who was dying of cancer, fears regarding her own upcoming medical tests and possible relapse, and her sense that her future was uncertain due to her illness-induced unemployment.

During her six CAS sessions, Linda achieved CAS scores of 8, 9 and 10, 10 being the highest possible score. As a result of the CAS procedures, Linda was able to work through her fears about her own cancer, as well as her relative’s precarious medical condition.

Linda also made steady progress in reducing her anxiety during the study period. In her first CAS session, she progressed from having an anxious feeling “like a high-tension wire humming” to feeling “quiet and still.” Similarly, during her second session, Linda moved from feeling “jumpy and worried” at the beginning of the session to feeling “mellow” at the end. Facing an upcoming MRI, she started her third session feeling like a “jumping bean” and very weary from all the medical procedures, but by the end of the session, she described herself as feeling “very relaxed. Like my lungs have more room to breathe.”

By the fourth session, Linda’s feelings of greater peace and calmness seem to have become more prominent in her life outside of the CAS sessions. As she entered the fourth session, she announced that she did not feel tense anymore and that, to the contrary, she felt “relaxed and mellow.” She was now able to deal with the possibility of her cancer recurring. Although she had the image that her cancer was like a “geyser bubbling and boiling underneath the smooth surface,” she also arrived at a feeling of certainty that she was not going to die from it. This led her to the realization that she needed to remain very positive in her cancer support group, but also that she must give priority to her own needs over those of other group members.

At the beginning of her fifth session, she reported feeling “calmer now—not so much comes up.” Nevertheless, she also sensed that she was keyed up “like electricity humming” about the possible adverse effects on her health of an upcoming airplane trip. During the session, she was able to replace her sense of worry with a more relaxed sense she described as a “big space inside.”

Linda ended her sixth and final CAS session feeling more empowered and less consumed by her illness. She said, “I don’t want to be ‘Cancer Girl’ and be defined by this.” She was able to identify and move out a part of herself that was reluctant to let go of her identification with the cancer. After doing so, she said, “I feel stronger now, more like me.” At the end of her final session she told her coach, “I feel very peaceful, very calm. I feel done.”

In her exit interview, Linda said that she had found the CAS intervention very valuable because “it stopped the process of being tense and anxious. Sometimes you get on autopilot and you don’t even know you are tense.” She described her present state as “much more calm on a day-to-day basis.”

When asked whether she would recommend Focusing to others with breast cancer, Linda replied, “Definitely. If done during treatment it could help a lot. It would take the fears away. ...Also, I think it is important to help people after treatment when all the support and attention is gone. There are no guideposts about what to do now.”

When asked how Focusing compared to the other CAM modalities she had experienced, including acupuncture, hypnosis, and meditation, she replied, “Focusing has a more lasting effect. With hypnosis, something might go away, but you don’t know how. With Focusing, you are more engaged, more in control. Connecting the body and the mind seems to make a difference.”

Discussion

Body-oriented psychotherapists increasingly need to find ways to address their clients’ trauma and to cultivate psychosocial health and wellbeing in all patients, including patients with life-threatening illnesses. Increasingly there is recognition that a cancer diagnosis can be traumatizing for patients (Ott, et al., 2006; Stark, Kiely, Smith, Velikova, House & Selby, 2002; Trask, et al., 2001). There is growing patient demand for complementary and alternative medicine (CAM) and mind-body services geared toward helping them cope with cancer and readjust to life after treatment. As noted in the data above, this brief psychosocial body-based intervention of Clearing a Space resulted in a greater sense of calmness, enhanced emotional self-regulation, improved coping, increased mental clarity, greater overall well-being, and a sense of empowerment in dealing with the fear, anxiety, and other issues related to cancer.

One of the most important and practically useful findings gathered from the exit interviews was that a majority of the participants were equally satisfied with receiving the treatment by telephone as in person. This suggests that providers can offer this beneficial, body based intervention in a convenient and cost-effective format. This delivery method is well matched for this population, for whom travel can be burdensome.

Furthermore, participants found that Focusing had certain advantages as compared to other mindfulness procedures. More specifically, the participants commented on the relational benefits of this method, which are not incorporated into other mindfulness measures. A further benefit for many of the participants was the structured step-wise nature of the intervention, which guided them to turn their attention inward to their body sense and to find there a sense of peace and spiritual well-being.

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Appendix

CLEARING A SPACE PROTOCOL

Before we begin, it would be helpful for you to choose a comfortable space. You could be lying down or sitting in a comfortable chair...hopefully somewhere where you won't be distracted or interrupted. So take some moments to get comfortable and let me know when you feel ready to begin.

1. When you are ready, you might want to close your eyes, if that feels right, and then begin becoming aware of your body as it rests into a comfortable position...feeling how your body is being supported by the chair - or if you are lying down, sensing that surface, and then just taking a few deep breaths – in and out. You might notice your breathing as it begins to slow down with each exhalation (5 seconds pause) and just allow your attention to gently come into the center of your body. Ask yourself, “How am I right now?” (PAUSE) or “Is there anything that might be in the way of feeling fine?” (5 seconds pause). Just letting your body do the answering and let me know when something shows up. (10 seconds pause). Now taking a moment to sit with it with friendly acceptance, notice the quality of that in the body. (10 seconds pause).
2. Now seeing if there is a word, phrase or image that captures the quality of how all of that feels in your body, let me know if you find something (5 second pause)...saying the word, phrase or image back to yourself, check to see if it fits the sense you have there exactly. Is that still the right way to capture your concern?

3. Now giving this concern your accepting, friendly attention for a few moments so that you can acknowledge that it’s really there (5 second pause) then putting it aside for a while by imagining that you are placing the whole thing outside of your body, in a safe place at the right distance away. Sometimes it helps to imagine that you are sitting on a park bench, wrapping each *concern* up, and placing it on the bench next to you – or at whatever distance would feel right. And let me know when you have been able to set it aside or if you need more help doing this. (10 second pause).
4. You might find yourself noticing whether you feel a little lighter or clearer inside without that one.
5. Now again bringing your attention inside ask, “Except for that, am I feeling fine?” (5 seconds). Wait and see if something else wants your attention next and let me know whether there is anything else there. (PAUSE).
6. Now allow a felt sense of that *concern* to form (PAUSE) and see if a word, phrase, or image captures the quality of how this *concern* feels in your body. (PAUSE) And then, after spending a little time with it, see if you can place it outside your body in a safe place as well. (10 second pause) You might be noticing now whether you feel a little lighter or clear inside without that one. (PAUSE).
- (Allow the person to clear out up to five concerns before moving on to #7 If they cannot set aside a concern or they get stuck here...you may continue working with them until you have reached the time limit and note that they did not reach a cleared space)*
7. Now in addition to those issues, most of us have a background sense – always feeling a little anxious, or sad, or harried, or tense – and just checking inside you might see if you can find a background sense that’s there for you today? Now see if you can place that out as well and let me know whether you have been able to do that. (10 seconds pause).
8. Now bringing your attention back inside your body and noticing, is there a clearer space there? (10 seconds)
- (If they get to a cleared space at this point, skip ahead to #10 if not, continue through #9)*
9. **IF THEY DO NOT GET TO A CLEARED SPACE (Choose one or more of the following):**
- 9A. Is there something your body might want or need from you right now? (PAUSE) If you could imagine yourself doing that how would it feel?
- 9B. Is there anything else there that might be in the way of feeling fine?
- 9C. There may not be one, but see if there is a forward step that comes right from this place.
- (If they cannot set aside a concern or they get stuck here...you may continue working with them until you have reached the time limit and note that they did not reach a cleared space)*
10. **IF THEY DO GET TO A CLEARED SPACE (Choose one or more of the following):**
- 10A. You may find yourself welcoming this space and allowing yourself to rest in it. (10 second PAUSE). Remembering that you are not your problems, even though you have them. (PAUSE). See if a word, phrase, image or gesture captures how it feels. (10 seconds). Now check to see if this fits how it feels there.
- 10B. Spending a little time with whatever comes there for you, you might check to see if there is a way to remember or mark this spot so you can come back to it if you would like to.
- 10C. Now you might notice what it would be like to have more of this in your life (PAUSE)
- 10D. There may not be one, but see if there is a forward step that comes right from this place.
11. **CLOSING TO USE WITH OR WITHOUT CLEARED SPACE (Use both of the following):**
- 11A. Now that we’re about to end for today, you might ask take a moment to check-in with yourself and ask, how am I feeling right now?
- 11B. And when you are ready, slowly and gently bring yourself back into the room (END).

Biography

Joan Klagsbrun Ph.D., has been a psychotherapist in the Boston area for 34 years and has been a longtime Focusing practitioner and teacher. She teaches Focusing nationally and internationally to psychotherapists and health care professionals. Her work is on the interface of health, spirituality and psychology. Joan is an Adjunct Faculty Member, Division of Clinical Mental Health Counseling, Graduate School of Arts & Sciences, Lesley University. She has authored many articles and a video entitled *A Focusing Approach to Life Changing Illness*. She can be reached at joanklag@mac.com

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The Effects of Body Experience and Mindfulness on Body-Image Disturbance and Eating Disorders

Jennifer Bruha, Ph.D.

Abstract

Objective: The role of body experience and mindfulness in body-image disturbance and eating disorders were examined. Method: Participants were 128 adult females, with and without anorexia and with higher- versus lower-symptomatology bulimia, who completed eight surveys on a Web site. Descriptive statistics, ANOVAs, and Pearson Product Correlations were calculated. Results: Individuals with anorexia and higher-symptomatology bulimia scored significantly higher in body-image disturbance and significantly lower in body experience and mindfulness, with more negative thinking and lower overall life satisfaction, when compared to individuals without anorexia and lower-symptomatology bulimia, respectively. Positive moderate correlations were found indicating similarities between individuals with anorexia and higher-symptomatology bulimia and between individuals without anorexia and lower-symptomatology bulimia. Discussion: Individuals with eating disorders do not practice mindfulness, possibly because they equate being mindful with “feeling fat.” This may be attributed to lack of learning, cognitive impairments, or willful choice, all of which are explored.

Keywords

Eating disorders - Body image - Mindfulness - Body consciousness - Well-being

Introduction

Anorexia Nervosa and Bulimia Nervosa are eating disorders that have as a core feature the presence of body-image disturbance. Anorexia is characterized by starvation and emaciation, but a subtype of individuals with anorexia engage in repeated episodes of binge-eating and purging (American Psychiatric Association, Diagnostic and Statistical Manual, IV-TR, 2000). Bulimia is characterized by a pattern of binge-eating and purging, or compensatory behaviors including fasting, misusing laxatives and diuretics, and extreme over-exercising (DSM-IV-TR, 2000). Body-image disturbance is generally defined as a disturbance in how accurately an individual perceives their body image, and an over-evaluation and preoccupation with body weight and shape (Delinsky, 2005; Shafran, Fairburn, Robinson, & Lask, 2003). With both these conditions, individuals perceive their bodies as being and looking different from reality, in most cases appearing larger. Weight and shape-checking behaviors and body-avoidance behaviors are characteristic of body-image disturbance as well as a negative evaluation of body image (Shafran et al., 2003). Moreover, individuals with body-image disturbance appear to demonstrate minimal body consciousness, comprising body experience, or awareness and attention to sensations and feelings, and mindfulness, a more advanced form of awareness (Brown & Ryan, 2003). Research suggests body experience and mindfulness are important in achieving good health, safety and comfort, and growth and development.

Purpose and Significance

Females with and without eating disorders often experience a heightened level of self-consciousness and self-criticism due, in part, to the socio-cultural perception of thinness and beauty in the West. This often fuels body-image disturbance, which is associated with higher levels of disordered eating behaviors. Although body experience, or awareness of inner and outer sensations and feelings, and to a greater extent, mindfulness, or attention and awareness in the present, with an ability to self-reflect, have been incorporated into Eastern philosophies and practices as a means of treatment for various ailments and disorders (e.g., anxiety, depression), the effects of such practices on Western mental health disorders such as anorexia and bulimia have only received minimal attention. Thus, the relationship between and effects of body experience and mindfulness on eating disorders are not well understood. Results of this study will potentially contribute to the growing body of research in the treatment of anorexia and bulimia from a Cognitive-Behavioral viewpoint, with an emphasis on the relationship between body-image disturbance and mindfulness.

Summary of Research Questions

In the United States, negative body-image and dissatisfaction with body weight and shape are increasing among females, raising the prevalence rates of eating disorders (Jones et al., 2001, Lask & Bryant-Waugh, 2000). In addition, there is evidence suggesting that body experience and mindfulness are important in the development and maintenance of a positive body-image, but may be low in women with eating disorders as they focus on the negative aspects of their bodies (Anderson, 2006). Thus, it is hypothesized that women who score higher on measures of anorexia and bulimia will score higher on tests measuring body-image disturbance, lower on tests measuring mindfulness, and lower on positive affect and life satisfaction. In contrast, it is predicted that women who score lower on eating disorder measures, would score lower in body-image disturbance, higher in body experience and mindfulness, and higher on positive affect and life satisfaction. Finally, it is hypothesized that scores on tests will be similar between participants with anorexia and higher-symptomatology bulimia and between those without anorexia and lower-symptomatology bulimia.

Methods

Design

This was a Web-based study, and the address was www.body-imagesurvey.com. Use of the World Wide Web for research purposes has increased substantially, making it a popular source for participants due to the larger and more diverse pool.

Sample

A sample of 128 adult women, ages 18 to 50, participated in this research study, and inclusion was determined by their responses and scores on the Eating Questionnaire-Revised and the Eating Attitude Test, which indicate presence, if any, and severity of eating disorders.

Participants with eating disorders were recruited from eating disorder websites, flyers posted in treatment facilities and in the offices of therapists who work with eating disordered individuals, and from college professors who offered extra credit to female students who completed the surveys online. A short statement summarizing the purpose of the study was posted on such websites and flyers along with the website address and a link. Confounding variables were determined in demographic questions and factored into statistical analysis.

Procedures and Analysis

On the study's website, there was a home page with warnings, a consent form, a list of demographic questions, questionnaires, and a list of eating disorder resources. The home page noted the following: That participants must be female and 18 or older and that the study consists of eight questionnaires, which would take approximately a total of 30-60 minutes to complete. Each participant was given a consent form that stated their rights to participate in the survey, to decline answering questions, to withdraw without penalty at any time, and to obtain results when available. The following demographic information was gathered in questions: age, ethnicity, socioeconomic status, marital/relationship status, educational grade level, family stability, history of trauma, history of eating disorders, and history of treatment.

Responses from questionnaires were scored and descriptive statistics were calculated. One-way ANOVAs were computed to determine the frequencies and significance of participants with and without anorexia on tests measuring body-image disturbance, body experience and mindfulness, and well-being. One-way ANOVAs were also calculated to determine frequencies and significance among participants with higher-symptomatology and lower-symptomatology bulimia on all tests. Pearson Product Correlations were calculated to determine if there were statistically significant relationships between presence and severity of eating disorders, degree of body-image disturbance, inner and outer body experience, mindfulness, and overall well-being and satisfaction. Correlations (with $p < .05$) ranging from .01 - .30, .31 - .70, and .71 - .99 were categorized as low, moderate, and high correlations, respectively, and a distribution of test results is presented in a table.

Instruments

Potential participants were asked to complete eight questionnaires that included: The Eating Questionnaire-Revised to assess for bulimia; the Eating Attitudes Test to assess for anorexia; the Body Image Avoidance Questionnaire and Body Checking Questionnaire to assess for presence and severity of body-image disturbance; the Mindful Attention Awareness Scale and the Kentucky Inventory of Mindfulness Skills to assess body experience and mindfulness; the Positive and Negative Affect Schedule to assess affect and well-being; and the Satisfaction With Life Scale to assess subjective life satisfaction.

Participants were screened using the Eating Questionnaire-Revised (EQ-R) developed by Williamson, Davis, Goreczny, McKenzie, & Watkins (1989) and was designed for the purpose of assessing behaviors that are characteristic of Bulimia Nervosa. The EQ-R is a 15-item, self-report questionnaire. Item scores are summed up in a forward procedure ranging from a = 1 to e = 5 for a total score, with items 7 and 10 reverse-scored in which a = 5 and e = 1.

The Eating Attitudes Test (EAT), developed by Garner & Garfinkel (1979), assesses behaviors and attitudes characteristic of Anorexia Nervosa. The EAT is a 40-item, self-report questionnaire that uses a 6-point Likert scale. Scores may range from 0 to 120, with scores of 30 and above indicating that the criteria for a diagnosis of anorexia have been met.

The Body Image Avoidance Questionnaire (BIAQ), developed by Rosen, Srebnik, Saltzberg, & Wendt (1991), is a 19-item questionnaire that assesses body avoidance and body over-evaluation along four dimensions: Clothing, social activities, eating restraint, and grooming and weighing behaviors. Responses fall along a 6-point Likert-type scale ranging from 0 (*never*) to 5 (*always*), and more negative responses signify more intense body dissatisfaction (Rosen et al., 1991).

The Body Checking Questionnaire (BCQ), constructed by Reas, Whisenhunt, Netemeyer, & Williamson (2002), is a 23-item questionnaire that assesses behaviors related to body, weight, and shape checking, both overall and with specific body parts. Responses fall along a 5-point Likert-type scale ranging from 1 (*never*) to 5 (*very often*).

The Mindful Attention Awareness Scale (MAAS) by Brown & Ryan (2003) measures attention and awareness to one's body and the environment. Responses fall along a 6-point Likert scale ranging from 1 (*almost always*) to 6 (*almost never*), in which higher scores reflect more mindfulness.

The Kentucky Inventory of Mindfulness Skills (KIMS), developed by Baer, Smith, & Allen (2004), is a self-report measure designed to address the question, "What does one do (or refrain from doing) when being mindful?" (p.193). The KIMS measures mindfulness skills presented by Marsha Linehan (1993a, 1993b), who has researched mindfulness extensively, in the context of Dialectic Behavior Therapy (DBT). Four mindfulness skills are each measured separately in a comprehensive scale that consists of: Observing, or noticing internal stimuli such as sensations, cognitions, and emotions, and external stimuli such as odors; describing, or using words to label feelings; acting with awareness, or focusing one's attention on one thing at a time; and accepting without judgment, or accepting one's experience in the moment without making judgments (Baer et al., 2004). Responses fall on a 5-point Likert-type scale from 1 (*never or very rarely true*) to 5 (*almost always or always true*), with higher scores indicating a greater degree of mindfulness.

The Positive and Negative Affect Schedule (PANAS) by Watson, Clark, & Tellegen (1988) is comprised of two 10-item scales, the Positive Affect Scale (PAS), which measures enthusiasm, energy, and alertness, and Negative Affect Scale (NAS), which measures negative states such as anger, contempt, disgust, and fear (Watson et al., 1988). Using a 5-item Likert-type scale ranging from 1 (*very slightly or not at all*) to 5 (*extremely*), participants were asked to indicate how they felt in general.

The Satisfaction With Life Scale (SLS), by Diener, Emmons, Larsen, & Griffin (1985) measures level of subjective well-being and overall life satisfaction. The SLS is a 5-item scale that measures degree of life satisfaction using a 7-point Likert-type scale ranging from 1 (*strongly disagree*) to 7 (*strongly agree*) with a total score between 5 and 35, in which higher scores indicate greater life satisfaction.

Method

Descriptive Statistics

Demographic information was assessed in a series of questions posed after participants consented to participate in the study, and frequencies of demographic information were calculated among participants ($M = 26.7$, $SD = 8.37$). Participants' ethnicities comprised the following, from highest to lowest: Caucasian ($n = 97$, 75.8%); Asian-American ($n = 10$, 7.8%); African-American ($n = 6$, 4.7%); Latina/Chicana ($n = 6$, 4.7%); Other (n

= 5, 3.9%); Native-American ($n = 2$, 1.6%); and Pacific-Islander ($n = 2$, 1.6%). Participants' highest level of education completed comprised the following: Some college ($n = 67$, 52.3%); 4-year degree (e.g., B.A., B.S.) ($n = 24$, 18.8%); advanced degree ($n = 24$, 18.8%); and high school diploma or GED ($n = 13$, 10.2%). Annual household income was reported: Less than \$30,000 ($n = 57$, 44.5%); \$30,001 - \$60,000 ($n = 31$, 24.2%); over \$90,000 ($n = 24$, 18.8%); and \$60,001 - \$90,000 ($n = 16$, 12.5%). Fifty-four participants (42.2%) of participants reported a history of sexual and/or physical abuse, whereas 73 (57.0%) reported no past abuse.

Seventy-five participants (58.6%) reported a previous diagnosis of an eating disorder, including: Anorexia ($n = 30$, 23.4%); bulimia ($n = 15$, 11.7%); both anorexia and bulimia ($n = 13$, 10.2%); and other (e.g., EDNOS, Body Dysmorphic Disorder, Binge Eating Disorder) ($n = 13$, 10.2%). Fifty-three participants (41.4%) reported no previous diagnosis of an eating disorder.

Eighty participants (62.5%) identified as having been previously diagnosed with a psychiatric disorder, with the most common being mood disorders, including: Depression ($n = 51$, 39.8%); bipolar disorder ($n = 9$, 7.0%); and dysthymia ($n = 1$, 0.8%). The second largest category reported was anxiety disorders, including: Anxiety disorder and Generalized Anxiety Disorder ($n = 25$, 19.5%); PTSD ($n = 15$, 11.7%); OCD ($n = 5$, 3.9%); and panic disorder ($n = 1$, 0.8%). Other psychiatric disorders reported by participants were ADHD ($n = 3$, 2.3%); Borderline Personality Disorder ($n = 4$, 3.1%), and other ($n = 5$, 3.9%).

Eighty-five participants (66.4%) reported having no known relatives with an eating disorder, and 43 (33.6%) reported having a relative. Forty-six participants (35.9%) reported currently being in treatment for an eating disorder, and 29 with an eating disorder (22.7%) have been in treatment for more than one year, while 9 (7.0%) for less than one year. Of those in treatment, 41 (32.0%) identified as being in individual therapy, 10 (7.8%) in group therapy, 3 (2.3%) in family therapy, and 4 (3.1%) are in nutritional counseling. Of those individuals currently in eating disorder programs, 7 (5.5%) are in inpatient treatment programs, 7 (5.5%) are in outpatient treatment, and 4 (3.1%) are in both.

Sixty-four individuals (50%) reported being treated in the past for an eating disorder. Of those, 26 (20.3%) were treated for less than one year, and 26 (20.3%) for more than one year. Of those treated in the past, 32 (25.0%) received individual therapy, 21 (16.4%) group therapy, 10 (7.8%) family therapy, and 1 (0.8%) nutritional counseling. Nineteen (14.8%) were in inpatient treatment at some time, 8 (6.3%) in outpatient treatment, and 21 (16.4%) in both.

Fifty-five (43.0%) of individuals reported currently taking psychiatric medications, while 72 (56.3%) reported taking no psychiatric medications. Medications were divided into 5 basic categories based on their psychiatric effects, including: Antidepressants, SSRIs, and SNRIs; anticonvulsant mood stabilizers; antipsychotics; stimulants; and benzodiazepines and depressants.

In addition, 12 (9.4%) of individuals reported drug (e.g., marijuana) or alcohol abuse, with last use varying between "last night" to several months ago. One hundred fourteen (89.1%) reported no substance abuse.

Participants who scored a total of 30 or more on the Eating Attitudes Test were categorized as having Anorexia Nervosa ($n = 65$), and those with 29 or less were categorized as not having anorexia ($n = 63$), as directed in the scoring materials (Garner & Garfinkel, 1979). A one-way Analysis of Variance was computed, comparing participants' EAT scores with and without anorexia on all of the following tests: The EQ-R; BIAQ; BCQ; MAAS; KIMS; PANAS; and SLS (see Table 1).

Table 1
Means, Standard Deviations, and Probabilities for Participants With and Without Anorexia

Tests	N = 65 Anorexia group		N = 63 Non-anorexia group		P
	M	SD	M	SD	
EQ-R	42.89	17.74	31.25	12.17	0.0001
EAT	50.25	11.52	14.73	8.31	0.0001
BIAQ	53.29	14.36	29.19	12.21	0.0001
Clothing factor	24.34	8.45	15.19	8.00	0.0001
Social situations factor	10.06	4.99	2.67	3.91	0.0001
Eating restraint factor	9.22	3.09	3.60	2.12	0.0001
Grooming and weighing	9.68	3.07	7.73	3.21	0.001
BCQ	77.12	21.49	50.62	21.66	0.0001
OAS	33.95	8.78	23.73	9.00	0.0001
BPS	29.34	8.60	18.19	8.80	0.0001
IC	13.83	6.22	8.70	4.90	0.0001
MAAS	41.14	12.04	58.48	16.59	0.0001
KIMS	103.57	16.28	121.00	17.30	0.0001
Observe skill	35.80	9.14	36.79	7.58	0.51
Describe skill	22.85	5.55	27.13	5.07	0.0001
Act with awareness skill	24.77	4.95	29.51	5.84	0.0001
Accept without judgment	20.15	7.95	27.57	9.04	0.0001
PAS	26.95	7.56	34.35	7.82	0.0001
NAS	33.32	8.21	24.70	8.93	0.0001
SLS	14.66	7.68	23.13	8.48	0.0001

Eating Questionnaire-Revised
Eating Attitudes Test
Body Image Avoidance Questionnaire
 Clothing
 Social Situations
 Eating Restraint
 Grooming and Weighing
Body Checking Questionnaire
 Overall Appearance Scale
 Body Parts Scale
 Idiosyncratic (ritualistic) Checking
Mindful Attention Awareness Scale
Kentucky Inventory of Mindfulness Skills
 Observe
 Describe
 Act with Awareness
 Accept without Judgment
Positive and Negative Affect Schedule
 Positive Affect Scale
 Negative Affect Scale
Satisfaction with Life Scale

Level of bulimia was determined by participants' total scores on the Eating Questionnaire-Revised, with higher scores reflecting higher-symptomatology bulimia (Williamson et al., 1989). Total scores were divided at the midpoint, 45, with scores of 44 or less (low to medium scores) indicating lower-symptomatology bulimia and scores of 45 or greater (medium to high scores) indicating higher-symptomatology bulimia. A one-way Analysis of Variance was computed comparing individuals with lower-symptomatology bulimia ($n = 67$) on the EQ-R and individuals with higher-symptomatology bulimia ($n = 50$) on the BIAQ, BCQ, MAAS, KIMS, PANAS, and SLS (see Table 2). Statistically significant differences were found between with higher- and lower-symptomatology groups on all tests.

Table 2

Means, Standard Deviations, and Probabilities for Participants With Higher-Symptomology and Lower-Symptomology Bulimia

Tests	N = 50 Higher-symptomology Bulimia		N = 67 Lower-symptomology Bulimia		P
	M	SD	M	SD	
EAT	48.54	14.90	20.51	16.07	0.0001
BIAQ	54.70	13.56	31.46	15.21	0.0001
Clothing factor	26.06	7.69	14.90	8.12	0.0001
Social situations factor	10.64	5.01	3.25	4.39	0.0001
Eating restraint factor	8.90	3.49	4.58	3.30	0.0001
Grooming and weighing	9.10	3.33	8.73	3.22	0.13
BCQ	74.80	22.18	57.07	26.14	0.0001
OAS	32.82	9.15	25.97	10.54	0.001
BPS	28.58	8.95	20.87	10.55	0.0001
IC	13.40	6.08	10.24	6.10	0.005
MAAS	39.88	12.01	56.27	17.11	0.0001
KIMS	101.52	15.74	119.81	17.68	0.0001
Observe factor	35.04	9.85	37.07	7.41	0.41
Describe factor	22.34	5.34	26.87	4.99	0.0001
Act with awareness factor	24.68	4.99	28.94	6.26	0.0001
Accept without judgment	19.46	7.52	26.93	9.31	0.0001
PAS	25.24	7.09	34.13	7.77	0.0001
NAS	35.40	7.44	24.75	8.87	0.0001
SLS	12.52	6.93	23.51	8.09	0.0001

Eating Questionnaire-Revised
 Eating Attitudes Test
 Body Image Avoidance Questionnaire
 Clothing
 Social Situations
 Eating Restraint
 Grooming and Weighing
 Body Checking Questionnaire
 Overall Appearance Scale
 Body Parts Scale
 Idiosyncratic (ritualistic) Checking
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 Kentucky Inventory of Mindfulness Skills
 Observe
 Describe
 Act with Awareness
 Accept without Judgment
 Positive and Negative Affect Schedule
 Positive Affect Scale
 Negative Affect Scale
 Satisfaction with Life Scale

Hypotheses

Hypothesis 1: Participants with anorexia will score higher on tests measuring body-image disturbance (BIAQ and BCQ), lower in tests measuring mindfulness as determined by the MAAS and KIMS, lower in positive affect (and higher in negative affect), and lower in overall well-being and life satisfaction. Participants without anorexia will demonstrate the reverse, scoring lower on the BIAQ and BCQ, higher in mindfulness on the MAAS and KIMS, higher in positive affect, and higher in life satisfaction.

Hypothesis 2: Participants with higher-symptomatology bulimia will score higher on tests measuring body-image disturbance (BIAQ and BCQ), lower on tests measuring body experience and mindfulness (MAAS and KIMS), lower in positive affect (PAS), and lower in life satisfaction (SLS). Participants with lower-symptomatology bulimia will score lower on the BIAQ and BCQ, higher on the MAAS and KIMS, higher in positive affect (PAS), and higher on the SLS.

Hypothesis 3: Participants with anorexia will score similarly to participants with higher-symptomatology bulimia; that is, higher on tests measuring body-image disturbance (BIAQ and BCQ), lower in body experience and mindfulness (MAAS and KIMS), lower in positive affect (PAS), and lower in life satisfaction (SLS), in comparison to participants without anorexia and lower-symptomatology bulimia. It is further hypothesized that individuals without anorexia will score similarly to those with lower-symptomatology bulimia in that they will score lower on the BIAQ and BCQ, higher on the MAAS and KIMS, higher in positive affect (PAS), and higher on the SLS.

Results

Hypothesis 1: The findings support the first hypothesis. A one-way Analysis of Variance was calculated, comparing participants with and without anorexia on all tests and revealed statistically significant differences between both groups (see Table 1). Participants with anorexia scored significantly higher than those without anorexia on the BIAQ and all four skills and on the BCQ and its three subscales, indicating participants with anorexia engaged in more body-avoidance and body-checking behaviors, characteristic of body-image disturbance. Participants with anorexia scored significantly lower than those without anorexia on the MAAS and KIMS, including three of its four component factors, the describe skill, the act with awareness skill, and the accept without judgment skill. With regard to the observe skill, the group with anorexia scored lower than the group without anorexia but not at a statistically significant level. In addition, individuals with anorexia scored significantly lower in positive affect on the PANAS, and scored significantly lower than those without anorexia on the SLS, measuring life satisfaction.

EQ-R data. Individuals with anorexia ($M = 42.89$, $SD = 17.74$) reported more symptoms of bulimia at a statistically significant level than individuals without symptoms of anorexia ($M = 31.25$, $SD = 12.17$), $F(1, 126) = 18.63$, $p < 0.0001$. This suggests individuals with anorexia are more likely to engage in behaviors characteristic of bulimia such as binge-eating followed by compensatory behaviors such as vomiting, abusing laxatives or diuretics, over-exercising, or fasting.

BIAQ data. As predicted, individuals with anorexia ($M = 53.29$, $SD = 14.36$) scored significantly higher in body-avoidance behaviors than individuals without anorexia ($M = 29.19$, $SD = 12.21$) on the BIAQ, $F(1, 126) = 104.36$, $p < 0.0001$. Participants with anorexia scored significantly higher than those without anorexia in the four factors comprising the BIAQ, including: clothing, social situations, eating restraint, and grooming and weighing (see Table 1).

BCQ data. Participants with anorexia ($M = 77.12$, $SD = 21.49$) scored higher on the BCQ than individuals without anorexia ($M = 50.62$, $SD = 21.66$), $F(1, 126) = 48.28$, $p < 0.0001$, and on its three composing scales (see Table 1). Taken together, higher scores on these scales indicate individuals with anorexia are more likely to engage in body-checking behaviors that focus on their appearance and body parts, often in comparison to others.

MAAS data. As predicted, participants with anorexia scored significantly lower in surveys measuring body experience and mindfulness, whereas participants without anorexia scored significantly higher in both. Participants with anorexia ($M = 41.14$, $SD = 12.04$) scored 17.34 points lower than those without anorexia ($M = 58.48$, $SD = 16.59$) on the MAAS, $F(1, 126) = 46.00$, $p < 0.0001$. This suggests that individuals with anorexia experience less mindfulness, or less attention and awareness to one's present state, and possibly a tendency toward engaging in blunted or restricted consciousness that limits one's emotional and physical availability (Brown & Ryan, 2003).

KIMS data. The group with anorexia ($M = 103.57$, $SD = 16.28$) scored lower at a

statistically significant level than the group without anorexia ($M = 121.00$, $SD = 17.30$) on the KIMS, $F(1, 126) = 34.77$, $p < 0.0001$, and on three of its four component factors. Participants with anorexia ($M = 22.85$, $SD = 5.55$) scored significantly lower than those without anorexia ($M = 27.13$, $SD = 5.07$) in the describe skill, $F(1, 126) = 20.75$, $p < 0.0001$, which suggests that the group with anorexia has more difficulty with identifying and labeling observed phenomena. The group with anorexia ($M = 24.77$, $SD = 4.95$) scored significantly lower than the group without anorexia ($M = 29.51$, $SD = 5.84$) in the act with awareness skill, $F(1, 126) = 24.55$, $p < 0.0001$, suggesting that participants with anorexia have more difficulty attending to one thing at a time. In the fourth factor, or accept without judgment skill, the group with anorexia ($M = 20.15$, $SD = 7.95$) scored significantly lower than the group without anorexia ($M = 27.57$, $SD = 9.04$), $F(1, 126) = 24.35$, $p < 0.0001$. Therefore, participants with anorexia are less likely to be nonjudgmental about their experiences, and they are more inclined to label their thoughts, feelings, and sensations as being good or bad, right or wrong, worthwhile or worthless, rational or irrational, and valued or de-valued. On the observe skill, the group with anorexia ($M = 35.80$, $SD = 9.14$) scored lower than the group without anorexia ($M = 36.79$, $SD = 7.58$), but not at a statistically significant level, $F(1, 126) = 0.45$, $p < 0.51$, suggesting that anorexics minimally practice attending to external and internal stimuli on a daily basis than the non-eating disordered (Baer et al., 2004). This raises the possibility that what they notice and attend to are the physical sensations of “fatness,” and are thus mindful of their “fatness.”

PANAS data. Participants with anorexia ($M = 26.95$, $SD = 7.56$) scored significantly lower than participants without anorexia ($M = 34.35$, $SD = 7.82$) on the Positive Affect Scale, $F(1, 126) = 29.60$, $p < 0.0001$, and they ($M = 33.32$, $SD = 8.21$) scored significantly higher than participants without anorexia ($M = 24.70$, $SD = 8.93$) on the Negative Affect Scale, $F(1, 126) = 32.38$, $p < 0.0001$. This suggests participants with anorexia may experience more “subjective distress” (Watson et al., 1988).

SLS data. As hypothesized, individuals with anorexia ($M = 14.66$, $SD = 7.68$) scored lower at a statistically significant level than individuals without anorexia ($M = 23.13$, $SD = 8.47$) on the Satisfaction With Life Scale, $F(1, 126) = 35.09$, $p < 0.0001$, suggesting that participants with anorexia report having less overall life satisfaction.

Hypothesis 2: The findings support the second hypothesis in that one-way ANOVAs were calculated, comparing participants with higher-symptomatology and lower-symptomatology bulimia on all tests and revealed statistically significant differences between the two groups. A one-way ANOVA was computed comparing individuals with low to medium scores (lower-symptomatology bulimia) ($n = 67$) on the EQ-R and individuals with medium to high scores (higher-symptomatology bulimia) ($n = 50$) on the EQ-R (see Table 2). Participants with higher-symptomatology bulimia scored significantly higher than those with lower-symptomatology bulimia in body-image disturbance (on the BIAQ and BCQ), in body experience and mindfulness (on the MAAS and KIMS), and lower in positive affect, well-being, and life satisfaction (on PANAS and SLS).

EAT data. Scores on the EAT were compared using Analysis of Variance to evaluate group differences among individuals with higher-symptomatology bulimia ($M = 48.54$, $SD = 14.90$), and lower-symptomatology bulimia ($M = 20.51$, $SD = 16.07$), $F(2, 125) = 46.29$, $p < 0.0001$, suggesting those with more severe bulimia also have more symptoms of anorexia.

BIAQ data. Individuals with higher-symptomatology bulimia ($M = 54.70$, $SD = 13.56$) versus those with lower-symptomatology bulimia ($M = 31.46$, $SD = 15.21$) scored significantly higher on the BIAQ, $F(2, 125) = 37.81$, $p < 0.0001$, and on three of its four comprising factors: clothing, social situations, and eating restraint (see Table 2). While the higher-symptomatology group ($M = 9.10$, $SD = 3.33$) scored higher than the lower-symptomatology group ($M = 8.73$, $SD = 3.28$) in grooming and weighing on the BIAQ, it was not a statistically significant difference, $F(2, 125) = 2.05$, $p < 0.13$. This suggests the higher-symptomatology group may engage in behaviors that focus on grooming and weighing more often, but not to the extent, bordering on obsession and preoccupation with weight that is characteristic of body-image disturbance and more severe eating disorders.

BCQ data. Participants with higher-symptomatology bulimia ($M = 74.80$, $SD = 22.18$) in comparison to those with lower-symptomatology bulimia ($M = 57.07$, $SD = 26.14$) scored higher at a statistically significant level on the BCQ, $F(2, 125) = 8.23$, $p < 0.0001$ and its three comprising scales, the OAS, BPS, and IC (see Table 2). Higher scores on all three scales, characteristic of the higher-symptomatology group, reflect a greater degree of body dissatisfaction, a negative body-image, a preoccupation with body weight and shape, a fear of fat and weight gain, and more frequent body checking behaviors (e.g., staring into mirrors, comparing the size of one’s thighs with the width of a chair) (Reas et al., 2002).

MAAS data. Individuals with higher-symptomatology bulimia ($M = 39.88$, $SD = 12.01$) scored lower on the MAAS than individuals with lower-symptomatology bulimia ($M = 56.27$, $SD = 17.11$) at a statistically significant level, $F(2, 125) = 17.64$, $p < 0.0001$, suggesting individuals who scored higher on the MAAS (the lower-symptomatology group) may be more mindful, or attentive, aware, and receptive to one’s experiences, physically and emotionally, and in turn, experience greater overall well-being. Individuals who scored lower (the

higher-symptomatology group) may experience less mindfulness, suggesting they are less attentive and aware of their present state, physically and emotionally, which is associated with lower levels of overall well-being.

KIMS data. Similarly, on the KIMS, individuals with higher-symptomatology bulimia ($M = 101.52$, $SD = 15.74$) scored lower than the lower-symptomatology group ($M = 119.81$, $SD = 17.68$), $F(2, 125) = 16.85$, $p < 0.0001$. There were statistically significant differences in three of its four comprising skills: describe (Factor 2); act with awareness (Factor 3); and accept without judgment (Factor 4). However, differences were not statistically significant between groups in (Factor 1) observe (see Table 2).

Participants with higher-symptomatology bulimia ($M = 22.34$, $SD = 5.34$), scored significantly lower than those with lower-symptomatology bulimia ($M = 26.87$, $SD = 4.99$), in the describe skill, $F(2, 125) = 10.31$, $SD = 4.99$, which suggests that individuals with higher-symptomatology bulimia are less likely to practice labeling or describing cognitions, feelings, and sensations they experience. Individuals with higher-symptomatology bulimia ($M = 24.68$, $SD = 4.99$), compared to those with lower-symptomatology ($M = 28.94$, $SD = 6.26$), scored significantly lower in the act with awareness skill, $F(2, 125) = 8.37$, $p < 0.0001$, suggesting participants with higher-symptomatology bulimia are significantly less likely to practice paying undivided attention to external and internal phenomena, may be more easily distracted, and less focused on the present state (Baer et al., 2004). Participants with higher-symptomatology bulimia ($M = 19.46$, $SD = 7.52$), versus lower-symptomatology participants ($M = 26.93$, $SD = 9.31$), had statistically significantly lower scores in the accept without judgment skill, $F(2, 125) = 10.81$, $p < 0.0001$, indicating that individuals with more severe bulimia are less likely to practice being nonjudgmental or non-evaluative in their experiences, and are more likely to judge their feelings, cognitions, and sensations as good or bad, right or wrong, valuable or worthless (Baer et al., 2004).

PANAS data. Individuals with higher-symptomatology bulimia scored higher in negative affect ($M = 35.40$, $SD = 7.44$) than positive affect ($M = 25.24$, $SD = 7.09$) while individuals with lower-symptomatology bulimia scored higher in positive affect ($M = 34.13$, $SD = 7.77$) than negative affect ($M = 24.75$, $SD = 8.86$). Likewise, participants with higher-symptomatology bulimia scored statistically significantly lower on the PAS than those with lower-symptomatology bulimia, $F(2, 125) = 21.54$, $p < 0.0001$, and scored statistically significantly higher on the NAS, $F(2, 125) = 24.90$, $p < 0.0001$.

SLS data. Lastly, as predicted, the higher-symptomatology bulimia group ($M = 12.52$, $SD = 6.93$) reported having less overall life satisfaction than the lower-symptomatology group ($M = 23.51$, $SD = 8.09$) at a statistically significant level, $F(2, 125) = 30.57$, $p < 0.0001$. While one cannot assume a cause-and-effect relation, it leaves open the possibility that one or more of these factors influence their subjective satisfaction or dissatisfaction with life in general.

Hypothesis 3: The findings support the third hypothesis that participants with anorexia and higher-symptomatology bulimia score similarly on all tests, while participants without anorexia and lower-symptomatology bulimia also score similarly on all tests (BIAQ, BCQ, MAAS, KIMS, PANAS, SLS). Pearson Product Correlations were calculated comparing the relationship between scores on the EAT (for anorexia) and EQ-R (for degree of bulimia) with all tests (see Table 3).

Table 3
Table of Correlations

Tests	EQ-R		EAT	
	<i>r</i>	<i>p</i>	<i>r</i>	<i>p</i>
EQ-R	1.00	-	0.47	0.01
EAT	0.47	0.01	1.00	-
BIAQ	0.43	0.01	0.79	0.01
Clothing factor	0.34	0.01	0.62	0.01
Social situations factor	0.39	0.01	0.73	0.01
Eating restraint factor	0.38	0.01	0.83	0.01
Grooming and weighing	0.21	0.05	0.29	0.01
BCQ	0.39	0.01	0.65	0.01
OAS	0.32	0.01	0.61	0.01
BPS	0.42	0.01	0.65	0.01
IC	0.36	0.01	0.55	0.01
MAAS	-0.41	0.01	-0.55	0.01
KIMS	-0.33	0.01	-0.51	0.01
Observe skill	-0.03	-	-0.03	-
Describe skill	-0.23	0.01	-0.37	0.01
Act with awareness skill	-0.28	0.01	-0.42	0.01
Accept without judgment	-0.32	0.01	-0.51	0.01
PAS	-0.40	0.01	-0.50	0.01
NAS	0.44	0.01	0.56	0.01
SLS	-0.36	0.01	-0.50	0.01
Eating Questionnaire-Revised				
Eating Attitudes Test				
Body Image Avoidance Questionnaire				
Clothing				
Social Situations				
Eating Restraint				
Grooming and Weighing				
Body Checking Questionnaire				
Overall Appearance Scale				
Body Parts Scale				
Idiosyncratic (ritualistic) Checking				
Mindful Attention Awareness Scale				
Kentucky Inventory of Mindfulness Skills				
Observe				
Describe				
Act with Awareness				
Accept without Judgment				
Positive and Negative Affect Schedule				
Positive Affect Scale				
Negative Affect Scale				
Satisfaction with Life Scale				

Anorexia Nervosa. Pearson Product Correlations were calculated between Eating Attitudes Test scores and all questionnaires ($p < 0.01$). A positive moderate correlation was found between the EAT and EQ-R ($r = 0.47$), indicating that as scores on the EAT increased, scores on the EQ-R also increased, and vice versa.

Pearson Product Correlations were calculated and positive correlations between the EAT and tests measuring body-image disturbance were determined. A high positive correlation was calculated between the EAT and BIAQ ($r = 0.79$). Positive correlations were also calculated between the EAT and the BIAQ's four factors (see Table 3). Thus, as symptoms of anorexia increased, body-avoidant behaviors and body-image disturbance also increased. A moderate positive correlation was calculated with the BCQ ($r = 0.65$) and its three scales, the OAS ($r = 0.61$), the BPS ($r = 0.65$), and the IC ($r = 0.55$), indicating that as scores in anorexia increased, so did the scores measuring body-checking behavior and body-image disturbance.

Negative moderate correlations were found between the EAT and MAAS ($r = -0.55$) and the EAT and KIMS ($r = -0.51$), suggesting that as symptoms of anorexia increased, mindfulness and body experience decreased. Findings were mixed for the four skills comprising the KIMS: A low negative correlation was found with the observe skill ($r = -0.03$), and no probability was reported; and moderate negative correlations were calculated with the describe skill ($r = -0.37$), the act with awareness skill ($r = -0.42$), and the accept without judgment skill ($r = -0.51$).

As predicted, a moderate negative correlation was found between the EAT and positive affect ($r = -0.50$) and a moderate positive correlation was calculated with negative affect ($r = 0.56$). Therefore, as scores in anorexia increased, positive affect decreased and negative affect increased. A moderate negative correlation was also calculated between the EAT and SLS ($r = -0.50$), suggesting as symptoms of anorexia increased, life satisfaction decreased.

Bulimia Nervosa. Pearson Product Correlations were calculated between the EQ-R, which measured degree of bulimia, and tests measuring body-image disturbance, mindfulness, affect, and life satisfaction ($p < 0.01$). Moderate, positive correlations were calculated comparing the EQ-R and BIAQ ($r = 0.43$) and for three of its four factors, clothing ($r = 0.34$), social situations ($r = 0.39$), and eating restraint ($r = 0.38$). A low positive correlation was calculated between the EQ-R and the BIAQ's fourth factor, grooming and weighing ($r = 0.21$), $p < 0.05$. Moderate positive correlations were further determined between the EQ-R and body-checking behaviors: A correlation of $r = 0.39$ was found between the EQ-R and BCQ, and its scales, including, the OAS ($r = 0.32$), the BPS ($r = 0.42$), and IC ($r = 0.36$), indicating as symptoms of bulimia increased body-checking behaviors increased.

A moderate negative correlation was determined between the EQ-R and MAAS ($r = -0.41$) and between the EQ-R and KIMS ($r = -0.33$). However, correlations between the EQ-R and KIMS' four skills varied. A low negative correlation ($r = -0.31$) with no probability was found between the EQ-R and observe skill. Low negative correlations were additionally found between the EQ-R and describe skill ($r = -0.23$) and act with awareness skill ($r = -0.28$), but a moderate negative correlation was determined between the EQ-R and accept without judgment skill ($r = -0.32$).

Furthermore, a negative moderate correlation was calculated between the EQ-R and PAS ($r = -0.40$), while a moderate positive correlation was determined with the NAS ($r = 0.44$). The opposite was true for the lower-symptomatology group in that there was a positive correlation with positive affect and a negative correlation with negative affect. Finally, a negative, moderate correlation was calculated between the EQ-R and SLS ($r = -0.36$), indicating that as symptoms of bulimia increased, overall well-being and life satisfaction decreased.

Discussion

As hypothesized, the findings reveal that individuals with eating disorders are more likely to have more severe body-image disturbance, are less likely to exhibit and practice mindfulness, demonstrate more negative than positive affect, and generally report less overall well-being and life satisfaction. Individuals with anorexia and higher-symptomatology bulimia engage in significantly more body-avoidance and body-checking behaviors, indicative of more severe body-image disturbance, greater body-dissatisfaction, and an obsessive preoccupation with weight, appearance, and eating, which, in turn, fuels the harmful eating behaviors (e.g., fasting, restricting foods, binge-eating and purging) and body-image problems. Individuals who are more mindful are less likely to struggle with body-image problems and eating disorders as demonstrated by the finding that participants without anorexia scored higher than those with anorexia on the MAAS and KIMS.

Individuals with anorexia and higher-symptomatology bulimia are less likely to describe and manage the thoughts, feelings, and sensations involved in eating, are more likely to make judgments about food, eating, and the body, and may make potentially harmful decisions such as deciding to vomit after eating because the food will turn into fat, or so they think, thereby complicating what is an otherwise normal, everyday process, eating. Individuals with anorexia or higher-symptomatology bulimia appear less mindful, if at all, and are generally less aware of the present state, their emotions, and their subjective physical experiences. They may react and display little if any forethought, and are generally less aware of how their reactions affect others, sometimes making hasty decisions that often result in harmful behaviors to self (e.g., purging, fasting) or others (e.g., talking about how disgusting fat is around people who are overweight). Thus, communication may be hampered by the lack of mindfulness, over-reactivity, and cognitive impulsiveness.

It is unclear, though, whether individuals with anorexia and higher-symptomatology bulimia are unable to practice mindfulness - in part, due to a lack of experience - or if they, consciously or unconsciously, choose not to be mindful; possibly because being alert to their present state reminds them of their weight and body shape. To individuals with anorexia or severe bulimia, mindfulness may be associated with weight and shape to such an extent that being mindful equals feeling fat. They may focus on their "fatness," regardless of whether or not they are overweight, and their subjective physical imperfections, unable to consciously separate the act of being mindful from their obsessive preoccupation with weight and shape. This leads to two questions. Are individuals with anorexia and higher-symptomatology bulimia incapable of being mindful due to the very nature of their preoccupation with weight, appearance, and food, and does this mean that reducing or eliminating the preoccupation, would open the door for mindfulness? Or, do they willfully choose not to attend to the present in order to avoid the "fat feelings"? The inability to answer these two questions represents one limitation of this study as there can be no conclusion as to whether the lack of mindfulness in participants with anorexia and higher-symptomatology bulimia is due to a lack of learning, negative reinforcement, cognitive impairments, or willful choice.

They may have also learned to not be mindful but to be self-critical and self-judgmental through repetition and negative reinforcement. This may relate to their tendency toward having perfectionist standards for themselves, which they may have learned through negative reinforcement; for example, being told by parents or teachers when younger that 90% on a test is not "good enough," but that they must earn 100% to be rewarded or praised. The resulting feeling may be shame or embarrassment, as they are labeled or label themselves a "bad student" or "stupid," and even fear if punishment has been administered. Perfectionism becomes a necessary evil, and mindfulness may become a perceived threat.

One may argue individuals with anorexia and higher-symptomatology bulimia simply have not learned how to be mindful, and thus, it is an impairment in that it has not yet been learned. Just as children learn by watching their parents modeling behaviors, from simple chores such as ironing to complex behaviors such as learning language, mindfulness may be conceptualized in much the same way. Mindfulness can be learned behaviorally, as in the case of an individual who learns how to engage in meditation or yoga from watching their parents or an instructor, and cognitively as well, for example, when two parents have a disagreement and practice mindful communication in the form of active listening, reflecting, and acknowledging the thoughts, feelings, and sensations that the argument brings up. Participants with anorexia and higher-symptomatology bulimia may have never learned how to be mindful, which is not necessarily indicative of an impairment. It merely suggests they need to be taught mindfulness, beginning with the skills of mindfulness - observing, describing, acting with awareness, and accepting without judgment - as a part of treatment.

Another possibility is that neurologically individuals with anorexia or higher-symptomatology bulimia are so damaged from deprivation that they are unable to think clearly, focus on the here and now, and make a conscious decision to be or not to be mindful. Cognitive impairments may result from neurological damage to any of the four lobes, but in particular, the frontal lobe, which is responsible for executive functioning, decision-making, and processing. There may be a loss of neurons or neuronal pathways from the starvation, thereby slowing the entire cognitive process. This is suggestive of previous research which demonstrates that cognitive processing slows with starvation, regardless if the starvation is willful or is a byproduct of a disease (e.g., cancer) or a manmade tragedy (e.g., the holocaust). Cognitive impairments may result from the slowing of the central nervous system brought on by neuronal degeneration, as neurons lose their myelin sheath (fat) that covers the axons and aids in speed of processing. In a constant state of starvation, the body takes the fat from wherever it is - including organs and nerve cells - to use as energy for basic bodily functions such as maintaining a heart beat. Neuronal processing becomes secondary and slows down without the myelin sheath, causing cognitive impairments.

In contrast, it is possible that mindfulness, and lack thereof, is a choice; that someone with anorexia or higher-symptomatology bulimia makes a choice not to pay attention or be aware of internal and external phenomena because of what mindfulness represents. As stated, paying attention to one's body may be equated with feeling fat, seeing fat (that is not necessarily there), and being fat. This preoccupation with fat and weight is mindfulness and body experience taken to the extreme, or some might classify it as an obsession, which is really not about the body at all. Individuals with anorexia may choose to obsess over their body, which is different from being mindful about the body. Obsessions appear to be real and absolute to the obsessive person, but they are not grounded in reality. Whereas mindfulness is very much about reality and one's experiences - internal and external - in reality. Thus, individuals with anorexia and higher-symptomatology bulimia may choose to obsess and then compulsively act on these choices to maintain the veil of reality and certainty to avoid thinking about the fat.

Therefore, it is proposed that treatment for eating disorders and/or body-image disturbance be multi-dimensional and include the teaching, learning, and practicing of mindfulness skills, alongside cognitive-behavioral therapy, which may include individual, group, and family therapeutic interventions as well as nutritional counseling. Mindfulness should be conceptualized and differentiated from "feeling fat," as some individuals may equate the two. Working with eating disordered individuals to develop an awareness of emotions - beginning with naming and describing them - followed by the safe expression of emotions and emotion management may increase their cognitive awareness, emotional intelligence, and coping skills. An individual with anorexia will often say "I feel fat," (which, as stated, is not a feeling) when upon deeper exploration, they discover it is not about the fat, but about feeling overwhelmed, vulnerable, or anxious. Mindful attention and awareness to emotions may make emotions more manageable and controllable. With control issues being at the core of eating disorders, the statement "I feel fat" creates the illusion that the individual has more control over their life in a world in which so much is out of our control; also a core issue for individuals with sexual and physical trauma. Thus, using mindfulness as a tool of emotion management may lessen control issues, feelings of vulnerability, and create a sense of empowerment.

Finally, this raises the question of whether participants with lower-symptomatology bulimia are more like the non-eating disordered participants or those with higher-symptomatology bulimia. Based on the ANOVA scores, one could conclude that individuals without anorexia, who scored similarly to those with lower-symptomatology bulimia, are more similar cognitively and possibly behaviorally as they engage in significantly fewer body-checking and body-avoidance behaviors, characteristic of body-image disturbance, and display significantly more mindfulness skills in general. Both also demonstrate significantly more positive affect, overall well-being, and life satisfaction. However, a diagnosis of bulimia implies there is some level of preoccupation with food and/or weight, regardless of the level of behavioral acting out, raising the possibility that participants with lower- and higher-symptomatology bulimia are more similar. This raises the possibility that anorexia, compared to bulimia, may be the more pathological and severe of the two eating disorders, and that the ability to be mindful may be more hampered by the physical and psychological effects of deprivation.

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Biography

Jennifer Bruha, Ph.D. was born and raised in the San Francisco bay area, the eldest of two daughters to Don and Janis Bruha. She attended UCLA and earned a Bachelors degree in Psychology, followed by a Masters degree in Counseling Psychology and a Certificate in Chemical Dependency Counseling from Notre Dame de Namur University. She earned a second Masters degree and Doctorate (Ph.D.) in Clinical Psychology from the Institute of Transpersonal Psychology. She has been working as a clinician since 2003 at Our Common Ground adolescent treatment facility and since 2009 at the adult facility, facilitating Drug Education and Relapse Prevention. Her research interests include addiction, eating disorders, and trauma. Contact information: jbruha@sbcglobal.net

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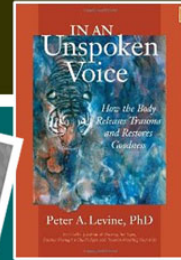
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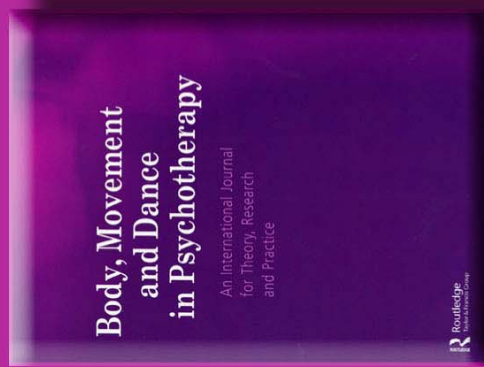
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Title, full authorship, **abstract of about 100 words and 3-5 key words precede the text**. Please include an endnote with author's degrees, training, mailing address, e-mail fax, acknowledgement of research support, etc.

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The editors are eager to receive letters, particularly communications commenting on and debating works already published in the journal, but also suggestions and requests for additional features or departments. They may be sent to the email address below. A selection of those received will be published in the next volume of the journal.

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